STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155768	A. BUILDING -- B. WING	03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EVANSVILLE PROTESTANT HOME	3701 WASHINGTON AVE EVANSVILLE, IN 47714

(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: 03/05/24 Facility Number: 001125 Provider Number: 155768 AIM Number: 201272600 At this Emergency Preparedness survey, Evansville Protestant Home was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 49 certified beds. At the time of the survey, the census was 43. Quality Review completed on 03/07/24	E 0000	Life Safety Code Plan of Correction is respectfully submitted to the Indiana State Department of Health. The preparation and execution of this plan of correction or any other corrective action set forth here in does not constitute an admission or agreement by Evansville Protestant Home of the facts alleged or in conclusions set forth in the state of deficiencies. The plan of correction and specific actions are solely executed for provisions by federal and state law.	
E 0004 SS=C Bldg. --	403.748(a), 416.54(a), 418.113(a), 441.184(a), 482.15(a), 483.475(a), 483.73(a), 484.102(a), 485.625(a), 485.68(a), 485.727(a), 485.920(a), 486.360(a), 491.12(a), 494.62(a) Develop EP Plan, Review and Update Annually §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anna Michelle Perry	HFA	03/22/2024

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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	Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. .			
	Based on record review and interview, the facility failed to develop and maintain an emergency	E 0004	E004 The administrator reviewed and	03/29/2024

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	155768	A. BUILDING -- B. WING	03/05/2024

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	preparedness plan that was reviewed and updated at least annually in accordance with 42 CFR 483.73(a). This deficient practice could affect all residents in the facility. Findings include: Based on review of the Emergency Manual on 03/05/24 between 9:45 a.m. and 1:15 p.m. with the Maintenance Director present, the facility did provide an emergency preparedness manual, however, it has not been reviewed and updated during the past twelve months. The most recent date of review was 02/15/23. Based on interview at the time of review, the Maintenance Director confirmed the Emergency Manual has not been reviewed and updated within the past twelve month period, and further said it is scheduled to be reviewed and updated during the March 2024 Safety Meeting. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		updated the emergency plan including policies and procedures based on the facility and community based risk assessment and communication plan utilizing an all-hazards approach. The Safety Committee team verified all disaster preparedness manuals are current, updated and accessible. Manuals are located at each nurse's station and in the Administrator's office, Environmental Services office, and Dietary office. Current staff shall be in-serviced regarding location and regulation. The Safety Committee team shall review the plan at least annually and ensure compliance through Quality Assurance meeting.	
E 0013 SS=C Bldg. --	403.748(b), 416.54(b), 418.113(b), 441.184(b), 482.15(b), 483.475(b), 483.73(b), 484.102(b), 485.625(b), 485.68(b), 485.727(b), 485.920(b), 486.360(b), 491.12(b), 494.62(b) Development of EP Policies and Procedures §403.748(b), §416.54(b), §418.113(b), §441.184(b), §460.84(b), §482.15(b), §483.73(b), §483.475(b), §484.102(b), §485.68(b), §485.625(b), §485.727(b), §485.920(b), §486.360(b), §491.12(b), §494.62(b). (b) Policies and procedures. [Facilities] must develop and implement emergency			

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	preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(b):] Policies and procedures. The LTC facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least every 2 years.			

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	*[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. Based on record review and interview, the facility failed to develop and implement emergency preparedness policies and procedures. The policies and procedures must be reviewed and updated at least annually in accordance with 42 CFR 483.73(b). This deficient practice could affect all residents in the facility. Findings include: Based on review of the Emergency Manual on 03/05/24 between 9:45 a.m. and 1:15 p.m. with the Maintenance Director present, there was documentation in the plan for facility policies and procedures, however the policies and procedures have not been reviewed by the facility within the most recent twelve month period. The most recent date of review was 02/15/23. Based on interview at the time of review, the Maintenance Director confirmed the policies and procedures within the Emergency Manual have not been reviewed and updated within the past twelve month period, and further said the Emergency	E 0013	The administrator reviewed and updated the emergency plan including policies and procedures based on the facility and community based risk assessment and communication plan utilizing an all-hazards approach. The Safety Committee team verified all disaster preparedness manuals are current, updated and accessible. Manuals are located at each nurse’s station and in the Administrator's office, Environmental Services office, and Dietary office. Current staff shall be in-serviced regarding location and regulation. The Safety Committee team shall review the plan at least annually and ensure compliance through Quality Assurance meeting.	03/29/2024

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	Manual is scheduled to be reviewed and updated during the March 2024 Safety Meeting. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.			
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c). (c) The [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 every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Manual on 03/05/24 between 9:45 a.m. and 1:15 p.m. with the Maintenance Director present, the facility's Emergency Manual did include a plan to develop	E 0029	The administrator reviewed and updated the emergency plan including policies and procedures based on the facility and community based risk assessment and communication plan utilizing an all-hazards approach. The Safety Committee team verified all disaster preparedness manuals are current, updated and accessible. Manuals are located at each nurse’s station and in the Administrator's office,	03/29/2024

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	155768	A. BUILDING -- B. WING	03/05/2024

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	and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws, however the communication plan has not been reviewed by the facility within the most recent twelve month period. The most recent date of review was 02/15/24. Based on interview at the time of review, the Maintenance Director confirmed the Communication Plan within the Emergency Manual has not been reviewed and updated within the past twelve month period, and further said it was scheduled to be reviewed and updated during the March 2024 Safety Meeting. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.		Environmental Services office, and Dietary office. Current staff shall be in-serviced regarding location and regulation. The Safety Committee team shall review the plan at least annually and ensure compliance through Quality Assurance meeting.	
E 0036 SS=C Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency			

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	155768	A. BUILDING -- B. WING	03/05/2024

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	preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The			

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	dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. Based on record review and interview, the facility failed to develop and maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Manual on 03/05/24 between 9:45 a.m. and 1:15 p.m. with the Maintenance Director present, there was documentation available to show the facility had an emergency preparedness training and testing program, however the training and testing program has not been reviewed by the facility within the most recent twelve month period. The most recent date of review was 02/15/23. Based on interview at the time of review, the Maintenance Director confirmed the training and testing policy and procedure within the Emergency Manual has not been reviewed and updated within the past twelve month period, and further said it was scheduled to be reviewed and updated during the March 2024 Safety Meeting. This finding was reviewed with the Administrator and Maintenance Director during the exit conference.	E 0036	E036 The administrator reviewed and updated the emergency plan including policies and procedures based on the facility and community based risk assessment and communication plan utilizing an all-hazards approach. The Safety Committee team verified all disaster preparedness manuals are current, updated and accessible. Manuals are located at each nurse's station and the Administrator's office, Environmental Services office, and Dietary office. Current staff shall be in-serviced regarding location and regulation. The Safety Committee team shall review the plan at least annually and ensure compliance through Quality Assurance Meeting.	03/29/2024

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K 0000 Bldg. 02	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: 03/05/24 Facility Number: 001125 Provider Number: 155768 AIM Number: 201272600 At this Life Safety Code survey, Evansville Protestant Home 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 facility consists of two buildings connected by a service corridor. The north building is a one story facility determined to be of Type II (000) and fully sprinklered. The south building is a one story facility determined to be of Type II (000) and fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors and all resident sleeping rooms. The facility has a capacity of 49 and had a census of 43 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered except one detached wood framed storage shed.	K 0000	Life Safety Code Plan of Correction is respectfully submitted to the Indiana State Department of Health. The preparation and execution of this plan of correction or any other corrective action set forth here in does not constitute an admission or agreement by Evansville Protestant Home of the facts alleged or in conclusions set forth in the state of deficiencies. The plan of correction and specific actions are solely executed for provisions by federal and state law.	

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	Quality Review completed on 03/07/24			
K 0233 SS=C Bldg. 02	NFPA 101 Clear Width of Exit and Exit Access Doors Clear Width of Exit and Exit Access Doors 2012 EXISTING Exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. 19.2.3.6, 19.2.3.7 Based observation and interview, the facility failed to ensure sleeping room exit doors were at least 32 inches wide for 10 of 10 resident sleeping room doors. This deficient practice could affect up to 8 residents in the North Unit. Findings include: Based on observations on 03/05/24 between 1:15 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, the following resident sleeping room door openings in the North Unit measured only 30 inches: Rooms 1 through 10. This was confirmed by the Maintenance Director who provided the measurements of the door openings. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0233	K233 Sleeping room exit door waiver for 10 doors on North Nursing is being requested. Please see attached Life Safety Code Waiver Request Form and additional summary documentation.	03/29/2024
K 0345 SS=F Bldg. 02	NFPA 101 Fire Alarm System - Testing and Maintenance			

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	Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm system in accordance with NFPA 72, as required by LSC 101 Sections 19.3.4.5.1 and 9.6. NFPA 72, Section 14.3.1 states that unless otherwise permitted by 14.3.2, visual inspections shall be performed in accordance with the schedules in Table 14.3.1, or more often if required by the authority having jurisdiction. Table 14.3.1 states that the following must be visually inspected semi-annually: a. Control unit trouble signals b. Remote annunciators c. Initiating devices (e.g. duct detectors, manual fire alarm boxes, heat detectors, smoke detectors, etc.) d. Notification appliances e. Magnetic hold-open devices This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 03/05/24 between 9:45 a.m. and 1:15 p.m. with the Maintenance Director present, there was documentation provided regarding an annual fire alarm system inspection dated 04/26/23 by the facility's fire alarm inspection vendor, furthermore, there were quarterly inspections available dated 07/17/23, 10/30/23, and 01/23/24 by the facility's fire alarm	K 0345	K345 The facility modified the vendor form to include information column of visual inspection semi annually of facility's fire alarm devices such as smoke detectors and heat detectors. The Maintenance team shall be educated to the new report and its required completion and submission to Safety Committee 2x per year. The Safety Committee team shall be responsible for ensuring compliance and the semi annual form will be reviewed 2x per year at Safety Committee.	03/29/2024

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	155768	A. BUILDING 02 B. WING	03/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
EVANSVILLE PROTESTANT HOME	3701 WASHINGTON AVE EVANSVILLE, IN 47714

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	inspection vendor, however, the quarterly inspection documents did not provide information about a semi-annual visual inspection of the facility's fire alarm devices, such as smoke detectors and heat detectors. The facility's pull stations were tested during each quarterly inspection. Based on interview at the time of record review, the Maintenance Director agreed the quarterly inspections did not provide information of a semi-annual visual inspection of the facility's fire alarm system devices, such as smoke detectors and heat detectors. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)			
K 0353 SS=E Bldg. 02	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in 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			

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	Based on observation and interview, the facility failed to ensure the ceiling in 1 of 4 sprinklered smoke compartments was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect at least 20 residents, staff, and visitors. Findings include: Based on observations on 03/05/24 between 1:15 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, the following was noted: a. There were two sprinkler escutcheon rings missing and one hanging down one inch in the Treatment Room. The two missing escutcheon rings and the one hanging down left a one half inch gap around each sprinkler pipe that penetrated the ceiling. b. There were two, half inch holes in the Dining Room ceiling near the exit door that were not properly fire stopped. c. There was a half inch gap around a low point drain that penetrated the ceiling within the furnace room adjacent to the Dining Room that was not properly fire stopped. Based on interview at the time of each observation, the Maintenance Director acknowledged the holes/gaps penetrating the ceiling in the previously mentioned areas that were not properly fire stopped. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0353	K353 The facility's Maintenance team has performed facility wide audit to ensure escutcheon plates are in proper position to allow sprinkler heads to function at full capacity. NO additional concerns were noted. Vendor has been to facility to replace the missing escutcheon plates noted in the citation. There was also two half inch gaps noted in the ceiling near an exit door that were not properly fire stopped. Both holes have been filled with approved fire caulk by maintenance team and facility wide audit performed of ceilings to ensure additional compliance.	03/29/2024
K 0712 SS=F	NFPA 101 Fire Drills			

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Bldg. 02	Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 1 of 3 shifts during 1 of 4 quarters. This deficient practice could affect all residents, as well as staff and visitors in the facility. Findings include: Based on review of the facility's fire drill reports on 03/05/24 between 9:45 a.m. and 1:15 p.m. with the Maintenance Director present,, the facility lacked fire drill documentation for the first shift (day) of the fourth quarter (October, November, and December) of 2023. Based on interview at the time of record review, the Maintenance Director confirmed the lack of a fire drill report for the first shift of the fourth quarter of 2023. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b) 3.1-51(c)	K 0712	K712 Citation noted a missed first shift fire drill in month of November. This particular month the facility had actual fire at 6pm with text book response from staff and fire department. The ancillary director counted the actual event as a drill and did not realize the timing was an issue. The facility utilizes a 12 month calendar form to track that all shifts participate in drills as practice for an actual event. A first shift drill has been conducted since that time and the facility is on track for each shift to practice a fire drill in the 1st quarter of this year for compliance. The calendar year form shall be turned into Safety Committee team quarterly to ensure future compliance with rotating shifts.	03/29/2024
K 0923 SS=E	NFPA 101 Gas Equipment - Cylinder and Container			

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Bldg. 02	Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.			

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	11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 1 oxygen transfilling room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.3 states storage for nonflammable gases with a total volume equal to or less than greater than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. 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 at least 20 residents, staff, and visitors. Findings include: Based on observations on 03/05/24 between 1:15 p.m. and 3:15 p.m. during a tour of the facility with the Maintenance Director, there were two medium sized oxygen cylinders freestanding on the floor in the oxygen transfilling/storage room. The two oxygen cylinders were not supported in a proper cylinder stand or otherwise secured from falling. Based on interview at the time of the observation, the Maintenance Director acknowledged the two oxygen cylinders freestanding on the floor and not supported in a cylinder stand or otherwise secured from falling. This finding was reviewed with the Administrator and Maintenance Director during the exit conference. 3.1-19(b)	K 0923	K923 The facility understands all cylinders of nonflammable gases such as oxygen should be properly secured from falling. The cylinder which was not secured was a Hospice cylinder brought in by a different vendor than what the facility uses. Staff have been educated that cylinders are required to be secured and an additional bracket stand was brought to oxygen room by our current vendor. Hospice was informed of the citation and asked to not deliver unless they also pick up a cylinder. Hospice informed facility they do not utilize concentrators and will continue to bring cylinders. Maintenance team has been educated to routinely check the oxygen room for compliance and spot check resident rooms when performing rounds for additional compliance. Facility audit by Maintenance team revealed no additional concerns.	03/29/2024