STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155618	A. BUILDING -- B. WING	06/13/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MAJESTIC CARE OF CARMEL	12999 N PENNSYLVANIA ST CARMEL, IN 46032

(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: 06/13/23 Facility Number: 001149 Provider Number: 155618 AIM Number: 200145500 At this Emergency Preparedness survey, Majestic Care of Carmel was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 104 certified beds. At the time of the survey, the census was 58. Quality Review conducted on 06/14/23	E 0000	**E000** The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or of any violation or regulation. This provider respectfully requests the 2567 Plan of Correction be the letter of credible allegation and **REQUESTS A DESK REVIEW IN LIEU OF A POST SURVEY REVISIT** on or after 8/01/2023. Despite the citations the EPP survey states: At this Emergency Preparedness survey, Majestic Care of Carmel was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. Page 1 ln.9-13	
E 0035 SS=C Bldg. --	483.475(c)(8), 483.73(c)(8) LTC and ICF/IID Sharing Plan with Patients §483.73(c)(8); §483.475(c)(8) *[For LTC Facilities at §483.73(c):] [(c) The LTC facility must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:]			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
John Seib	Executive Director	06/29/2023

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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	*[For ICF/IIDs at §483.475(c):] [(c) The ICF/IID must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years. The communication plan must include all of the following:] (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. Based on record review and interview, the facility failed to ensure the emergency preparedness plan (EPP) includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42 CFR 483.75(c)(8). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Executive Director and the Maintenance Director on 06/13/23 between 8:45 a.m. and 12:05 p.m., the Emergency Preparedness Binder provided did not address a method for sharing information contained within the EPP Binder that the facility deems appropriate with clients, their families, or representatives. Based on interview at the time of records review, the Executive Director stated that this requirement is met by providing a sheet of paper with the necessary information upon admission, however the facility had run out of copies and had not been distributing the required information recently and they did not have a copy available for review.	E 0035	**E035 LTC and ICF/IID SHARING PLAN WITH PATIENTS** Based on record review and interview, the facility failed to ensure the Emergency Preparedness Plan (EPP) includes a method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives in accordance with 42CFR 483.75(c)(8). This deficient practice could affect all occupants. Findings include: Based on records review and interview with the Executive Director and the Maintenance Director on 06/13/23 between 8:45a.m. and 12:05 p.m., the Emergency Preparedness binder provided did not address a method for sharing information contained within the EPP binder that the facility deems appropriate with clients, their families or	08/01/2023

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	This finding was acknowledged by the Executive Director and the Maintenance Director at the time of records review and again at the exit conference with the Executive Director, Maintenance Director, and Assistant Maintenance personnel present.		representatives. Based on interview at the time of records review, the Executive Director stated that this requirement is met by providing a sheet of paper with the necessary information upon admission, however the facility had run out of copies and had not been distributing the required information recently and they did not have a copy for review. **What corrective action(s) will be accomplished for those residents found to have been affected by this practice?** · The Executive Director and or designee notified all clients, their families and / or their representatives of the location of a copy of the Emergency Preparedness Plan (EPP) which is available for review via(1) Flyer; (2) Posting at the AL front entry; and (3) Posting at the SNF Ambulance entrance. An addendum has been added to the facility welcome packet to further inform new residents on or before 8/01/2023. **How will you identify all other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. · The Executive Director and or designee notified all clients,	

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			their families and / or their representatives of the location of a copy of the Emergency Preparedness Plan (EPP) which is available for review via(1) Flyer; (2) Posting at the AL front entry; and (3) Posting at the SNF Ambulance entrance . An addendum has been added to the facility welcome packet to further inform new residents along with the posting regarding the same on or before 8/01/2023. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur?** · The Executive Director and or designee notified all clients, their families and / or their representatives of the location of a copy of the Emergency Preparedness Plan (EPP) which is available for review via (1) Flyer; (2) Posting at the AL front entry; and (3) Posting at the SNF Ambulance entrance. An addendum has been added to the facility welcome packet to further inform new residents along with the posting regarding the same on or before 8/01/2023. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** · The Executive Director and	

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			or designee notified all clients, their families and / or their representatives of the location of a copy of the Emergency Preparedness Plan (EPP) which is available for review via (1) Flyer; (2) Posting at the AL front entry; and (3) Posting at the SNF Ambulance entrance An addendum has been added to the facility welcome packet to further inform new residents along with the posting regarding the same on or before 8/01/2023. · The Safety Committee will monitor and report to the Continuous Quality Improvements Committee on their results from the inspections. · The Maintenance Director and Administrator are responsible for these results.	
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: 06/13/23 Facility Number: 001149 Provider Number: 155618 AIM Number: 200145500 At this Life Safety Code survey, Majestic Care of Carmel was found not in compliance with	K 0000	**E000** The creation and submission of the Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies or of any violation or regulation. This provider respectfully requests the 2567 Plan of Correction be the letter of credible allegation and **REQUESTS A DESK REVIEW IN LIEU OF A POST SURVEY REVISIT** on or after 8/01/2023.	

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This two-story facility was determined to be of Type II (111) construction and fully sprinklered. 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 rooms. The healthcare portion of the facility has a capacity of 104 and had a census of 58 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review conducted on 06/14/23		Despite the citations the EPP survey states: At this Emergency Preparedness survey, Majestic Care of Carmel was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. Page 1 ln.9-13	
K 0222 SS=F Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the			

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	staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in			

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	accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 1. Based on observation and interview, the facility failed to ensure 3 of 3 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions: (a) The force shall not be required to exceed 15 lbf (67 N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect 22 residents. Findings include: Based on observation and interview with the Executive Director and the Maintenance Director on 06/13/23 during a facility tour between 12:05 p.m. and 1:45 p.m., the following exit doors were equipped with a 15 second delayed egress. When the exit doors were tested the irreversible process to release the lock was not initiated or took excessive pressure to release the door. A) The double doors into the service hall	K 0222	**K 222 EGRESS DOORS** This requirement is not met as evidenced by: 1. Based on observation and interview, the facility failed to ensure 3 of 3 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of the force to the release device required in 7.2.1.5.10 under all of the following condition: (a) The force shall not be required to exceed 15lbf (67N). (b) The force shall not be required to be continuously applied for more than 3 seconds. (c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening. (d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only.. Findings include:	08/01/2023

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	corridor, delayed egress did not function. B) Door #1 exit door near the generator took excessive pressure to pull and did not function. Additionally, the provided signage stated the door should be pushed to activate the delayed egress when in fact the door needs to be pulled. C) Several other exit doors equipped with delayed egress signage took excessive pressure to activate the process. The Maintenance Director stated the mechanisms would need to be adjusted. This finding was acknowledged by the Executive Director and the Maintenance Director at the time of discovery and again at the exit conference with the Executive Director, Maintenance Director, and Assistant Maintenance personnel present. 2. Based on observation and interview, the facility failed to ensure all exterior exit doors were readily accessible and able to open on first try. This deficient practice could affect all occupants in the facility. Findings include: Based on observation and interview with the Executive Director and the Maintenance Director on 06/13/23 during a facility tour between 12:05 p.m. and 1:45 p.m., the exit door to the north, facing the neighboring pool, would not open easily on the first try when tested. The Surveyor, then the Maintenance Director tried to open the door. Then, the Executive Director kicked the door and was able to open the stuck door after considerable effort. The Maintenance Director stated that during COVID they had used this door extensively but not much recently. This finding was acknowledged by the Executive Director and the Maintenance Director at the time		Based on observation and interview with the Executive Director and Maintenance Director on 6/13/23 during a facility tour … the following exit doors were equipped with a 15 second delayed egress. When the exit doors were tested the irreversible process to release the lock was not initiated or took excessive pressure to release the door. (A) The double doors into the service hall corridor, the delayed egress did not function. (B) Door #1 exit door near the generator took excessive pressure to pull and did not function. Additionally, the provided signage stated the door should be pushed to activate the delayed egress when in fact the door needs to be pulled. (C) Several other exit doors equipped with delayed egress signage took excessive pressure to activate the process. The Maintenance Director stated the mechanisms would need to be adjusted. 2. Based on observation and interview, the facility failed to ensure all exterior exit doors were readily accessible and able to open on first try… Findings include: Based on observation and interview with the Executive Director and Maintenance Director	

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	of discovery and again at the exit conference with the Executive Director, Maintenance Director, and Assistant Maintenance personnel present. 3.1-19(b)		on 6/13/23 during a facility tour … the exit door to the north, facing the neighborhood pool, would not open easily on the first try when tested. The surveyor, then the maintenance director tried to open the door. Then the Executive Director kicked the door and was able to open the stuck door after considerable effort. **What corrective action(s) will be accomplished for those residents found to have been affected by this practice?** · The Maintenance Director contacted SAFECARE to address issues with the Delayed egress functions with the identified doors to ensure that the delayed egress was functioning properly. Specifically Safecare addressed identified issues with the double doors into the service hall corridor; Door #1; and reviewed all other doors equipped with delayed egress to ensure that the delayed egress activated without excessive pressure and functioned properly. · The signage posted at door #1 was modified to reflect the need to pull the door instead of pushing it to activate the delayed egress. · The Maintenance Director performed maintenance on the exit door to the north, facing the neighborhood pool to ensure that it opens easily and is readily accessible on the first try without use of excessive pressure.	

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			· The Maintenance Director performed an inspection of all egress doors to ensure that all egress doors in the facility open easily and are readily accessible and are equipped with accurate signage. **How will you identify all other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents, visitors, and staff have for egress have the potential to be affected by the alleged deficient practice. · The Maintenance Director performed an inspection of all egress doors to ensure that all remaining egress doors in the facility open easily and are readily accessible with accurate signage. · The Maintenance Director with the assistance of SAFECARE performed an inspection of all egress doors to ensure that all remaining egress doors equipped with delayed egress systems in the facility are functioning properly. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur?** · The Maintenance Director will monitor the egress doors weekly for four weeks and at least	

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			monthly thereafter as a required task added to the TELS system to ensure that all egress doors in the facility open easily and are readily accessible and are equipped with accurate signage. · The Maintenance Director will monitor the egress doors equipped with delayed egress systems weekly for four weeks and at least monthly thereafter as a required task added to the TELS system to ensure that all egress doors with delayed egress systems are functioning properly. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** · The Executive Director/designee will complete a Life Safety CQI audit tool daily for seven days; weekly for seven weeks; monthly thereafter to monitor compliance until compliance has been maintained for two consecutive quarters. If threshold of 100% is not achieved an action plan will be developed to assure compliance. · The Maintenance Director/designee and Executive Director will review the Life Safety CQI and any issues identified through the CQI process will be addressed immediately via corrective action plan. Maintenance Director/designee will also review the results with the	

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			Safety Committee at their monthly meetings. · The Safety Committee will monitor results of the inspections and report to the Continuous Quality Improvements Committee on their results from the inspections. · The Maintenance Director and Administrator are responsible for these results.	
K 0281 SS=E Bldg. 01	NFPA 101 Illumination of Means of Egress Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 Based on observation and interview, the facility failed to ensure continuity of egress lighting for 2 of 2 exits. For the purposes of this requirement, exit access shall include only designated stairs, aisle, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways and exit passageways leading to a public way. This deficient practice could affect up to 15 residents. Finding include: Based on observation and interview with the Executive Director and the Maintenance Director on 06/13/23 during a facility tour between 12:05 p.m. and 1:45 p.m., the (1) exit access in "the Tube" did not have egress lighting which would	K 0281	**K 281 ILLUMINATION OF MEANS OF EGRESS** Based on observation and interview, the facility failed to ensure continuity of egress lighting for 2 of 2 exits. For the purposes of this requirement exit access shall include only designated stairs, aisle, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways and exit passages leading to the public way. Findings include:	08/01/2023

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	remain on powered by the generator in the event of an emergency. The provided light had a switch, which when tested turned off the light illuminating the exit access. Based on interview at the time of observations, the Maintenance Director confirmed there were no other lighting devices illuminating this exit access passageway. Additionally, (2) the light in the North Stair Tower did not illuminate bright enough to provide lighting in the stairwell. The Maintenance Director stated that perhaps some bulbs were burned out and the ceiling light in the stair tower would need attention. No windows or other lighting source were visible in the aforementioned stair tower. This finding was acknowledged by the Executive Director and the Maintenance Director at the time of discovery and again at the exit conference with the Executive Director, Maintenance Director, and Assistant Maintenance personnel present. 3.1-19(b)		Based on observation and interview with the Executive Director and the Maintenance director on 6/13/23 during a facility tour… the (1) exit access in "the tube" did not have egress lighting which would remain on powered by the generator in the event of an emergency. The provided light had a switch, which when tested turned off the light illuminating the exit access. Based on an interview at the time of observations, the maintenance director confirmed there were no other lighting devices illuminating the exit access passageway. Additionally, (2) the light in the North stair tower did not illuminate bright enough to provide lighting in the stairwell. The Maintenance Director stated that some bulbs were burned out and the ceiling light in the stair tower would need attention. **What corrective action(s) will be accomplished for those residents found to have been affected by this practice?** · The Maintenance Director had an electrician modify the light so that it was not turned on and off by a switch and ensured that the light would remain on and powered by the generator in the event of an emergency. · The Maintenance Director replaced the lights in the North Stair Tower to ensure that the stairwell is illuminated bright	

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			enough to provide lighting in the stairwell. · The Maintenance Director performed an inspection to ensure continuity of egress lighting for all other designated stairs, aisles, corridors, ramps, escalators, walkways and exit passages leading to the public way. **How will you identify all other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents, visitors, and staff could be affected by the alleged deficient practice. · The Maintenance Director performed an inspection to ensure continuity of egress lighting for all other designated stairs, aisles, corridors, ramps, escalators, walkways and exit passages leading to the public way. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur?** · The Maintenance Director will monitor designated stairs, aisles, corridors, ramps, escalators, walkways and exit passages leading to the public way for continuity of egress lighting for four weeks and at least monthly thereafter as a required task added to the TELS system to	

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			ensure continuity in egress lighting leading to the public way. · The Maintenance Director will monitor the egress doors equipped with delayed egress systems weekly for four weeks and at least monthly thereafter as a required task added to the TELS system to ensure that all egress doors with delayed egress systems are functioning properly. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** · The Executive Director/designee will complete a Life Safety CQI audit tool daily for seven days; weekly for seven weeks; monthly thereafter to monitor compliance until compliance has been maintained for two consecutive quarters. If threshold of 100% is not achieved an action plan will be developed to assure compliance. · The Maintenance Director/designee and Executive Director will review the Life Safety CQI and any issues identified through the CQI process will be addressed immediately via corrective action plan. Maintenance Director/designee will also review the results with the Safety Committee at their monthly meetings. · The Safety Committee will monitor results of the inspections	

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			and report to the Continuous Quality Improvements Committee on their results from the inspections. · The Maintenance Director and Administrator are responsible for these results.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms			

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	(exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage room, was provided with a properly working self-closing device. This deficient practice could affect more than 2 residents, as well as staff and visitors in the Activities Office. Findings include: Based on observation and interview with the Executive Director and the Maintenance Director on 06/13/23 during a facility tour between 12:05 p.m. and 1:45 p.m., the Activities Office, greater than 50 square feet contained several combustible items, such as, paper, plastic, and cardboard boxes. The corridor door to this office suite was not equipped with a self-closing mechanism and did not self-close and latch into the door frame. This finding was acknowledged by the Executive Director and the Maintenance Director at the time of discovery and again at the exit conference with the Executive Director, Maintenance Director, and Assistant Maintenance personnel present. 3.1-19(b)	K 0321	**K 321 HAZARDOUS ENCLOSURES** Based on observation and interview, the facility failed to ensure 1 of over 10 hazardous area doors, such as storage room, was provided with a properly working self-closing device. Findings include: Based on observations and interview with the Executive Director and Maintenance Director on 06/13/23 during a facility tour… the Activities Office, greater than 50 square feet contained several combustible items, such as, paper, plastic, and carboard boxes. The corridor door to this office suite was not equipped with a self-closing mechanism and did not self-close and latch into the door frame. What corrective action(s) will be accomplished for those residents found to have been affected by this practice? · The Maintenance Director serviced the door to the Activities office to ensure that the door was equipped with a self-closing mechanism and that the door self closes and latches to the door frame. · The Maintenance Director performed an inspection of all	08/01/2023

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			other storage areas to ensure that storage areas are equipped with a functional self-closing mechanism and that each storage door latches to the door frame. **How will you identify all other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents, visitors, and staff could be affected by the alleged deficient practice. · The Maintenance Director performed an inspection of all other storage areas to ensure that storage areas are equipped with a functional self-closing mechanism and that each storage door latches to the door frame. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur?** · The Maintenance Director will monitor the hazardous area doors to ensure they self close and latch to the doorframe weekly for four weeks and at least monthly thereafter as a required task added to the TELS system to ensure that all egress doors with delayed egress systems are functioning properly. **How will the corrective**	

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			action(s) be monitored to ensure the deficient practice will not recur? · The Executive Director/designee will complete a Life Safety CQI audit tool daily for seven days; weekly for seven weeks; monthly thereafter to monitor compliance until compliance has been maintained for two consecutive quarters. If threshold of 100% is not achieved an action plan will be developed to assure compliance. · The Maintenance Director/designee and Executive Director will review the Life Safety CQI. Any issues identified through the CQI process will be addressed immediately via corrective action plan. Maintenance Director/designee will also review the results with the Safety Committee at their monthly meetings. · The Safety Committee will monitor results of the inspections and report to the Continuous Quality Improvements Committee on their results from the inspections. · The Maintenance Director and Administrator are responsible for these results.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in			

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	accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on observation and interview, the facility failed to maintain the ceiling construction of 4 of 4 closets and rooms. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 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 affects all residents. Findings include: Based on observation and interview with the Executive Director and the Maintenance Director on 06/13/23 during a facility tour between 12:05 p.m. and 1:45 p.m., the suspended ceiling had missing panels in the following locations: A) The IT storage closet. B) All linen closets on the North Hall, first and second Floor. C) The Med Room at the 1st floor nurses station. The Executive Director stated he was unsure why so many ceiling tiles were missing.	K 0353	**K 353 SPRINKLER SYSTEM – MAINTENANCE AND TESTING** Based on observation and interview, the facility failed to maintain the ceiling construction of 4 of 4 closets and rooms. The ceiling tiles trap hot air and gasses around the sprinkler and cause the sprinkler to operate at a specified temperature. Findings include: Based on observation and interview with the Executive Director and the Maintenance director on 6/13/23 … The suspended ceiling had missing panels in the following locations. A) The IT Storage closet. B) All linen closets on the North Hall, first and second floor. C) The Med Room at the first floor nurses station. **What corrective action(s) will be accomplished for those**	08/01/2023

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	This finding was acknowledged by the Executive Director and the Maintenance Director at the time of discovery and again at the exit conference with the Executive Director, Maintenance Director, and Assistant Maintenance personnel present. 3.1-19(b)		**residents found to have been affected by this practice?** · A) The Maintenance Director replaced ceiling tiles that had been removed on the IT storage closet. · B) The Maintenance Director replaced ceiling tiles that had been removed in the linen closets on the North Hall on both first and second floor. · C) The Maintenance Director replaced the ceiling tiles that had been removed in the Med Room at the first floor nursing station. **How will you identify all other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents, visitors, and staff could be affected by the alleged deficient practice. · A) The Maintenance Director replaced ceiling tiles that had been removed on the IT storage closet. · B) The Maintenance Director replaced ceiling tiles that had been removed in the linen closets on the North Hall on both first and second floor. · C) The Maintenance Director replaced the ceiling tiles that had been removed in the Med Room at the first floor nursing station. · The Maintenance Director	

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			reviewed all ceiling tiles in the facility to ensure that the ceiling tiles are properly in place in accordance with the NFPA. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur?** · The Maintenance Director will monitor the ceiling tiles weekly for four weeks and at least monthly thereafter as part of environmental rounds and set it as a required task added to the TELS system to ensure compliance. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** · The Executive Director/designee will complete a Life Safety CQI audit tool daily for seven days; weekly for seven weeks; monthly thereafter to monitor compliance until compliance has been maintained for two consecutive quarters. The Daily Construction Audit will be completed daily until construction on the skilled nursing unit is complete. If threshold of 100% is not achieved an action plan will be developed to assure compliance. · The Maintenance Director/designee and Executive Director will review the Life Safety	

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			CQI and Daily Construction Audit. Any issues identified through the CQI process will be addressed immediately via corrective action plan. Maintenance Director/designee will also review the results with the Safety Committee at their monthly meetings. · The Safety Committee will monitor results of the inspections and report to the Continuous Quality Improvements Committee on their results from the inspections. · The Maintenance Director and Administrator are responsible for these results.	
K 0361 SS=F Bldg. 01	NFPA 101 Corridors - Areas Open to Corridor Corridors - Areas Open to Corridor Spaces (other than patient sleeping rooms, treatment rooms and hazardous areas), waiting areas, nurse's stations, gift shops, and cooking facilities, open to the corridor are in accordance with the criteria under 18.3.6.1 and 19.3.6.1. 18.3.6.1, 19.3.6.1 Based on interview and observation, the facility failed to ensure 1 of 1 dining area was not open to the corridor. LSC 19.3.6.1 states corridors shall be separated from all other areas by partitions complying with 19.3.6.2 through 19.3.6.5 (see also 19.2.5.4), 19.3.6.1 (7) states places, other than patient sleeping rooms, treatment rooms, and hazardous areas, shall be permitted to be open to the corridor and unlimited in area provided that all of the following criteria are met: (a) The space and the corridors onto which it opens, where located	K 0361	**K 361 CORRIDORS – AREAS OPEN TO THE CORRIDOR** Based on observation and interview, the facility failed to ensure that 1 of 1 dining area was not open to the corridor. LSC 19.3.6.1 states that corridors shall be separated from all other areas by partitions … 19.3.6.1 (7) states places other than patient sleeping rooms, treatment rooms, and	08/01/2023

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	in the same smoke compartment, are protected by an electrically supervised automatic smoke detection system in accordance with 19.3.4. (b) Each space is protected by automatic sprinklers, or the furnishings and furniture, in combination with all other combustibles within the area, are of such minimum quantity and arrangement that a fully developed fire is unlikely to occur. (c) The space does not obstruct access to required exits. This deficient practice could affect all on the 2nd floor. Findings include: Based on observation and interview with the Executive Director and the Maintenance Director on 06/13/23 during a facility tour between 12:05 p.m. and 1:45 p.m., the newly renovated space called Dining Room #2 in LTC was open to the corridor due to the removal of the doors and windows. No supervised smoke detection was present in the aforementioned dining room. Based on interview at the time of observation, the Maintenance Director stated the area was recently renovated. This finding was acknowledged by the Executive Director and the Maintenance Director at the time of discovery and again at the exit conference with the Executive Director, Maintenance Director, and Assistant Maintenance personnel present. 3.1-19(b)		hazardous areas, shall be permitted to be open to the corridor and unlimited in area provided that all of the following criteria are met: (a) The space and the corridor into which it opens, where located in the same smoke compartment, are protected by an electronically supervised automatic smoke detection system in accordance with 19.3.4. (b) Each space is protected by automatic sprinklers, or the furnishings and Furniture, in combination with all combustibles within the area are of such minimum quantity and arrangement that a fully developed fire is unlikely to occur. (c) the space does not obstruct access to required exits. Findings include: Based on observation and interview with the Executive Director and the Maintenance director on 6/13/23, the newly renovated space called dining room #2 in LTC was open to the corridor due to the removal of the door and the windows. No supervised smoke detection was present in the aforementioned dining room. **What corrective action(s) will be accomplished for those residents found to have been affected by this practice?** · The Maintenance Director facilitated installation of an electronically supervised	

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			automatic smoke detection system in Dining Room #2 LTC in accordance with 19.3.4. Dining Room #2 LTC was already protected by automatic sprinklers and does not obstruct any exits. · The Maintenance Director performed an inspection of all areas in facility open to the corridor to ensure that the rooms are equipped with electronically supervised automatic smoke detection system and do not obstruct exits in accordance with the code. **How will you identify all other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents, visitors, and staff on the 2nd floor could be affected by the alleged deficient practice. · The Maintenance Director performed an inspection of all areas in facility open to the corridor to ensure that the rooms are equipped with electronically supervised automatic smoke detection system and do not obstruct exits in accordance with the code. No additional deficiencies noted. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice**	

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			will not recur? · The Maintenance Director will review all new construction with the assistance of a fire safety professional to ensure any newly renovated areas are compliant with the code. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** · The Executive Director/designee will complete a Life Safety CQI audit tool daily for seven days; weekly for seven weeks; monthly thereafter to monitor compliance until compliance has been maintained for two consecutive quarters. If threshold of 100% is not achieved an action plan will be developed to assure compliance. · The Maintenance Director/designee and Executive Director will review the Life Safety CQI. Any issues identified through the CQI process will be addressed immediately via corrective action plan. Maintenance Director/designee will also review the results with the Safety Committee at their monthly meetings. · The Safety Committee will monitor results of the inspections and report to the Continuous Quality Improvements Committee on their results from the inspections.	

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	155618	A. BUILDING 01 B. WING	06/13/2023

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			· The Maintenance Director and Administrator are responsible for these results.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window			

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	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 all corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 6 staff and 15 residents. Findings include: Based on observation and interview with the Executive Director and the Maintenance Director on 06/13/23 during a facility tour between 12:05 p.m. and 1:45 p.m., the following corridor doors failed to latch positively into their respective door frames: a) Therapy Door #1 to the corridor did not have latching hardware. Only a claw type manual turn knob was installed on the door, and it did not automatically latch when closed. The Executive Director stated that this door had recently been installed. b) Therapy Door #2 to the corridor did not have latching hardware. Only a claw type manual turn knob was installed on the door, and it did not automatically latch when closed. The Executive Director stated that this door had recently been installed. c) 1st Floor Cable room corridor door, equipped with a self-closing device, failed to close and latch. d) The Administrator and Director of Nursing Services corridor door was held open with a brick. The Executive Director agreed the brick would	K 0363	**K 363 CORRIDOR - DOORS** Based on observation and interview, the facility failed to ensure all corridor doors had no impediments to closing and latching into the door frame and would resist the passage of smoke. The deficient practice could affect 6 staff and 15 residents. Findings include: Based on observation and interview with the Executive Director and the Maintenance director on 6/13/23, the following corridor doors failed to latch positively into their respective door frames: a) Therapy Door #1 to the corridor did not have latching hardware. Only a claw type manual turn knob was installed on the door, and it did not automatically latch when closed. b) Therapy Door #2 to the corridor did not have latching hardware. Only a claw type manual turn knob was installed on the door, and it did not automatically latch when closed. c) 1st floor Cable room corridor door, equipped with a self closing device, failed to close and latch.	08/01/2023

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	impede the doors' ability to close. This finding was acknowledged by the Executive Director and the Maintenance Director at the time of discovery and again at the exit conference with the Executive Director, Maintenance Director, and Assistant Maintenance personnel present. 3.1-19(b)		d) The administrator and director of nursing services corridor door was held open with a brick. **What corrective action(s) will be accomplished for those residents found to have been affected by this practice?** · (a) The Maintenance Director had a latching hardware installed on Therapy door #1. Therapy door #1 now functions with a self closing device and automatically latches to the door frame when closed. · (b) The Maintenance Director had a latching hardware installed on Therapy door #2. Therapy door #2 now functions with a self closing device and automatically latches to the door frame when closed. · (c) The Maintenance Director serviced the 1st Floor Cable Room corridor door with the self closing device to ensure that it automatically closes and latches to the door frame. · (d) The Maintenance Director removed the brick holding the Administrator and Director of Nursing services Door open. The Door is no longer impeded from closing. The Director of Nursing was immediately educated not to use of objects to obstruct the office door from closing. **How will you identify all other**	

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			residents having the potential to be affected by the same deficient practice and what corrective action will be taken? · All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. · The Maintenance Director performed an audit of all corridor doors in the facility to all self closing doors close completely and latch to the door frame OR are otherwise impeded from closing and latch firmly to the door frame. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur?** · Staff were provided in-service training on the standard in NFPA 101 Corridor – Doors specifically focusing on the requirement that corridor doors must latch and close automatically if there is a closer. · The Executive Director/designee will complete a Life Safety CQI audit tool daily for seven days; weekly for seven weeks; monthly thereafter to monitor compliance until compliance has been maintained for two consecutive quarters. If threshold of 100% is not achieved an action plan will be developed to assure compliance. Audit will also be completed at the	

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			conclusion of construction in addition to the CQI schedule set forth above. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** · The Executive Director/designee will complete a Life Safety CQI audit tool daily for seven days; weekly for seven weeks; monthly thereafter to monitor compliance until compliance has been maintained for two consecutive quarters. If threshold of 100% is not achieved an action plan will be developed to assure compliance. Audit will also be completed at the conclusion of construction in addition to the CQI schedule set forth above. · The Maintenance Director/designee and Executive Director will review the Life Safety CQI and any issues identified through the CQI process will be addressed immediately via corrective action plan. Maintenance Director/designee will also review the results with the Safety Committee at their monthly meetings. · The Safety Committee will monitor results of the inspections and report to the Continuous Quality Improvements Committee on their results from the inspections. · The Maintenance Director	

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			and Administrator are responsible for these results.	
K 0761 SS=F Bldg. 01	Based on observation, records review, and interview; the facility failed to ensure annual inspection and testing of 9 of 9 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,	K 0761	**K 761 Maintenance, Inspection, Testing - Doors** Based on observation, record review, and interview; the facility failed to ensure annual inspection and testing of 9 of 9 fire door assemblies were completed… Findings include: Based on records review and interview with the Executive Director and the Maintenance director on 6/13/23, documentation of an annual inspection of fire door assemblies 8/01/2023d 5/25/23 showed 5 passed and 11 failed doors. The provided inspection report did not include the door leading from the Environmental Services Office into the Laundry area, which is part of the fire wall assembly. During the tour several doors and door Jamb assemblies were missing tags indicating the ratings. The Maintenance Director stated that a company had been hired to come and certify the aforementioned doors and provide/install the appropriate rating plates. **What corrective action(s) will be accomplished for those residents found to have been**	08/01/2023

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	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 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 Executive Director and the Maintenance Director on 06/13/23 between 8:45 a.m. and 12:05 p.m. and observations between 12:05 p.m. and 1:45 p.m., documentation of an annual inspection of fire door assemblies dated 5/25/23 showed 5 passed and 11 failed doors. The provided inspection report did not include the door leading from the Environmental Services office into the Laundry area, which is part of the fire wall assembly. During the tour several doors and door jamb assemblies were missing tags indicating the ratings. The Maintenance Director stated that a company had been hired to come and certify the aforementioned doors and provide/install the appropriate rating plates.		**affected by this practice?** · All 11 doors identified in the annual inspection on 5/23/23 as having failed inspection were evaluated and certified according to NFPA. · The door leading from the Environmental Services Office into the Laundry area identified on the facility tour was also evaluated and certified accordingly. **How will you identify all other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. · The Maintenance Director performed an audit of all doors and door jambs in the facility to ensure that all door and door jamb certifications were tagged indicating their appropriate ratings. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur?** · The Maintenance Director will perform an inspection of facility door jambs and doors every six months and after any construction to ensure ratings are affixed at least every six months. · The Executive	

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	This finding was acknowledged by the Executive Director and the Maintenance Director at the time of discovery and again at the exit conference with the Executive Director, Maintenance Director, and Assistant Maintenance personnel present. 3.1-19(b)		Director/designee will complete a Life Safety CQI audit tool daily for seven days; weekly for seven weeks; monthly thereafter to monitor compliance until compliance has been maintained for two consecutive quarters. If threshold of 100% is not achieved an action plan will be developed to assure compliance. Audit will also be completed at the conclusion of construction in addition to the CQI schedule set forth above. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** · The Executive Director/designee will complete a Life Safety CQI audit tool daily for seven days; weekly for seven weeks; monthly thereafter to monitor compliance until compliance has been maintained for two consecutive quarters. If threshold of 100% is not achieved an action plan will be developed to assure compliance. Audit will also be completed at the conclusion of construction in addition to the CQI schedule set forth above. · The Maintenance Director/designee and Executive Director will review the Life Safety CQI and any issues identified through the CQI process will be addressed immediately via corrective action plan.	

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			Maintenance Director/designee will also review the results with the Safety Committee at their monthly meetings. · The Safety Committee will monitor results of the inspections and report to the Continuous Quality Improvements Committee on their results from the inspections. · The Maintenance Director and Administrator are responsible for these results.	
K 0927 SS=F 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 storage/transfer room was provided with a sign indicating that transferring is occurring and not occurring. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs indicating that trans-filling is occurring, and that smoking is the immediate area is not permitted. This deficient practice could affect all residents.	K 0927	**K 927 GAS EQUIPMENT – TRANSFILLING CYLINDERS** Based on observation and interview, the facility failed to ensure that 1 of 1 oxygen storage/transfer was provided a sign indicating that transferring is occurring and not occurring. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs	08/01/2023

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	Findings include: Based on observation and interview with the Executive Director and the Maintenance Director on 06/13/23 during a facility tour between 12:05 p.m. and 1:45 p.m., the oxygen storage/transfer room near the elevator, did not have a posted sign indicating when transferring of oxygen occurs in this location and when it is not occurring. The posted sign suggests that it is always occurring. Based on interview at the time of observation, the Maintenance Director stated there was not a sign stating when trans-filling oxygen is occurring and when it was not. This finding was acknowledged by the Executive Director and the Maintenance Director at the time of discovery and again at the exit conference with the Executive Director, Maintenance Director, and Assistant Maintenance personnel present. 3.1-19(b)		indicating that transfilling is occurring, and that smoking in the immediate vicinity is not permitted. Findings include: Based on observation and interview with the Executive Director and the Maintenance director on 6/13/23, the oxygen storage/transfer room near the elevator, did not have a posted sign indicating when transferring oxygen occurs int his location and when it is not occurring. The posted sign suggests that it is always occurring. **What corrective action(s) will be accomplished for those residents found to have been affected by this practice?** · The Maintenance Director replaced the posted sign outside of the Oxygen storage/transfer room near the elevator, which indicated that transfilling was always occurring, with a sign that can be manipulated by staff to reflect when oxygen transfilling was occurring and when it is not. **How will you identify all other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** · All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. · The Maintenance Director	

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			replaced the posted sign outside of the Oxygen storage/transfer room near the elevator, which indicated that transfilling was always occurring, with a sign that can be manipulated by staff to reflect when oxygen transfilling was occurring and when it is not. **What measures will be put into place or what systemic changes you will make to ensure the deficient practice will not recur?** · The Maintenance Director replaced the posted sign outside of the Oxygen storage/transfer room near the elevator, which indicated that transfilling was always occurring, with a sign that can be manipulated by staff to reflect when oxygen transfilling was occurring and when it is not. · Staff were provided in-service training on Oxygen storage and transferring, including but not limited to the use of the new sign to indicate when transfilling is and is not occurring. **How will the corrective action(s) be monitored to ensure the deficient practice will not recur?** · The Executive Director/designee will complete a Life Safety CQI audit tool daily for seven days; weekly for seven weeks; monthly thereafter to monitor compliance until compliance has been maintained	

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			for two consecutive quarters. If threshold of 100% is not achieved an action plan will be developed to assure compliance. Audit will also be completed at the conclusion of construction in addition to the CQI schedule set forth above. · The Maintenance Director/designee and Executive Director will review the Life Safety CQI and any issues identified through the CQI process will be addressed immediately via corrective action plan. Maintenance Director/designee will also review the results with the Safety Committee at their monthly meetings. · The Safety Committee will monitor results of the inspections and report to the Continuous Quality Improvements Committee on their results from the inspections. · The Maintenance Director and Administrator are responsible for these results.	