STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155728	A. BUILDING -- B. WING	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MANDERLEY HEALTH CARE CENTER	806 S BUCKEYE ST OSGOOD, IN 47037

(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: 04/15/2024 Facility Number: 000493 Provider Number: 155728 AIM Number: 100291300 At this Emergency Preparedness survey, Manderley Health Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 71 certified beds. At the time of the survey, the census was 50 Quality Review completed on 04/18/24	E 0000	**The facility recognizes that it must persuade your office that appropriate systems are in place to assure ongoing compliance with the federal regulations for participation in the Medicare and Medicaid programs. Please accept the following as our process to ensure that the necessary steps will be taken to provide the best care possible to the residents at Manderley Healthcare. Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. Manderley Healthcare respectfully requests consideration of a desk review for the alleged deficiencies within this plan of correction.**	
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	K 0000	**The facility recognizes that it must persuade your office that appropriate systems are in**	

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

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	483.90(a). Survey Date: 04/15/2024 Facility Number: 000493 Provider Number: 155728 AIM Number: 100291300 At this Life Safety Code survey, Manderley Health Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V(000) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridor, in all areas open to the corridor and has smoke detectors hard wired to the building electrical system in all resident sleeping rooms. The facility has a capacity of 71 and had a census of 50 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing storage services were sprinklered. The facility has a detached building housing the facility's emergency generator which was fully sprinklered. Quality Review completed on 04/18/24		**place to assure ongoing compliance with the federal regulations for participation in the Medicare and Medicaid programs. Please accept the following as our process to ensure that the necessary steps will be taken to provide the best care possible to the residents at Manderley Healthcare. Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. Manderley Healthcare respectfully requests consideration of a desk review for the alleged deficiencies within this plan of correction.**	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance			

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	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 1. Based on record review and interview, the facility failed to maintain 1 of 1 fire alarm systems in accordance with NFPA 72, National Fire Alarm Code as required by LSC 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 building occupants. Findings include: During record review with the Maintenance Director on 04/15/2024 between 11:15 AM and 1:45 PM, no documentation was available regarding a visual semi-annual fire alarm system inspection. The annual fire alarm system testing was completed on 05/31/2023. Based on interview at the time of record review, the Maintenance Supervisor stated he does not do a visual semi-annual fire alarm system inspection, but that	K 0345	**F345 Fire Alarm System-Testing and Maintenance** 1 The facility allegedly failed to have a visual semi-annual fire alarm system inspection completed. The facility immediately contacted Quality Fire Protection to schedule completion of the required visual fire alarm system inspection. Any identified concerns will be immediately addressed. The facility allegedly failed to maintain the fire alarm system to assure that it had accurate time information. The facility immediately corrected the time information in the fire alarm system to reflect the accurate time. 2 The alleged deficiency has the potential to affect all residents, staff, or visitors in the facility but non were effected. The Maintenance Director completed a visual inspection of	05/24/2024

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	the contractor could complete it if requested. This finding was reviewed with the Administrator and the Maintenance Supervisor at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain the fire alarm system to assure that it had accurate time information in accordance with the requirements of NFPA 101- 2012 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 2010 edition, Sections 14.1, 14.1.1. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation of the fire alarm control panel annunciator on 04/15/2024 at 1:51 PM during a tour of the facility with the Maintenance Supervisor, the time on the fire alarm control panel indicated the time was 2:22 PM. Additionally, the fire alarm control panel indicated the time was 3:54 PM upon observation at 3:24 PM. Based on interview at the time of observations, the Maintenance Supervisor agreed the fire alarm control panel and the fire alarm control panel annunciator displayed the incorrect times. This finding was reviewed with the Administrator and the Maintenance Supervisor at the exit conference. 3.1-19(b)		the facility fire alarm system. Any identified concerns were immediately addressed. 3 The Administrator completed a 1:1 education with the facility Maintenance Director regarding the requirements to meet NFPA72 and NFPA101-National Fire Alarm Code 4 The Maintenance Director/Administrator/Designee will complete one day a week rounds to visually inspect the fire alarm system and validate the fire alarm system reflects the accurate time and review the maintenance binder to ensure the semi-annual fire alarm system inspection is in the maintenance binder x 12 weeks. This will continue for no less than 3 months and compliance is achieved. The Maintenance Director/Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
K 0353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing			

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Bldg. 01	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 1. Based on observation and interview; the facility failed to ensure 1 of 2 sprinkler heads in shower room 1, 1 of 1 kitchen storage rooms, 1 of 1 men's bathroom near the dining room, and 1 of 1 women's bathroom near the dining room covered with rust/corrosion were replaced. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2) Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect any resident, staff, or visitor in shower room 1, kitchen storage room, and the men's and women's bathroom near the dining room.	K 0353	**F353-Sprinkler System-Maintenance and Testing** 1. The facility allegedly failed to ensure 1 of 2 sprinkler heads in shower room 1, 1 of 1 sprinkler heads in kitchen storage rooms, 1 of 1 men's bathroom sprinkler heads near the dining room and 1 of 1 women's bathroom near the dining room were free of rust/corrosion. The facility immediately addressed the alleged deficiency by ordering the replacement sprinkler heads and will install them immediately upon receipt. The facility allegedly failed to	05/24/2024

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	Findings include: Based on observation during a tour of the facility on 04/15/2024 between 1:45 PM and 4:00 PM with the Maintenance Supervisor, 1 of 2 sprinkler heads in shower room 1, 1 of 1 kitchen storage rooms, 1 of 1 men's bathroom near the dining room, and 1 of 1 women's bathroom near the dining room were covered with corrosion/rust. Based on interview at the time of observation, the Maintenance Supervisor agreed there was corrosion/rust on the aforementioned sprinkler heads. This finding was reviewed with the Administrator and the Maintenance Supervisor at the exit conference. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was maintained with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect		ensure 1 of 1 sprinkler systems was maintained with spare sprinklers, a spare sprinkler cabinet and a spare sprinkler wrench on the premises. The facility immediately obtained and initiated compliance with a spare sprinkler cabinet, spare sprinkler wrench and spare sprinkler supported within the cabinet upon receipt of order. The facility allegedly failed to maintain ceiling construction in 2 locations shower room 1. The construction of the ceiling in the 2 locations of shower room 1 will be repaired upon receipt of the sprinkler head installation. 2 The alleged deficient practice has the potential to affect all residents, staff and visitors and non were effected. The Maintenance Director completed an audit of all sprinkler heads, ensured a spare with a spare cabinet and wrench were in place, and all ceiling construction for concerns. Any identified concerns were immediately addressed. 3 The Administrator completed a 1:1 education with the facility	

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	all residents and staff in the facility. Findings include: Based on observation during a tour of the facility with the Maintenance Supervisor and Administrator on 04/15/2024 between 1:45 PM and 4:00 PM, there was a spare sprinkler cabinet in the utility service room with spare sprinkler heads, however the spare sprinkler heads were not supported within the spare sprinkler cabinet and were sitting on top of the shelves within the cabinet. Based on interview at the time of observation, the Maintenance Supervisor agreed the spare sprinkler heads were not supported within the spare sprinkler cabinet. This finding was reviewed with the Maintenance Supervisor and Administrator at the exit conference. 3.1-19(b) 3. Based on observation and interview, the facility failed to maintain the ceiling construction in 2 locations in shower room 1. NFPA 13, 2010 edition, Section 3.3.5.4 defines a smooth ceiling as a continuous ceiling free from significant irregularities, lumps, or indentations. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. Section 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect several staff and residents within the same smoke compartment as shower room 1. Findings include:		Maintenance Director regarding the requirements to meet NFPA13, NFPA25. 4.The Maintenance Director/Administrator/Designee will complete one day a week rounds to visually inspect the sprinkler heads, sprinkler cabinet, spare sprinkler head and wrench, and ceiling construction to ensure code is followed x 12 weeks. This will continue for no less than 3 months and compliance is achieved. The Maintenance Director/Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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	Based on observation during a tour of the facility on 04/15/2024 between 1:45 PM and 4:00 PM, a penetration of 3/8 inches was observed in the ceiling near the sprinkler above the toilet in shower room 1 and a penetration of 3/16 of an inch was observed near the second sprinkler in shower room 1. Based on interview at the time of observation, the Maintenance Supervisor agreed the penetrations were present and provided the measurements of the penetrations. This finding was reviewed with the Maintenance Supervisor and Administrator at the exit conference. 3.1-19(b)			
K 0362 SS=E Bldg. 01	NFPA 101 Corridors - Construction of Walls Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give			

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	brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 Based on observation and interview, the facility failed to ensure corridor walls in 2 of 5 smoke compartments in the facility were constructed to resist the transfer of smoke. This deficient practice could affect over 15 residents, staff, and visitors in the vicinity the TV lounge and the 100 hallway. Findings include: Based on observation during a tour of the facility on 04/15/2024 between 1:45 PM and 4:00 PM with the Maintenance Supervisor, penetrations of 9/16 inches in the walls were observed in the TV lounge and near rooms 105 and 102. Based on interview at the time of observations, the Maintenance Supervisor stated penetrations near rooms 102 and 105 were due to the passage of cords and the penetration in TV lounge was for a TV that had been present previously. The Maintenance Supervisor stated each hall had a penetration in it due to a cord being run to a device attached to the wall. This finding was reviewed with the Maintenance Supervisor and Administrator at the exit conference. 3.1-19(b)	K 0362	**F362 Corridors-Construction of Walls** 1 The facility allegedly failed to ensure corridor walls in 2 of 5 smoke compartments in the facility were constructed to resist the transfer of smoke. The facility immediately corrected the alleged deficient practice to ensure construction of the 2 out of 5 smoke compartments in the facility were resistant to transfer of smoke. 2 The alleged deficient practice has the potential to affect over 15 residents, staff, and visitors in the vicinity of the TV lounge and the 100 hallways and non were effected. The Maintenance Director completed an audit of all corridor walls to ensure smoke compartments were constructed to resist the transfer of smoke. Any identified concerns were immediately addressed. 3 The Administrator completed a 1:1 education with the facility Maintenance Director regarding the requirements to meet NFPA101. 4 The Maintenance Director/Administrator/Designee	05/24/2024

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			will complete one day a week rounds to ensure smoke compartments are constructed to resist the transfer of smoke for 12 weeks. This will continue for no less than 3 months and compliance is achieved. The Maintenance Director/Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
K 0521 SS=F Bldg. 01	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 Based on observation and interview, the facility failed to ensure 4 of 4 egress corridors were not used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. LSC 19.5.2.1 requires air conditioning, heating, ventilating ductwork and related equipment to be installed in accordance with NFPA 90A, Standard for the Installation of Air Conditioning and Ventilating Systems. NFPA 90A, 2012 Edition, Section 4.3.12.1.1 states egress corridors shall not be used	K 0521	**K521 HVAC** 1 The facility allegedly failed to ensure 4 of 4 egress corridors were not used as a portion of a return air system/plenum for heating, ventilating, or air conditioning (HVAC) ductwork serving adjoining areas. The facility immediately renewed	05/24/2024

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	as a portion of a supply, return, or exhaust air system serving adjoining areas unless otherwise permitted by 4.3.12.1.3.1 through 4.3.12.1.3.4. This deficient practice could affect all residents, staff and visitors. Findings include: Based on interview during record review on 4/15/2024 between 11:15 AM and 1:45 PM, the Maintenance Supervisor stated the facility has a waiver for the fire/smoke dampers and the system shuts down with fire alarm system activation. Based on observations with the Maintenance Supervisor during a tour of the facility from 1:45 PM to 4:00 PM, all resident sleeping rooms and all rooms in the south wing were using the egress corridor as a return air system. These findings were reviewed with the Administrator and the Maintenance Supervisor during the exit conference. 3.1-19(b)		their Life Safety Code Waiver. 1 The alleged deficient practice has the potential to affect all residents, staff and visitors and non were effected. The facility immediately renewed their Life Safety Code Waiver Request 2 The Administrator completed a 1:1 education with the facility Maintenance Director regarding the requirements to meet NFPA90A and LSC 19.4.2.1 3 The Maintenance Director/Administrator/Designee will validate Life Safety Code Waiver is in place and not expired weekly for 12 weeks. This will continue for no less than 3 months and compliance is achieved. The Maintenance Director/Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	
K 0920 SS=D Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords			

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	Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 power strips in room 204 was not used as a substitute for fixed wiring. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. LSC Section 4.5.7 states any building service equipment or safeguard provided for life safety shall be designed, installed, and approved in accordance with all applicable NFPA standards. NFPA 99, Standard for Health Care Facilities, 2012 edition, defines patient care areas as any portion of a health care facility wherein patients are intended to be examined or treated.	K 0920	**K920 Electrical Equipment-Power Cords and Extensions** 1 The facility allegedly failed to ensure 1 of 1 power strips in room 204 was not used as a substitute for fixed wiring. The Maintenance Director immediately removed the power strip from room 204 and the mini fridge was plugged into fixed wiring. 2 The alleged deficient practice has the potential to affect residents, staff and visitors and non were effected. The Maintenance Director	05/24/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155728	A. BUILDING 01 B. WING	04/15/2024

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	Patient care vicinity is defined as a space, within a location intended for the examination and treatment of patients, extending 6 ft (1.8 m) beyond the normal location of the bed, chair, table, treadmill, or other device that supports the patient during examination and treatment. A patient care vicinity extends vertically to 7 ft 6 in. (2.3 m) above the floor. NFPA 99, Section 10.4.2.3 states household or office appliances not commonly equipped with grounding conductors in their power cords shall be permitted provided they are not located within the patient care vicinity. This deficient practice could affect many residents, staff, and visitors Findings include: Based on observation during a tour of the facility with the Maintenance Supervisor on 04/15/2024 between 1:45 PM and 4:00 PM, a mini fridge was plugged into a power strip and not directly into the wall in room 204. Based on interview at the time of observation, the Maintenance Supervisor agreed the mini fridge was plugged into a power strip. This finding was reviewed with the Administrator and Maintenance Supervisor at the exit conference. 3.1-19(b)		completed an audit to ensure that power strips were not used as a substitute for fixed wiring. Any identified concerns were immediately addressed. 3 The Administrator completed a 1:1 education with the facility Maintenance Director regarding the requirements to meet NFPA70, NFPA99, LSC 9.1.2, LSC19.5.1 4 The Maintenance Director/Administrator/Designee will complete rounds to ensure power strips are not used as a substitute for fixed wiring as follows: Rotating locations to include common areas, resident rooms, dining rooms, kitchen, offices will be audited 3 days a week x 4 weeks, then 2 days a week x 4 weeks, then 1 day a week x 4 weeks. This will continue for no less than 3 months and compliance is achieved. The Maintenance Director/Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	

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K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container 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			

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	avoid confusion. Cylinders stored in the open are protected from weather. 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 a minimum distance of at least 20 feet separated combustible materials from oxygen storage equipment in 1 of 1 oxygen storage areas. NFPA 99, Section 11.3.2.3 requires oxidizing gases such as oxygen shall be separated from combustibles by one of the following: (1) a minimum distance of 20 feet. (2) a minimum distance of 5 feet if the required storage location is protected by an automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. This deficient practice could affect any staff in the liquid oxygen shed. Findings include: Based on observation during a tour of the facility with the Maintenance Supervisor on 04/15/2024 between 1:45 PM and 4:00 PM, the facility stores liquid oxygen in a metal shed unattached to the rest of the building. The shed was not sprinklered. The facility had 4 liquid oxygen containers stored in the shed with a lift and rags, safety glasses, and an apron on a wooden shelf directly over the liquid oxygen containers. The Maintenance Supervisor removed the lift at the time of observation. The Maintenance Director stated he built the shelf to store the rags, safety glasses, and apron in this location. This finding was reviewed with the Maintenance Supervisor and Administrator at the exit conference.	K 0923	**F923 Gas Equipment-Cylinder and Container Storage** 1 The facility allegedly failed to ensure a minimum distance of at least 20 feet to separate combustible material from oxygen storage equipment in 1 of 1 oxygen storage areas. The Maintenance Director immediately removed combustible material from the oxygen storage area. 2 The alleged deficient practice has the potential to affect any staff and non were effected in the liquid oxygen shed. The Maintenance Director completed an audit of the liquid oxygen shed to ensure any combustible material had been removed. Any identified concerns were immediately addressed. 3 The Administrator completed a 1:1 education with the facility Maintenance Director regarding the requirements to meet NFPA99, NFPA13 4 The Maintenance Director/Administrator/Designee will complete rounds to ensure combustible material is not present in the liquid oxygen shed as follows: 3 days a week x 4	05/24/2024

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	3.1-19(b)		weeks, then 2 days a week x 4 weeks, the 1 day a week x 4 weeks. This will continue for no less than 3 months and compliance is achieved. The Maintenance Director/Administrator/Designee will present the results of these audits monthly to the QAPI committee for no less than 3 months. Any patterns that are identified will have an Action Plan initiated. The QAPI committee will determine when 100% compliance is achieved or if ongoing monitoring is required.	