STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155766	A. BUILDING -- B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

(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: 01/30/25 Facility Number: 000563 Provider Number: 155766 AIM Number: 100267610 At this Emergency Preparedness survey, Maple Manor Christian Home Inc. was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 57 certified beds. At the time of the survey, the census was 51. Quality Review conducted on 01/31/25	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: 01/30/25 Facility Number: 000563 Provider Number: 155766 AIM Number: 100267610 At this Life Safety Code survey, Maple Manor	K 0000		

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

Cullen | Istre | 02/21/2025

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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	Christian Home Inc was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type V (111) construction and fully sprinkled. The facility has a fire alarm system with smoke detection on all levels including the basement, the corridors, spaces open to the corridors and has hard wired smoke detectors in resident rooms 300, 301, 302, 303, 304, 305, 306, 307, 308. The facility has battery operated smoke alarms in the remaining resident sleeping rooms. The facility has a capacity of 57 and had a census of 51 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review conducted on 01/31/25			
K 0346 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Out of Service Based on record review and interview, the facility failed to provide a complete written policy for the protection of residents indicating procedures to be followed in the event the fire alarm system has to be placed out of service for four hours or more in a twenty four hour period in accordance with LSC, Section 9.6.1.6. This deficient practice affects all occupants. Findings include:	K 0346	Correct fire policy was in Maple Manor's Policy and Procedures manual, last reviewed September 2024, which includes "while patrolling the building, the employee will have no other responsibilities." This statement was added to the Disaster Plan on 2/10/2025. See attachment "Fire Alarm System"	02/19/2025

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	Based on records review and interview with the Maintenance Supervisor (MS) and Administrator (AD) on 01/30/25 between 10:20 a.m. and 1:07 p.m., the facility provided fire watch plan documentation but the plan did not state that the person(s) conducting the fire watch will have no other duties while conducting the fire watch. Based on interview at the time of record review, the Administrator agreed the fire watch did not indicate that the person(s) conducting the fire watch will have no other duties while conducting the fire watch. This finding was acknowledged by the MS at the time of observation and again at the exit conference with the MS and AD present. 3.1-19(b)		Addendum: The "Fire Alarm System Policy", effective 9/10/2019 and reviewed on 9/10/24, which indicates procedures to be followed in the event the fire alarm service has to be placed out of service for four hours or more, was located in the Maple Manor Policy and Procedure manual but did not coincide with the Disaster Plan manual procedure for fire protection in the event the fire alarm service is out of service. The "Fire Alarm System Policy" did correctly state that "while patrolling the building, the employee will have no other responsibilities." Historically, the Disaster Plan had been maintained and reviewed by the previous Administrator, while the Maple Manor Policy and Procedure manual was maintained and reviewed annually by the QAPI Coordinator. The "Fire Alarm System Policy" (Attachments 1, p. 2) was added to the appropriate section of the Disaster Plan manual on 2/10/25. As a QAPI action, the Disaster Plan will be reviewed and/or revised at least annually by the QAPI coordinator at the same time as the policy review for the Maple Manor Policy and Procedure manual. See attached "Disaster Plan Review Log," (Attachments 1, p. 3) which will be the monitoring system to ensure	

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			that the Disaster Plan manual is reviewed and/or revised annually and meets regulatory requirements. The “Disaster Plan Review Log” was placed in the front of the Disaster Plan manual on 2/19/2025. Each review will be discussed in QAPI meetings with team.	
K 0351 SS=F Bldg. 01	NFPA 101 Sprinkler System - Installation Based on observation and interview, the facility did not provide adequate signage for 1 of 1 fire department connection (FDC). NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, 13.7 Fire Department Connections. 13.7.1 Fire department connections shall be inspected quarterly to verify the following: (1) The fire department connections are visible and accessible. (2) Couplings or swivels are not damaged and rotate smoothly. (3) Plugs or caps are in place and undamaged. (4) Gaskets are in place and in good condition. (5) Identification signs are in place. (6) The check valve is not leaking. (7) The automatic drain valve is in place and operating properly. (8) The fire department connection clapper(s) is in place and operating properly. This deficient practice could affect all residents. Findings include: Based on facility tour and interview with the Maintenance Supervisor (MS) and Administrator	K 0351	Call was placed on 2/04/2025, to Ryan's Fire Protection, and they placed required signage on 2/14/2025. See the attached photo of required signage. Addendum: Ryan's Fire Protection was contacted on 2/4/2025 to notify of the need for a Fire Department Connection (FDC) identification sign at the FDC located by the parking lot entrance near the street. The appropriate FDC identification sign was placed at this location on 2/14/2025. A photograph of the required signage is attached (Attachments 1, pp. 4-5). The Maintenance Supervisor will be responsible for ensuring that the FDC signage remains in place. The Maintenance Supervisor will check that the signage is in place once weekly, with documented dates of the audits, beginning 2/19/2025. See attached "Maintenance Log: Fire	02/14/2025

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	(AD) on 01/30/25 between 1:07 p.m. and 3:30 p.m., the FDC located by the parking lot entrance, near the street, was not provide with a FDC identification sign. Based on interview at the time of observation, the MS stated there was no identification sign on the FDC. This finding was acknowledged by the MS at the time of observation and again at the exit conference with the MS and AD present. 3.1-19(b)		Department Connection Signage." (Attachments 2, pp. 1-3). The Maintenance Supervisor will submit this log to the QAPI Coordinator every month for the next 6 months to ensure compliance, then the QAPI team will discuss continuing or discontinuing the audits of these logs. divthe="" cited="" oxygen="" cylinder="" standing="" upright="" floor="" clean="" linen="" storage="" area="" removed="" from="" and="" designated="" stand="" 1="" 30="" “how="" store="" tanks”="" p.="" 12)="" posted="" inform="" staff="" proper="" placement="" portable="" tanks.="" message="" sent="" all="" clinical="" onshift="" communication="" system="" 20="" with="" reminder="" tanks="" cannot="" must="" stored="" racks="" room.="" recipient="" list="" 14).="" to="" cylinders="" are="" secured="" stands,="" administrative="" assistant="" perform="" daily="" monday="" through="" friday="" (unless="" holiday)="" visual="" observations="" secure="" any="" not="" properly.="" “portable="" tank="" (daily="" mon-fri).”="" 13) ="" maintaining="" logs="" keeping="" them="" available="" review.="" review="" findings="" least="" quarterly. <="" div="">divryan’s="" logs. <="" div="">=" div="">=" div="">	

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K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to maintain the ceiling construction throughout the facility. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect 3 staff. Findings include: Based on facility tour and interview with the Maintenance Supervisor (MS) and Administrator (AD) on 01/30/25 between 1:07 p.m. and 3:30 p.m., in the Social Services Office there was a 1-inch unsealed gap around the sprinkler head. This condition could delay the activation of the sprinklers. Based on interview at the time of observation, the MS agreed there was an unsealed gap in the ceiling around the sprinkler head. This finding was acknowledged by the MS at the time of observation and again at the exit conference with the MS and AD present. 3.1-19(b)	K 0353	Restored sleeve to its original position. Maintenance manager will continue his monthly checks of sprinkler head sleeves. See attached photo of restored sleeve and location (Attachments 1, pp. 6-7).	01/31/2025
K 0354 SS=F Bldg. 01	NFPA 101 Sprinkler System - Out of Service Based on record review and interview, the facility failed to provide correct written policies in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a	K 0354	Correct fire policy was in Maple Manor's Policy and Procedures manual, last reviewed September 2024, which includes "while	02/19/2025

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	24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.6 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine procedures that the impairment coordinator shall follow. A.15.5.2 (4) (b) states a fire watch should consist of trained personnel who continuously patrol the affected area. Ready access to fire extinguishers and the ability to promptly notify the fire department are important items to consider. During the patrol of the area, the person should not only be looking for fire, but making sure that the other fire protection features of the building such as egress routes and alarm systems are available and functioning properly. This deficient practice could affect all occupants in the facility. Findings include: Based on records review and interview with the Maintenance Supervisor (MS) and Administrator (AD) on 01/30/25 between 10:20 a.m. and 1:07 p.m., the facility provided fire watch plan documentation but the plan did not state that the person(s) conducting the fire watch will have no other duties while conducting the fire watch. Based on interview at the time of record review, the Administrator agreed the fire watch did not indicate that the person(s) conducting the fire watch will have no other duties while conducting the fire watch. This finding was acknowledged by the MS at the time of observation and again at the exit conference with the MS and AD present. 3.1-19(b)		patrolling the building, the employee will have no other responsibilities." This statement was added to the Disaster Plan on 2/10/2025. See attachment "Fire Alarm System" Addendum: The “Fire Alarm System Policy”, effective 9/10/2019 and reviewed on 9/10/24, which indicates procedures to be followed in the event the fire alarm service has to be placed out of service for four hours or more, was located in the Maple Manor Policy and Procedure manual but did not coincide with the Disaster Plan manual procedure for fire protection in the event the fire alarm service is out of service. The “Fire Alarm System Policy” did correctly state that “while patrolling the building, the employee will have no other responsibilities.” Historically, the Disaster Plan had been maintained and reviewed by the previous Administrator, while the Maple Manor Policy and Procedure manual was maintained and reviewed annually by the QAPI Coordinator. The “Fire Alarm System Policy” (Attachments 1, p. 2) was added to the appropriate section of the Disaster Plan manual on 2/10/25. As a QAPI action, the Disaster Plan will be reviewed and/or revised at least annually by the	

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			QAPI coordinator at the same time as the policy review for the Maple Manor Policy and Procedure manual. See attached "Disaster Plan Review Log," (Attachments 1, p. 3) which will be the monitoring system to ensure that the Disaster Plan manual is reviewed and/or revised annually and meets regulatory requirements. The "Disaster Plan Review Log" was placed in the front of the Disaster Plan manual on 2/19/2025. Each review will be discussed in QAPI meetings with team.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Based on observation and interview, the facility failed to ensure 2 of over 30 corridor doors would resist the passage of smoke. This deficient practice could affect 4 residents. Findings include: Based on facility tour and interview with the Maintenance Supervisor (MS) and Administrator (AD) on 01/30/25 between 1:07 p.m. and 3:30 p.m., the following corridor doors had holes which penetrated completely through the door: A) A 1/2 inch hole through the door above the latching hardware in Resident Room 108 B) Two 1/2 inch hole through the door above the latching hardware in the "100 Hall Nurses Station Storage Room."	K 0363	Repair was completed by filling each fire door with flame retarded caulk. See attached photos. Addendum: The deficient practice of failing to ensure that 2 of over 30 corridor doors would resist the passage of smoke resulted from replacement of door handles on those doors that did not fit the specifications of the old door handles, leaving a ½ inch hole through each door. The holes in the corridor doors to Resident Room 108 and to 100 Hall Nurse's Station Storage room were repaired on 1/31/2025 by filling each hole with flame retardant caulk (photos in	01/31/2025

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	This finding was acknowledged by the MS at the time of observation and again at the exit conference with the MS and AD present. 3.1-19(b)		Attachments 1, pp. 8-11). All corridor doors in the facility were checked by the Maintenance Supervisor on 1/31/2025 with no further findings. As the reason for the deficient practice was due to changing existing doorknobs, the Maintenance Supervisor will ensure that any doorknobs that are changed in the future and result in any means of smoke passage via a gap or hole, the holes will be immediately filled with flame retardant caulk at the time of the doorknob change. Moving forward, the Maintenance Supervisor will inspect all corridor doors at the following intervals to ensure they all resist the passage of smoke: Monthly inspection x 3 months, then quarterly inspections x 2 quarters, then QAPI will discuss changing to annually if no deficiencies identified. See attached “Maintenance Log: Corridor Door Inspection,” (Attachments 1, p. 12) to be completed at the specified time frames by the Maintenance Supervisor. The QAPI team will review these logs monthly x 3 months, then quarterly x at least 2 quarters, then annually thereafter if no deficiencies are identified. The QAPI team will then review all maintenance logs annually at the time of the annual Facility Assessment Review to ensure compliance. ="" div="">	

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K 0761 SS=F Bldg. 01	NFPA 101 Maintenance, Inspection & Testing - Doors Based on observation, records review, and interview; the facility failed to ensure annual inspection and testing of all fire door assemblies were completed in accordance of LSC 19.1.1.4.1.1 communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. 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, 5.2.4.1 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	K 0761	Maintenance Supervisor now has the correct form for each itemized area of inspection. See attachment. A Fire/smoke door inspector will conduct an inspection of each door by 2/28/2025, while the MS is getting his certification. Addendum: The reason for the deficient practice of not having appropriate documentation of an annual inspection for fire door assemblies was due to the lack of a clear understanding of fire door inspection documentation requirements per NFPA. An inspection of all fire doors will be completed by the Maintenance Supervisor by 2/28/2025, utilizing the attached form "Fire/Smoke Door Inspection" (Attachments 2, p. 4). While certification is not required, the Maintenance Supervisor will work to obtain a Fire Door Inspection Certification prior to next year's annual inspection date. This will enhance the Maintenance Supervisor's knowledge and ensure fire doors are properly inspected and maintained, and that NFPA compliance is achieved. During annual fire door inspections, the Maintenance Supervisor will utilize the attached "Fire/Smoke Door	02/28/2025

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	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 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 records review and interview with the Maintenance Supervisor (MS) and Administrator (AD) on 01/30/25 between 10:20 a.m. and 1:07 p.m., no documentation of an annual inspection for the fire door assemblies was available for review. Based on observation during the tour there are 90-minute fire door assemblies in the facility. Based on interview at the time of records review and observation, the MS stated that he is somewhat new and that they were doing monthly inspections on all the doors including the fire door assemblies. The provided documentation indicated only dates the inspections occurred and did not itemize which doors were inspected nor the detail of the inspections. The MS was able to locate a blank form for actual Fire Door inspections from his office and stated he would begin using the form which met the requirement. The MS stated that based on his new understanding that annual fire door inspections were not completed within the last year.		Inspection" form for each door inspected, which meets documentation requirements. Moving forward, the Maintenance Supervisor will inspect all fire doors annually. See attached "Annual Fire/Smoke Door Inspection Log" (Attachments 2, p. 5), to be completed by the Maintenance Supervisor. The QAPI team will review all maintenance logs annually at the time of the annual Facility Assessment Review to ensure compliance. ="" div="">="" div="">	

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	This finding was acknowledged by the MS at the time of observation and again at the exit conference with the MS and AD present. 3.1-19(b)			
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review, observation, and interview; the facility failed to conduct the required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient	K 0921	PCREE was purchased on 2/13/2025. See attached pictures. MS will use the Electrical Safety Inspection PCREE form to complete the inspections by 2/28/2025. Addendum: The Maintenance Supervisor was not aware of NFPA requirements for testing and maintenance of portable patient-care related electrical equipment (PCREE) at the time of the survey. The Maintenance Supervisor and QAPI Coordinator reviewed the NFPA PCREE testing requirements on 2/19/2025. A facility policy on PCREE testing and maintenance was implemented on 2/19/2025, see attached “Portable Patient-Care Related Electrical Equipment (PCREE) Testing and Maintenance Policy.” (Attachments 2, pp. 6-8) The facility purchased a Rigel Medical Biomedical Electrical Safety Tester on 2/13/2025. See attached picture of the device and invoice (Attachments 2, p. 9). The	02/28/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155766	A. BUILDING 01 B. WING	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAPLE MANOR CHRISTIAN HOME INC	643 W UTICA ST SELLERSBURG, IN 47172

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	practice affects all residents. The findings include: Based on records review and interview with the Maintenance Supervisor (MS) and Administrator (AD) on 01/30/25 between 10:20 a.m. and 1:07 p.m., no documentation was available for review for the testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Observation during the building tour revealed that the facility provided electric beds for all residents. The AD stated that PCREE such as oxygen concentrators, hospital style beds and other electrical medical equipment was present and in use at the facility. The MS stated that the facility was not aware that the PCREE was required to be tested. This finding was acknowledged by the Maintenance Supervisor at the time of records review and again at the exit conference with the MS and AD present. 3.1-19(b)		Maintenance Supervisor will complete inspections and testing of all current PCREE in the facility by 2/28/2025 and will complete the attached form “Electrical Safety Inspection PCREE” (Attachments 2, p. 10) for each piece of equipment. These documents will be kept and maintained by the Maintenance Supervisor. PCREE testing and inspections will be performed annually by the Maintenance Supervisor and will be documented on the attached “Maintenance Log: PCREE Electrical Safety Inspection.” (Attachments 2, p. 11) When any new equipment enters the facility, the Maintenance Supervisor will test and inspect the equipment for safety before it is put into use and complete the “Electrical Safety Inspection PCREE” form for each piece of new equipment. The QAPI team will review the PCREE log/forms after initial inspection to ensure compliance, then will review all maintenance logs annually at the time of the annual Facility Assessment Review to ensure compliance. ="" div="">	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Based on observation and interview, the facility failed to ensure 1 of over 20 cylinders of nonflammable gases such as oxygen were	K 0923	Posting in oxygen storage room to make sure oxygen cylinders are properly secured in the racks that	02/20/2025

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	155766	A. BUILDING 01 B. WING	01/30/2025

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	properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect 2 staff. Findings include: Based on facility tour and interview with the Maintenance Supervisor (MS) and Administrator (AD) on 01/30/25 between 1:07 p.m. and 3:30 p.m., one oxygen cylinder was standing upright on the floor in the Clean Linen oxygen storage area and was not properly chained or supported in a proper cylinder stand or cart. This finding was acknowledged by the MS at the time of observation and again at the exit conference with the MS and AD present. 3.1-19(b)		are on the floor. See attachment. Addendum: The cited oxygen cylinder that was standing upright on the floor in the Clean Linen oxygen storage area was removed from the floor and placed in the designated cylinder rack on 1/30/2025. The attached sign "How to Store Oxygen Tanks" (Attachments 2, p. 12) was posted in the Clean Linen oxygen storage area to inform staff of proper placement of portable oxygen tanks. A message was sent to all clinical staff in the OnShift communication system on 2/20/2025 with a reminder that oxygen tanks cannot be placed on the floor and must be stored in the cylinder racks in the oxygen storage room. See attached OnShift message with recipient list (Attachments 2, p. 14). To ensure all oxygen cylinders are secured in racks or stands, the Administrative Assistant will perform daily Monday through Friday (unless a holiday) visual observations of the oxygen storage area and secure any tanks not stored properly. The observations/audits will be documented on the attached "Portable Oxygen Tank Storage Area Audits (Mon-Fri)" (Attachments 2, p. 13). The Administrative Assistant will be responsible for maintaining the	

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			logs and keeping them available for review. The QAPI team will review the findings of the audits at least quarterly. ="" div="">="" div="">	