STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155522	A. BUILDING -- B. WING	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ELWOOD HEALTH AND LIVING	2300 PARKVIEW LN ELWOOD, IN 46036

(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: 05/24/23 Facility Number: 000372 Provider Number: 155522 AIM Number: 100289060 At this Emergency Preparedness survey, Elwood Health and Living was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 92 and had a census of 58 at the time of this survey. Quality Review completed on 05/31/23	E 0000		
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: 05/24/2023 Facility Number: 000372 Provider Number: 155522 AIM Number: 100289060 At this Life Safety Code survey, Elwood Health and Living was found not in compliance with Requirements for Participation in	K 0000	Submission of this plan of correction shall not constitute or be construed as an admission by Elwood Health and Living that the allegations in the survey report are accurate or reflect accurately the provisions of care and services to the residents at Elwood Health and Living. The facility requests the following plan of correction be considered its allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Penny R Broshar	Administrator	06/07/2023

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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	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 one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and battery operated smoke detectors in the resident sleeping rooms. The facility has a capacity of 92 and had a census of 58 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 05/31/23			
K 0291 SS=F 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 and interview, the facility failed to ensure 1 of 1 battery backup emergency light was tested annually for 90 minutes. 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, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having	K 0291	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All residents had the potential to be affected by this deficient practice. A form labeled “Annual Battery-Operated Emergency Light Test Form” was created to	06/28/2023

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	jurisdiction. This deficient practice could affect all residents in the facility. Findings include: Based on records review with the Maintenance Director on 05/24/23 at 10:45 a.m., annual testing for the battery backup emergency lights was unavailable. Based on an interview at the time of records review, the Maintenance Director stated the annual 90 minute testing for the battery backup emergency light has not been conducted in the past 12 months. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)		ensure that the 90 minute testing for the battery backup emergency light is completed annually. Currently, the test is completed in the Maintenance Directors TELS, however, it does not indicate the duration or date of completion. The new form will capture the location of where the test is performed, the start time, stop time, duration of test and date of test. This test was completed on 5/25/23. The Administrator or designee will audit for compliance one time monthly when ensuring the 30 second test is completed. Audit will also ensure that the 90 minute testing for the battery backup emergency light is completed annually. Will add to QAPI to ensure compliance for one year. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents had the potential to be affected by this deficient practice. A form labeled “Annual Battery-Operated Emergency Light Test Form” was created to ensure that the 90 minute testing for the battery backup emergency light is completed annually. Currently, the test is completed in the Maintenance Directors TELS, however, it does not indicate the duration or date of completion. The new form will capture the location	

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			of where the test is performed, the start time, stop time, duration of test and date of test. The Administrator or designee will audit for compliance one time monthly when ensuring the 30 second test is completed. Audit will also ensure that the 90 minute testing for the battery backup emergency light is completed annually. Will add to QAPI to ensure compliance for one year. **What measures will be put into place and what systemic change will be made to ensure that the deficient practice does not recur?** A form labeled “Annual Battery-Operated Emergency Light Test Form” was created to ensure that the 90 minute testing for the battery backup emergency light is completed annually. Currently, the test is completed in the Maintenance Directors TELS, however, it does not indicate the duration or date of completion. The new form will capture the location of where the test is performed, the start time, stop time, duration of test and date of test. The Administrator or designee will audit for compliance one time monthly when ensuring the 30 second test is completed. Audit will also ensure that the 90 minute testing for the battery backup emergency light is completed annually. Will add to QAPI to	

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			ensure compliance for one year. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE what quality assurance program will be put into place?** Administrator or designee will report to the Quarterly QAPI meetings an will report on compliance with audit for completion of 90 minute annual test for emergency lighting. Once one year of 100% compliance is reached, QAPI Committee may discuss the discontinuation of this audit.	
K 0363 SS=D 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			

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	doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of 1 resident room corridor doors was 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 1 resident in room 112. Findings include: Based on observation with the Maintenance Director on 05/24/23 at 1:20 p.m., the corridor door to resident room 112 would not close into the frame when tested. Based on interview at the time of observation, the Maintenance Director agreed the corridor door would not close into the door frame because the bed was obstructing the	K 0363	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** One resident room was affected by this deficient practice. The resident's bed was adjusted so that the door was able to properly latch. An audit of all rooms has been completed to ensure no beds impede the closure of resident room door. The Administrator or designee will audit all resident rooms 1 times weekly to ensure	06/28/2023

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	opening. The finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		that all doors latch properly. Once 100% compliance has been reached for 4 weeks, then audit will decrease to monthly. Administrator or designed will audit all resident rooms to ensure that door latches once a month for 3 months or until 100% compliance is reached. Once 100% compliance is reached for one quarter, Administrator or designee will report to QAPI for possible discontinuation of audit at this time. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All resident room, with the exception of private rooms or rehab suites, have to potential to be affected by this deficient practice. All resident beds placed in double occupancy rooms will measure no more than 88 ½ inches to ensure door closure. The Administrator or designee will audit all resident rooms 1 times weekly to ensure that all doors latch properly. Once 100% compliance has been reached for 4 weeks, then audit will decrease to monthly. Administrator or designed will audit all resident rooms to ensure that door latches once a month for 3 months or until 100% compliance is reached. Once 100% compliance is	

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			reached for one quarter, Administrator or designee will report to QAPI for possible discontinuation of audit at this time. **What measures will be put into place and what systemic change will be made to ensure that the deficient practice does not recur?** All resident beds placed in double occupancy rooms will measure no more than 88 ½ inches if they are placed on the side of the room with the door to ensure that the door latched properly. Any resident requiring a bed longer than 88 ½ inches will be placed on the window side of a double occupancy room. The Administrator or designee will audit all resident rooms 1 times weekly to ensure that all doors latch properly. Once 100% compliance has been reached for 4 weeks, then audit will decrease to monthly. Administrator or designed will audit all resident rooms to ensure that door latches once a month for 3 months or until 100% compliance is reached. Once 100% compliance is reached for one quarter, Administrator or designee will report to QAPI for possible discontinuation of audit at this time.	

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			How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE what quality assurance program will be put into place? Administrator or designee will report to Quarterly QAPI results of audits. Once 100% compliance has been reached for one quarter, QAPI Committee may discuss potential for discontinuation of this audit at that time.	
K 0511 SS=D Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 ground fault circuit interrupter (GFCI) was properly maintained for protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8. This deficient practice could affect 1 resident in 300 Hall shower room. Findings include: Based on observation with the Maintenance Director on 05/24/23 at 1:20 p.m., when the GFCI	K 0511	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** One resident had the potential to be affected by this deficient practice. An electrician was called and repair is scheduled for 6-15-23 and will be repaired. Maintenance Director checked all GFI's in facility for good working order. Maintenance Director or designee will check all GFI's one	06/28/2023

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	electric receptacle in the 300 Hall shower room was tested with a GFCI tester the GFCI receptacle failed to trip and did not break the electrical circuit. Based on interview at the time of observation, the Maintenance Director agreed the GFCI electric receptacle did not properly work when tested. The finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		time monthly for three months to ensure they remain in good working order. Maintenance Director or designee will report to Quarterly QAPI with results of audit. Once one quarter of 100% compliance has been reached, QAPI committee may discuss the discontinuation of this audit. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents residing on the 300 hall had the potential to be affected by this deficient practice. An electrician was called and repair is scheduled for 6-15-23 and will be repaired. Maintenance Director checked all GFI's in facility for good working order. Maintenance Director or designee will check all GFI's one time monthly for three months to ensure they remain in good working order. Maintenance Director or designee will report to Quarterly QAPI with results of audit. Once one quarter of 100% compliance has been reached, QAPI committee may discuss the discontinuation of this audit. **What measures will be put into place and what systemic change will be made to ensure that the deficient practice does not recur?** Maintenance Director will add an	

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			annual audit to TELS report to check all GFI's in the facility to ensure proper function. Maintenance Director checked all GFI's in facility for good working order. Maintenance Director or designee will check all GFI's one time monthly for three months to ensure they remain in good working order. Maintenance Director or designee will report to Quarterly QAPI with results of audit. Once one quarter of 100% compliance has been reached, QAPI committee may discuss the discontinuation of this audit. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE what quality assurance program will be put into place?** Maintenance Director checked all GFI's in facility for good working order. Maintenance Director or designee will check all GFI's one time monthly for three months to ensure they remain in good working order. Maintenance Director or designee will report to Quarterly QAPI with results of audit. Once one quarter of 100% compliance has been reached, QAPI committee may discuss the discontinuation of this audit.	
K 0761 SS=F Bldg. 01				

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	Based on records review and interview, the facility failed to ensure annual inspection and testing of fire door assemblies were completed in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80 5.2.1 states fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. NFPA 80, 5.2.3.1 states functional testing of fire door and window assemblies shall be performed by individuals with knowledge and understanding of the operating components of the type of door being sbject to testing, NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7. (6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or	K 0761	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Fire Door Inspection: All residents had the potential to be affected by this deficient practice. Facility Maintenance Director completed Online Training for Inspection, Testing and Maintenance of Swinging Fire Door Assemblies on 6/5/23. Maintenance Director completed a fire door inspection of all fire doors on 6/6/23. The Administrator or designee will audit Maintenance Log for the completion of Fire Door inspection. Results of this audit will be take to Quarterly QAPI and reviewed for one year to ensure that fire door inspection is completed. After one year of compliance, Administrator or designee will discuss in Quarterly QAPI for discontinuation of audit. Rolling Fire Door in Dining Room: During the inspection, the Maintenance Director and the Administrator were not certain of the last inspection of the rolling door (Serve out) in the main dining room. Upon further investigation, it was noted that this door was not a rolling fire door and would not require a tag. Attached (exhibit A) shows that the main dining room is separated with a 2 hour rated	06/28/2023

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	frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents. Findings include: Based on record review with the Maintenance Director (MD) on 05/24/23 at 11:45 a.m., documentation of an annual inspection for the fire door assemblies was not available for review. Based on interview at the time of records review, the MD stated he was not qualified to do a fire door inspection and an inspection has not been completed in the last year. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b) Based on observation and interview, the facility failed to maintain annual testing of 1 of 1 rolling fire door in accordance with NFPA 80. LSC 4.5.8 requires any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provision of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance. NFPA 80 5.2.1 requires fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. This deficient practice could affect 25 residents in the main dining room.		fire barrier wall. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** Fire Door Inspection All residents had the potential to be affected by this deficient practice. Facility Maintenance Director completed Online Training for Inspection, Testing and Maintenance of Swinging Fire Door Assemblies on 6/5/23. Maintenance Director completed a fire door inspection of all fire doors on 6/6/23. The Administrator or designee will audit Maintenance Log for the completion of Fire Door inspection. Results of this audit will be taken to Quarterly QAPI and reviewed for one year to ensure that fire door inspection is completed. After one year of compliance, Administrator or designee will discuss in Quarterly QAPI for discontinuation of audit. Rolling Fire Door in Dining Room: During the inspection, the Maintenance Director and the Administrator were not certain of the last inspection of the rolling door (Serve out) in the main dining room. Upon further investigation, it was noted that this door was not a rolling fire door and would not require a tag. Attached (exhibit A) shows that the main dining room	

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(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
	Findings include: Based on observation with the Maintenance Director on 05/24/23 at 12:00 p.m., there was a rolling fire door/window between the kitchen and dining room. There was no tag on the rolling fire door to indicate when the last annual test was performed and no documentation was provided. Based on interview at the time of observation, the Maintenance Director stated the rolling fire door had an inspection tag on it but it was no longer there. The finding was reviewed with the Administrator during the exit conference. 3.1-19(b)		is separated with a 2 hour rated fire barrier wall. **What measures will be put into place and what systemic change will be made to ensure that the deficient practice does not recur?** Fire Door Inspection: Facility Maintenance Director completed Online Training for Inspection, Testing and Maintenance of Swinging Fire Door Assemblies on 6/5/23. Maintenance Director completed a fire door inspection of all fire doors on 6/6/23. Facility will ensure that any future Maintenance Directors complete training for Inspection, Testing and Maintenance of Swinging Fire Door Assemblies. The Administrator or designee will audit Maintenance Log for the completion of Fire Door inspection. Results of this audit will be taken to Quarterly QAPI and reviewed for one year to ensure that fire door inspection is completed. After one year of compliance, Administrator or designee will discuss in Quarterly QAPI for discontinuation of audit. Rolling Fire Door in Dining Room: During the inspection, the Maintenance Director and the Administrator were not certain of the last inspection of the rolling door (Serve out) in the main dining room. Upon further investigation, it was noted that this door was not a	

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	155522	A. BUILDING 01 B. WING	05/24/2023

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			rolling fire door and would not require a tag. Attached (exhibit A) shows that the main dining room is separated with a 2 hour rated fire barrier wall. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE what quality assurance program will be put into place?** The Administrator or designee will audit Maintenance Log for the completion of Fire Door inspection. Results of this audit will be taken to Quarterly QAPI and reviewed for one year to ensure that fire door inspection is completed. After one year of compliance, Administrator or designee will discuss in Quarterly QAPI for discontinuation of audit.	
K 0920 SS=D 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			

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	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 Based on observation and interview, the facility failed to ensure 1 of 1 power strip was not used as a substitute for fixed wiring to provide power equipment with a high current draw. 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 in 200 nurses station. Findings include: Based on observations during a tour of the facility with the Maintenance Director and Administrator on 05/24/23 at 1:00 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in the 200 Nurses Station. Based on interview at the time of observation, the Maintenance Director acknowledged a power strip was supplying power to high power draw equipment. The power strip was removed at the time of discovery. This finding was reviewed with the Administrator at the exit conference. 3.1-19(b)	K 0920	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All resident's on the 200 hall had the potential to be affected by this deficient practice. Power strip was removed and mini fridge was plugged into wall power source immediately at time of discovery. Maintenance Director or designee will audit facility one time weekly for power strips that are not permitted for the use of high current draw. Audit will continue for 2 weeks or until 100% compliance is reached. Audit will then reduce to 1 time monthly for 1 quarter or until 100% compliance is reached. Results of audit will be discussed at Quarterly QAPI. This audit will be added to facility TELS and will continue indefinitely **How other residents having the**	06/28/2023

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			potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All resident's on the 200 hall had the potential to be affected by this deficient practice. Power strip was removed and mini fridge was plugged into wall power source immediately at time of discovery. Maintenance Director or designee will audit facility one time weekly for power strips that are not permitted for the use of high current draw. Audit will continue for 2 weeks or until 100% compliance is reached. Audit will then reduce to 1 time monthly for 1 quarter or until 100% compliance is reached. Results of audit will be discussed at Quarterly QAPI. This audit will be added to facility TELS to review quarterly and will continue indefinitely. **What measures will be put into place and what systemic change will be made to ensure that the deficient practice does not recur?** All Staff will be educated on the facility policy for appropriate use of power strips at All Staff inservice on 6/27/23. Facility will continue to enforce policy. Maintenance Director will add monthly rounding in facility to TELS to check for power strips being used for high current draw	

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			equipment. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE what quality assurance program will be put into place?** Administrator or designee will audit weekly TELS for compliance for one quarter. Findings will be discussed at Quarterly QAPI. Once compliance has been reached for one quarter, QAPI committee may discuss in QAPI for discontinuation of this audit.	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview the facility failed to ensure 1 of 1 oxygen transfilling room met the requirements of NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.5.2.3.1 requires transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers to include the following:	K 0927	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Ten residents had the potential to	06/28/2023

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	(1) A designated area separated from any portion of the facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistant construction. (2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring. (3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted. (4) The individual transfilling the container(s) has been properly trained in the transfilling procedures. This deficient practice could affect 10 residents in the area. Findings include: Based on observation during a tour of the facility with the Administrator and Maintenance Director on 05/24/23 at 1:05 pm, the oxygen transfilling room door was found to have a 1/2 hour fire-rating. The room lacked separation by a fire barrier of 1 hour fire-resistive construction in that the door was not at least a 45-minute fire-rated self-closing door. Based on interview the Maintenance Director agreed the oxygen transfilling room door has a 1/2 hour fire rating. The finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		be affected by this deficient practice. Current fire door is only 30 minute fire rated. Door will be replaced by a fire door that is at least 45 minutes fire rated on 6/8/23. Maintenance Director or designee has completed a fire door inspection. All doors are rated appropriately at this time. Maintenance Director or designee will bring results of this audit to Quarterly QAPI to review for compliance. Once one quarter of compliance has been reached, QAPI committee may discuss the discontinuation of this audit. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents had the potential to be affected by this deficient practice. Current fire door is only 30 minute fire rated. Door will be replaced by a fire door that is at least 45 minutes fire rated on 6/8/23. Maintenance Director or designee has completed a fire door inspection. All doors are rated appropriately at this time. Maintenance Director or designee will bring results of this audit to Quarterly QAPI to review for compliance. Once one quarter of compliance has been reached, QAPI committee may discuss the discontinuation of this audit. **What measures will be put into**	

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			place and what systemic change will be made to ensure that the deficient practice does not recur? Facility Maintenance Director completed Online Training for Inspection, Testing and Maintenance of Swinging Fire Door Assemblies on 6/5/23. When Maintenance Director completes his annual fire door inspection, he will also ensure that the correct fire rating in on fire doors. Maintenance Director or designee will bring results of this audit to Quarterly QAPI to review for compliance. Once one quarter of compliance has been reached, QAPI committee may discuss the discontinuation of this audit. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, IE what quality assurance program will be put into place?** The Administrator or designee will audit Maintenance Log for the completion of Fire Door Inspection and rating. Once one quarter of compliance has been reached, QAPI committee may discus the discontinuation of this audit.	