STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155297	A. BUILDING -- B. WING	06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
MILLER'S HEALTH & REHAB BY MILLER'S MERRY MANOR	3530 MONROE STREET LA PORTE, IN 46350

(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: 06/13/2024 Facility Number: 000194 Provider Number: 155297 AIM Number: 100267790 At this Emergency Preparedness survey, Miller's Health and Rehab by Miller's Merry Manor was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 81 certified beds. Sixty-one beds are dually certified for Medicare and Medicaid, Twenty beds are certified only for Medicare. At the time of the survey, the census was 53. Quality Review completed on 06/18/24	E 0000		
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kari Mitchell	Administrator	07/02/2024

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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	The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the			

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	Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013.			

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	(xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Maintenance Director on 06/13/24 between 09:04 a.m. and 11:27 a.m., the generator lacked fuel sample testing required by LSC and NFPA 110. Based on interview at the time of record review, the Maintenance Director stated the fuel has been sampled since the last maintenance on the generator, but does not have any paperwork indicating that the fuel has been tested within the past 12 months. The findings were reviewed with the Administrator and Maintenance Director at the exit conference.	E 0041	It is the policy of Miller's Health & Rehab La Porte to ensure fuel sample testing is completed annually. All residents and staff have the potential to be affected by the deficient practice. To correct the deficient practice vendor was contacted to check on the status of fuel testing. Fuel was collected 5/31/24 and has been sent to lab for testing. Vendor has been contacted and informed us that the sample had been lost. A new sample has been collected on 7/1/24 and awaiting results. To ensure continued compliance scheduled testing will be reviewed annually or as needed by the administrator or her designee.	07/01/2024
K 0000 Bldg. 03	A Life Safety Code Certification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/13/2024	K 0000		

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	Facility Number: 000194 Provider Number: 155297 AIM Number: 100267790 At this Life Safety Code survey, Miller's Health and Rehab by Miller's Merry Manor 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 (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors and in resident rooms. The building is fully protected by a 750 kW diesel-powered generator. The facility has a capacity of 81. Sixty-one beds are dually certified for Medicare and Medicaid, Twenty are certified only for Medicare. The facility had a census of 53 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas which provide facility services were sprinklered. Quality Review completed on 06/18/24			
K 0325 SS=E Bldg. 03	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR) Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid			

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	and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater than 5 gallons complies with NFPA 30 * Dispensers are not installed within 1 inch of an ignition source * Dispensers over carpeted floors are in sprinklered smoke compartments * ABHR does not exceed 95 percent alcohol * Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11) * ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485			
	Based on observation and interview, the facility failed to ensure 1 of over 15 alcohol-based hand sanitizer dispensers were not installed over an ignition source. NFPA 101, Section 19.3.2.6(8) states dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1-inch horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1-inch horizontal distance from the ignition source (c) Beneath an ignition source within a 1-inch vertical distance from the ignition source This deficient practice could affect 20 residents in one smoke compartment. Findings include:	K 0325	It is the policy of Miller's Health & Rehab La Porte to ensure alcohol-based hand sanitizer dispensers are not installed over an ignition source. All residents and staff have the potential to be affected by the deficient practice. To correct the deficient practice the hand sanitizer dispenser was moved from above the ignition source. To ensure continued compliance an audit was completed to check placement of all hand sanitizer	07/01/2024

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	Based on observation with the Maintenance Director and Administrator on 06/13/24 between 11:31 a.m. and 1:27 p.m., an alcohol-based hand sanitizer dispenser was installed on the wall above an electrical outlet in resident room 101. Based on interview at the time of observation, the Maintenance Director confirmed the alcohol-based hand sanitizer dispenser was installed on the wall above an electrical outlet and agreed that the dispenser should not be in that location. The finding was reviewed with the Administrator and the Maintenance Director during the exit conference. 3.1-19(b)		dispensers are not installed over ignition sources. Any installed incorrectly were relocated. The Maintenance Director or other designee will be responsible to complete the QA tool "Maintenance Services QA Review". This tool will be completed weekly x4 weeks then monthly x3 months, and quarterly thereafter. Findings will be reviewed in the facility Quality Assurance & Performance Improvement (QAPI) meeting to ensure ongoing compliance for a minimum of 6 months and until the facility maintains 95% compliance for 60 days as part of the QA program using the QA tool "Maintenance Services QA Review" (ATTACHMENT A). Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting.	
K 0511 SS=E Bldg. 03	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 electrical wirings in room	K 0511	It is the policy of Miller's Health & Rehab La Porte to ensure	07/01/2024

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	121 was protected. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect approximately 15 residents and staff. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Administrator on 06/13/24 between 11:31 a.m. and 1:27 p.m., resident room 121 had an open junction box which left exposed wiring. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned issue and further clarified that a thermostat for the room had gone bad and needed replacing which is the location of the exposed wires. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		electrical wiring is protected. All residents and staff have the potential to be affected by the deficient practice. To correct the deficient practice the thermostat control was reinstalled. To ensure continued compliance rooms were audited for exposed wiring. Any issues were corrected. Maintenance Director or designee will do a room audit after completion of work. The Maintenance Director or other designee will be responsible to complete the QA tool "Maintenance Services QA Review". This tool will be completed weekly x4 weeks then monthly x3 months, and quarterly thereafter. Findings will be reviewed in the facility Quality Assurance & Performance Improvement (QAPI) meeting to ensure ongoing compliance for a minimum of 6 months and until the facility maintains 95% compliance for 60 days as part of the QA program using the QA tool "Maintenance Services QA Review" (ATTACHMENT A). Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting.	

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K 0712 SS=F Bldg. 03	NFPA 101 Fire Drills 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 ensure 2 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 9:00 p.m. and 6:00 a.m. for the last 4 quarters. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on record review with the Maintenance Director and Administrator on 06/13/24 between 09:04 a.m. and 11:27 a.m., the fire drill forms for a second shift drill on 11/30/23 conducted at 6:06 p.m. and a first shift fire drill on 10/31/23 conducted at 12:07 p.m. were indicated as being a silent drill. On both fire drills forms, the transmission of the fire alarm signals were completed the next day and not during the fire drills. Based on interview at the time of record review, the Administrator confirmed that the	K 0712	It is the policy of Miller's Health & Rehab La Porte to ensure fire drills include verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 9pm-6am. All residents and staff have the potential to be affected by the deficient practice. To correct the deficient practice a fire drill was conducted 6//24. To ensure continued compliance a check off spreadsheet (ATTACHMENT B) will be used to ensure that fire drills are conducted on alternating shifts and silent drills are conducted during the appropriate times. Audit will be completed monthly by Maintenance Director or designee.	07/01/2024

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	documentation indicated that the drills were silent drills and later acknowledged that the drills were outside of the time frame when silent drills are acceptable. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b) 3.1-51(c)			
K 0753 SS=D Bldg. 03	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 Based on observation and interview, the facility failed to ensure 1 of 46 resident rooms were maintained in accordance with 19.7.5.6. LSC 19.7.5.6 prohibits combustible decorations unless an exception was met. This deficient practice could affect approximately 3 residents and staff. Findings include: Based on observation with the Administrator and	K 0753	It is the policy of Miller's Health & Rehab La Porte to ensure resident rooms had no combustible decorations. All residents and staff have the potential to be affected by the deficient practice. To correct the deficient practice	07/01/2024

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	Maintenance Director on 06/13/24 between 11:31 a.m. and 1:27 p.m., resident room 212 contained a candle, with a wick, on top of a dresser adjacent to bed #2. Based on interview at the time of observation, Based on interview at the time of observation, the Administrator confirmed that the candle was present, which contained a wick, and further agreed that the candle is a fire hazard. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		the resident's candle wick was removed. To ensure continued compliance an audit was completed on resident's rooms to ensure no combustible decorations were found. Any items found were removed. Inservicing was completed with All Staff on or before 7/1/24 to report when combustible decorations are found. The Maintenance Director or other designee will be responsible to complete the QA tool "Maintenance Services QA Review". This tool will be completed weekly x4 weeks then monthly x3 months, and quarterly thereafter. Findings will be reviewed in the facility Quality Assurance & Performance Improvement (QAPI) meeting to ensure ongoing compliance for a minimum of 6 months and until the facility maintains 95% compliance for 60 days as part of the QA program using the QA tool "Maintenance Services QA Review" (ATTACHMENT A). Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting.	
K 0918 SS=F	NFPA 101 Electrical Systems - Essential Electric Syste			

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Bldg. 03	Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the facility failed to ensure an annual fuel quality test was performed for 1 of 1 facility's diesel powered generator. NFPA 99, Health Care Facilities Code,	K 0918	It is the policy of Miller's Health & Rehab La Porte to ensure fuel sample testing is completed annually.	07/01/2024

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2012 Edition Section 6.5.4.1.1.2 states Type 2 EES (Essential Electrical System) generator sets shall be inspected and tested in accordance with Section 6.4.4.1.1.3. Section 6.4.4.1.1.3 states maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Chapter 8. NFPA 110, Section 8.3.8 states a fuel quality test shall be performed at least annually using tests approved by ASTM standards. This deficient practice could affect all residents. Findings include: Based on record review with the Administrator and the Maintenance Director on 06/13/24 between 11:31 a.m. and 1:27 p.m., documentation of an annual fuel quality test for the diesel generator was not available for review. Based on interview at the time of record review, the Maintenance Director acknowledged the documentation could not be found and later stated that the fuel has been sampled, however it is unknown if the testing has been completed or if the results have been sent. This finding was reviewed with the Administrator and Maintenance Director at the exit conference. 3.1-19(b)		All residents and staff have the potential to be affected by the deficient practice. To correct the deficient practice vendor was contacted to check on the status of fuel testing. Fuel was collected 5/31/24 and has been sent to lab for testing. Vendor has been contacted and informed us that the sample had been lost. A new sample has been collected on 7/1/24 and awaiting results. To ensure continued compliance scheduled testing will be reviewed annually or as needed by the administrator or her designee.	
K 0920 SS=E Bldg. 03	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been			

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	155297	A. BUILDING 03 B. WING	06/13/2024

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	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 3 of 3 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 5 staff and an unknown number of residents. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Administrator on 06/13/24 between 11:31 a.m. and 1:27 p.m., a refrigerator (high power draw equipment) was plugged into a multi-plug adapter which was plugged into an outlet. Also, a microwave (high power draw equipment) was plugged into an extension cord which was plugged into a multi-plug adapter which both were located in the	K 0920	It is the policy of Miller's Health & Rehab La Porte to ensure flexible cords are not used as a substitute for fixed wiring to provide power equipment with a high current draw. All residents and staff have the potential to be affected by the deficient practice. To correct the deficient practice all cords were removed and items plugged directly into the wall. The Maintenance Director or other designee will be responsible to complete the QA tool "Maintenance Services QA Review". This tool will be completed weekly x4 weeks then	07/01/2024

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	Admission's office. Furthermore, the Inservice Office had a fridge (high power draw equipment) plugged into a mult-plug adapter. Based on interview at the time of observation, the Maintenance Director confirmed that the fridges and microwave were not directly plugged into an outlet. Findings were discussed with the Maintenance Director and Administrator at exit conference. 3.1-19(b)		monthly x3 months, and quarterly thereafter. Findings will be reviewed in the facility Quality Assurance & Performance Improvement (QAPI) meeting to ensure ongoing compliance for a minimum of 6 months and until the facility maintains 95% compliance for 60 days as part of the QA program using the QA tool "Maintenance Services QA Review" (ATTACHMENT A). Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting.	
K 0923 SS=E Bldg. 03	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			

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	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. 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 12 of 12 cylinders were segregated from full and empty cylinders and were marked to avoid confusion. NFPA 99, Section 11.6.5.2 states, if empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Section 11.6.5.3 states empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner. This deficient practice could affect approximately 10 staff and an unknown number of residents. . Findings include: Based on observation with the Maintenance Director and Administrator on 06/13/24 between 11:31 a.m. and 1:27 p.m., the oxygen storage area	K 0923	It is the policy of Millers Health & Rehab La Porte to ensure cylinders are segregated from full and empty cylinders and are marked to avoid confusion. All residents and staff have the potential to be affected by the deficient practice. To correct the deficient practice signage was ordered for the oxygen room. Once received full tanks will be placed on one side of the room and empty tanks on the opposite. Red tape was placed on the floor to distinguished the sides.	07/01/2024

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	contained approximately 12 liquid and portable oxygen cylinders that were not marked or separated as full and empty cylinders. Based on interview at the time of observation, the Administrator agreed the oxygen cylinders were not marked as full and empty cylinders and has the potential to cause issues if an emergency or evacuation arises. This finding was reviewed with the Administrator and Maintenance Director at exit conference. 3.1-19(b)		Inservicing was completed with All Staff on or before 7/1/24 on how cylinders should be stored. To ensure continued compliance oxygen room will be checked monthly by the Maintenance Director or designee. The Maintenance Director or other designee will be responsible to complete the QA tool "Maintenance Services QA Review". This tool will be completed weekly x4 weeks then monthly x3 months, and quarterly thereafter. Findings will be reviewed in the facility Quality Assurance & Performance Improvement (QAPI) meeting to ensure ongoing compliance for a minimum of 6 months and until the facility maintains 95% compliance for 60 days as part of the QA program using the QA tool "Maintenance Services QA Review" (ATTACHMENT A). Any identified trends will be corrected upon discovery, documented on facility QA tracking log and reported during monthly QA Committee meeting.	