

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155535	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 03/15/2016
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NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3550 CENTRAL AVE COLUMBUS, IN 47203
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K 0000 Bldg. 01	<p>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).</p> <p>Survey Date: 03/15/16</p> <p>Facility Number: 000572 Provider Number: 155535 AIM Number: 100267710</p> <p>At this Life Safety Code survey, Willow Crossing Health and Rehabilitation Center 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 16.2.</p> <p>This one story facility was determined to be of Type V (111) construction and was fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and hard wired smoke detectors in all resident sleeping rooms. The facility has a capacity of 80 and had a census of 66 at</p>	K 0000	Submission of this plan of correction does not constitute admission or agreement of the truth of facts alleged or correction set forth on the statement of deficiencies. This plan of correction is prepared and submitted because of requirement under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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K 0025 SS=E Bldg. 01	<p>the time of this survey.</p> <p>All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. The facility has one detached garage used for storage which is not sprinkled.</p> <p>Quality Review completed on 03/18/16 - DA</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5</p> <p>Based on observations and interview, the facility failed to ensure the smoke barrier in 1 of 1 ceiling and 1 of 4 attic smoke barrier walls were constructed to provide at least a one half hour fire resistance rating. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable wire to be protected so the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device</p>	K 0025	K025 requires that smoke barriers shall be constructed to provide at least a one half hour fire resistance rating.1. No residents were harmed.2. All residents have the potential to be harmed, thus the following corrective actions have been taken; 3. As a means to ensure ongoing compliance, the penetrations noted in the kitchen mop room ceiling, laundry room ceiling, boiler room ceiling and service hall smoke barrier wall have been fire stopped with a fire rated sealant.4. As a means of quality assurance, the	03/23/2016

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	<p>designed for the specific purpose. This deficient practice affects 39 residents who use the main dining room located adjacent to the kitchen and 6 residents who use the therapy room located next to the Service Hall smoke barrier wall.</p> <p>Findings include:</p> <p>Based on observations with the administrator and maintenance supervisor on 03/15/16 during a tour of the facility from 9:30 a.m. to 12:10 p.m., the following locations had ceiling penetrations not fire stopped;</p> <ol style="list-style-type: none"> 1. The kitchen mop room ceiling had a one inch gap around a sprinkler pipe low point drain penetration not fire stopped. 2. The laundry room ceiling had a one inch gap around a steel gas pipe penetration not fire stopped. 3. The boiler room ceiling had two, one half inch gaps around steel gas pipe penetrations not fire stopped. 4. The Service Hall smoke barrier wall above the drop ceiling had two, two inch gaps around cable bundles not fire stopped. <p>The kitchen, laundry room, and boiler room ceiling penetrations not fire stopped and the Service Hall smoke barrier wall not fire stopped was verified by the maintenance supervisor at the time of observations and acknowledged by the</p>		<p>Maintenance Director or designee will monitor for penetrations in smoke barriers as part of the preventative maintenance program. The preventative maintenance program will be reviewed during the monthly Quality Assurance meetings with the plan of action adjusted accordingly, if warranted.5. The above corrective actions will be completed on or before March 23, 2016.</p>	

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K 0027 SS=F Bldg. 01	<p>administrator at the exit conference on 03/15/16 at 12:10 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 Based on observation and interview, the facility failed to ensure 2 of 4 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.6 requires that doors in smoke barriers shall comply with LSC, Section 8.3.4. LSC, Section 8.3.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affects all residents in the facility.</p> <p>Findings include:</p> <p>Based on observations on 03/15/16</p>	K 0027	<p>K027 requires door openings in smoke barriers to have at least a 20-minute fire protection rating.1. No residents were harmed.2. All residents have the potential to be affected; thus the following corrective actions have been taken, 3. As a means to ensure ongoing compliance, the 100 Hall and 200 Hall smoke barrier doors have been repaired to allow for proper closure.4. As a means of quality assurance, the Maintenance Director or designee will monitor fire doors for proper closure as part of the preventative maintenance program. The preventative maintenance program will be reviewed during the monthly Quality Assurance meetings with the plan of action adjusted accordingly, if</p>	04/14/2016

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K 0029 SS=E Bldg. 01	<p>during a tour of the facility from 9:30 a.m. to 12:10 p.m. with the administrator and maintenance supervisor, the 100 Hall set of smoke barrier doors had a two inch gap along the center where the doors came together in the closed position and the 200 Hall set of smoke barrier doors had a three inch gap along the center where the doors came together in the closed position. This was verified by the administrator and maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 03/15/16 at 12:10 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 the corridor door to 1 of 4 hazardous areas, such as a combustibile storage room over 100 square feet, was provided with a self closing device which would cause the</p>	K 0029	<p>warranted.5. The above corrective actions will be completed on or before April 14, 2016.</p> <p>K029 requires that one hour fire rated construction or an approved automatic fire extinguishing ssytem protects hazardous areas.1. No residents were harmed.2. All residents have the potential to be affected; thus the</p>	03/23/2016

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K 0052 SS=F Bldg. 01	<p>door to automatically close and latch into the door frame. This deficient practice could affect 6 residents who use the physical therapy room.</p> <p>Findings include:</p> <p>Based on observation on 03/15/16 at 11:10 a.m. with the administrator and maintenance supervisor, the physical therapy storage room, which measured one hundred ten square feet and had six shelves of combustible cardboard boxes of plastic therapy supplies, had a door lacking a self closing device. This was verified by the administrator and maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 03/15/16 at 12:10 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, Based on record review and interview, the facility failed to ensure 75 of 75</p>	K 0052	<p>following corrective actions have been taken, 3. As a means to ensure ongoing compliance, an automatic closing device was installed on the physical therapy storage room.4. As a means of quality assurance, the Maintenance Director or desinee will ensure automatic closures are installed, if necessary, and monitored as part of the preventative maintenance program. The preventative maintenance program will be reviewed during the monthly Quality Assurance meeting with the plan of action adjusted accordingly, if warranted.5. The above corrective action will be completed on or before March 23, 2016.</p> <p>K052 requires that the fire alarm system required for life safety shall be tested and maintained. 1.</p>	03/15/2016			

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	<p>smoke detectors were tested for sensitivity every two years in accordance with the applicable requirements of NFPA 72, National Fire Alarm Code. NFPA 72, at 7-3.2.1 states, "Detector sensitivity shall be checked within one year after installation and every alternative year thereafter. After the second required calibration test, if sensitivity tests indicate the detectors have remained within their listed and marked sensitivity ranges, the length of time between calibration tests may be extended to a maximum of five years. If the frequency is extended, records of detector caused nuisance alarms shall be maintained. In zones or areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed. To ensure each smoke detector is within its listed and marked sensitivity range it shall be tested using the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method. (2) Manufacturer's calibrated sensitivity test instrument. (3) Listed control equipment arranged for the purpose. (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its acceptable sensitivity range. (5) Other calibrated sensitivity test 		<p>No residents were harmed. 2. All residents have the potential to be affected; thus the following corrective actions have been taken, 3. As a means to ensure ongoing compliance, a sensitivity test was completed on 75 smoke detectors on March 15, 2016. 4. As a means of quality assurance, the Maintenance Director or designee will ensure the sensitivity test is completed per the two year requirement and monitored as part of the preventative maintenance program. The preventative maintenance program will be reviewed during the monthly Quality Assurance meeting with the plan of action adjusted accordingly, if warranted. 5. The above corrective actions will be completed on or before March 15, 2016.</p>	

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	<p>method acceptable to the authority having jurisdiction.</p> <p>Detectors found to have sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or replaced.</p> <p>The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of aerosol into the detector. NFPA 72, 7-5.2 requires inspection, testing and maintenance reports be provided for the owner or a designated representative. It shall be the responsibility of the owner to maintain these records for the life of the system and to keep them available for examination by the authority having jurisdiction.</p> <p>This deficient practice affects all residents, staff and all visitors in the facility.</p> <p>Findings include:</p> <p>Based on record review on 03/15/16 at 9:45 a.m. with the maintenance supervisor, the most current smoke detector sensitivity test report available for review for seventy five smoke detectors located throughout the facility was dated 08/21/12, which was a period exceeding the two year requirement.</p> <p>Furthermore, there were no other records available for review to indicate a current</p>			

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K 0062 SS=E Bldg. 01	<p>two year Sensitivity test was conducted on the seventy five smoke detectors located in the facility. This was verified by the maintenance supervisor at the time of record review and acknowledged by the administrator at the exit conference on 03/15/16 at 12:10 p.m.</p> <p>3.1-19(b)</p> <p>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</p> <p>1. Based on observation and interview, the facility failed to replace 1 of over 300 sprinklers in the facility covered in corrosion. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected, tested and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 1998 edition, 2-2.1.1 requires any sprinkler shall be replaced which is painted, corroded, damaged, loaded, or in the improper orientation. This deficient practice could affect 32 residents who reside on the 200 Hall.</p> <p>Findings include:</p>	K 0062	<p>K062 requires automatic sprinkler systems to be continuously maintained in reliable operating condition and inspected and tested periodically. 1. No residents were harmed. 2. All residents have the potential to be affected; thus the following corrective actions have been taken, 3. As a means to ensure ongoing compliance, the sprinkler head in the 200 Hall mechanical room was replaced. Additionally, escutcheons were added to the sprinkler heads in resident room 205 and the kitchen mop sink room. 4. As a means of quality assurance, the Maintenance Director or designee will monitor sprinkler heads to signs of paint, corrosion, damage, loading and improper orientation as part of the preventative maintenance</p>	04/14/2016			

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	<p>Based on observation on 03/15/16 at 10:45 a.m. with the administrator and maintenance supervisor, the 200 Hall mechanical room sprinkler was completely covered in green corrosion. This was verified by the administrator and maintenance supervisor at the time of observation and acknowledged by the administrator at the exit conference on 03/15/16 at 12:10 p.m.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of over 300 sprinkler heads in the facility were maintained. This deficient practice could affect 2 residents who reside in room 205.</p> <p>Findings include:</p> <p>Based on observations on 03/15/16 during a tour of the facility from 9:30 a.m. to 12:10 p.m. with the administrator and maintenance supervisor, resident room 205 and the kitchen mop sink room each lacked the sprinkler escutcheons. This was verified by the administrator and maintenance supervisor at the time of observations and acknowledged by the administrator at the exit conference on 03/15/16 at 12:10 p.m.</p>		<p>program. Additionally, the Maintenance Director or designee will monitor for appropriate placement of escutcheons as part of the preventative maintenance program. The preventative maintenance program will be reviewed during the monthly Quality Assurance meeting with the plan of action adjusted accordingly, if warranted. 5. The above corrective actions will be completed on or before April 14, 2016.</p>	

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K 0074 SS=E Bldg. 01	<p>3.1-19(b)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13</p> <p>o Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2.</p> <p>o Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3</p> <p>o Newly introduced upholstered furniture and mattresses means purchased since March, 2003.</p> <p>Based on observation and interview, the facility failed to ensure window curtains in 7 of 44 resident rooms were flame retardant. This deficient practice could affect 14 residents who reside in resident rooms 211, 215, 218, 101, 102, 103 and 104.</p> <p>Findings include:</p>	K 0074	K074 requires that draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant. 1. No residents were harmed. 2. All residents have the potential to be affected; thus the following corrective actions have been taken, 3. As a means to ensure ongoing	03/24/2016

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K 0130 SS=E Bldg. 01	<p>Based on observations with the administrator and maintenance supervisor on 03/15/16 during a tour of the facility from 9:30 a.m. to 12:10 p.m., resident room 211, 215, 218, 101, 102, 103, and 104 each had a set of window curtains and lacked attached documentation they were inherently flame retardant. Based on interview at the time of observations with the maintenance supervisor, there was no documentation regarding flame retardant window curtains for resident rooms 211, 215, 218, 101, 102, 103 and 104. This was acknowledged by the administrator at the exit conference on 03/15/16 at 12:10 p.m.</p> <p>3.1-19(b)</p> <p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786</p> <p>Based on observation, interview and record review, the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. LSC 4.5.7 requires any device, equipment or system which is required for compliance with the provisions of this Code, such device, equipment or system shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80, 1999 Edition, the Standard for Fire</p>	K 0130	<p>compliance, the window curtains in resident rooms 211, 215, 218, 101, 102, 103 and 104 have been treated with a flame retardant spray. An audit was conducted to ensure any other window curtains in the facility had been properly treated with fire retardant spray.</p> <p>4. As a means of quality assurance, the Maintenance Director or designee will maintain a log indicating that window curtains have been treated with a fire retardant spray, as warranted, as part of the preventative maintenance program. The preventative maintenance program will be reviewed during the monthly Quality Assurance meeting with the plan of action adjusted, if warranted. 5. The above corrective actions will be completed on or before March 24, 2016</p> <p>K130 Miscellaneous 1. No residents were harmed. 2. All residents who utilize the Dining Room have the potential to be affected; thus the following corrective actions have been taken, 3. As a means to ensure ongoing compliance, the rolling fire door was inspected to ensure proper operation and full closure. 4. As a means of quality assurance, the Maintenance Director or designee will ensure the rolling fire door is inspected</p>	04/14/2016

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NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3550 CENTRAL AVE COLUMBUS, IN 47203
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(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
	<p>Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect 39 residents who use the main dining room, which is located adjacent to the kitchen.</p> <p>Findings include:</p> <p>Based on observation on 03/15/16 at 9:45 a.m. with the administrator and maintenance supervisor, there was a rolling fire door protecting the opening from the kitchen to the main dining room without an attached inspection tag. Based on interview at the time of observation, the maintenance supervisor verified there was no documentation of an annual inspection or test conducted on the rolling kitchen fire door to check for proper operation and full closure of the vertical rolling fire door. This was acknowledged by the administrator at the exit conference on 03/15/16 at 12:10 p.m.</p> <p>3.1-19(b)</p>		<p>annually to ensure proper operation and full closure as part of the preventative maintenance program. The preventative maintenance program will be reviewed during the monthly Quality Assurance meeting with the plan of action adjusted accordingly, if warranted. 5. The above corrective actions will be completed on or before April 14, 2016.</p>	

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K 0143 SS=E Bldg. 01	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association.</p> <p>8-6.2.5.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer location was provided with mechanical ventilation. This deficient practice could affect 29 residents who reside on 200 Hall.</p> <p>Findings include:</p> <p>Based on observation with the administrator and maintenance on 03/15/16 at 11:00 a.m., the 200 Hall liquid oxygen storage room, where six full liquid oxygen containers were stored, had a ceiling fan located in the center of the ceiling. Furthermore, the ceiling fan</p>	K 0143	K143 requires that the transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring 1. No residents were harmed. 2. All residents had the potential to be affected; thus the following corrective actions have been taken, 3. As a means to ensure ongoing compliance, the fan assembly was replaced to ensure proper mechanical ventilation. 4. As a means of quality assurance, the Maintenance Director or designee will monitor the function of the fan as part of the preventative maintenance program. The preventative maintenance	04/14/2016
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NAME OF PROVIDER OR SUPPLIER WILLOW CROSSING HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3550 CENTRAL AVE COLUMBUS, IN 47203		
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	was not operational. Based on an interview with the administrator on 03/15/16 at 11:10 a.m., the liquid oxygen storage room is used for the storage of liquid oxygen and used as a transferring location by the nursing staff. The liquid oxygen storage room ceiling fan not operational was verified by the maintenance supervisor and administrator at the time of observation and acknowledged by the administrator at the exit conference on 03/15/16 at 12:10 p.m. 3.1-19(b)		program will be reviewed during the monthly Quality Assurance meeting with the plan of action adjusted accordingly, if warranted. 5. The above corrective actions will be completed on or before April 14, 2016.		