STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155681	A. BUILDING -- B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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: 03/21/24 Facility Number: 002657 Provider Number: 155681 AIM Number: 200308930 At this Emergency Preparedness survey, Autumn Woods Health Campus was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 91 certified beds and had a census of 79 at the time of this visit. Quality Review completed on 03/25/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Dates: 03/21/24 Facility Number: 002657 Provider Number: 155681 AIM Number: 200308930 At this Life Safety Code survey, Autumn Woods Health Campus was found not in compliance with	K 0000	The submission of this plan of correction does not indicate an admission by Autumn Woods Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided and the living environment provided to the residents of Autumn Woods Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Christopher Wright		04/03/2024

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	155681	A. BUILDING 01 B. WING	03/21/2024

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AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

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	Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors, spaces open to the corridors and in all resident sleeping rooms. The facility has a capacity of 91 and had a census of 79 at the time of this survey. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 03/25/24		in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests a desk review for substantial compliance. If there are any questions, please contact me at (812) 941-9896. Sincerely, Brandy D'Angelo, HFA, BSW Autumn Woods Health Campus Brandy.Dangelo@autumnwoodshealthcampushc.com	
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 10 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. Section 7.5.2.2.1 states hangings or draperies shall not be placed over exit doors or located so that they conceal or obscure any exit, unless otherwise provided in 7.5.2.2.2.	K 0211	K211 Means of Egress – General 1. The Director of Plant Operations removed venetian blinds from the Private Dining Room EXIT. See Pictures Labeled K211 in file 2. All occupants had the potential	03/26/2024

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	This deficient practice could affect over 10 residents, staff and visitors if needing to exit to the outside of the facility from the Private Dining Room. Findings include: Based on observations with the Executive Director, the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 12:25 p.m. to 2:30 p.m. on 03/21/24, the Private Dining Room has one exit door to the outside of the facility which was marked as a facility exit with an 'EXIT' sign. The exit door was marked with the necessary delayed egress signage, but the signage was obscured because Venetian blinds were installed on the room side of the door. The exit door released to open after pushing on the door for 15 seconds. Based on interview at the time of the observations, the DPO agreed the aforementioned means of egress was not continually maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency due to the blinds being hung on the exit door. These findings were reviewed with the Executive Director, the DPO and the Facilities Management Support during the exit conference. 3.1-19(b)		to be affected by the deficient practice. 3. The Director of Plant Operations is now knowledgeable that all EXITS may not be covered by blinds nor any visual obstruction. 4. As a quality measure, the Director of Plant Operations will ensure that all facility Exits remain free from blinds or other visual obstructions when doing daily door checks. Any findings will be reviewed at least quarterly and ongoing in the campus Quality Assurance Performance Improvement meetings.	
K 0293 SS=E Bldg. 01	NFPA 101 Exit Signage Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.			

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	19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) Based on observation and interview; the facility failed to install exit signage in 1 of 10 means of egress in the facility in accordance with LSC 7.10. LSC 7.10.1.2.1 states exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect over 20 residents, staff and visitors if needing to exit the 100 Hall by resident sleeping Room 100. Findings include: Based on observations with the Executive Director, the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 12:25 p.m. to 2:30 p.m. on 03/21/24, the corridor door set serving as the entrance to the 300 Hall from the 100 Hall by resident sleeping Room 100 was not marked as a facility exit with an 'EXIT' sign. The corridor door set was equipped with delayed egress signage and was equipped with magnetic holding devices which could be released by entering a code at a keypad at the door set but the code to release the door to open was not posted. The door set released to open after pushing for 15 seconds. The 300 Hall is a secure wing housing Alzheimer's residents. The corridor door set serving as the entrance to the 300 Hall from the 100 Hall by resident sleeping Room 100 is one of the two	K 0293	K293 EXIT Signage 1. Director of Plant Operations installed EXIT Signage from 100 Hall entering the 300 Hall. The code to release the door into the 300 Hall has been added to the keypad on the 100 Hall side. See Pictures Labeled K293 in file 2. All occupants had the potential to be affected by the deficient practice. 3. The Director of Plant Operations is now knowledgeable that all facility EXITS must have signage. 4. As a quality measure, the Director of Plant Operations will ensure that all facility EXITs have EXIT signage when he is doing his daily door checks. Any finding will be reviewed at least. Quarterly and ongoing in the campus Quality Assurance Performance Improvement meetings.	03/27/2024

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	facility exits for the 100 Hall. Based on interview at the time of the observations, the DPO and the Facilities Management Support agreed the path of egress was not obvious with the corridor door set closed and should have an 'EXIT' sign installed at the door set in the 100 Hall by Room 100. These findings were reviewed with the Executive Director, the DPO and the Facilities Management Support during the exit conference. 3.1-19(b)			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops			

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	d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of over 16 hazardous areas such as boiler and fuel-fired heater rooms were separated from other spaces by smoke resistant partitions and doors. Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the kitchen. Findings include: Based on observations with the Maintenance Director and the Facilities Management Support during a tour of the facility from 12:30 p.m. to 2:15 p.m. on 02/29/24, the following was noted in the kitchen which contained one natural gas fired water heater room: a. the corridor door to the kitchen by the corridor door set to the service hall was equipped with a latching mechanism to latch the door into the door frame but the door failed to latch into the door frame when tested to close multiple times. b. the makeup air ductwork above the natural gas fired water heater which penetrated the ceiling of the water heater room in the kitchen had dropped down from its fixed position to rest on the floor of the room which exposed the attic above the water heater room. The water heater room was open to the kitchen. Based on interview at the time of the observations', the DPO stated the kitchen door	K 0321	K321 Hazardous Areas – Enclosure A. Door from service hall corridor to the kitchen. 1. The Director of Plant Operations repaired the door from the service hall corridor door to the kitchen, and it is now latching properly. See Pictures Labeled K321A & Audit Tool Labeled Tag K321 in file 2. All occupants had the potential to be affected by the deficient practice. 3. The Director of Plant Operations is now knowledgeable that all doors into hazardous areas must latch properly. 4. As a quality measure, the Director of Plant Operations/ designee will ensure that all doors into hazardous areas are latching properly when completing rounding of all hazardous area enclosures 5 X a week for 4 weeks, then 3 X a week for 4 weeks, then 2X a Week for 8 Weeks,	03/26/2024

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	frame and the bottom hinge on the kitchen door were loose which caused the latching mechanism to not latch the door into the door frame. The DPO stated the ductwork which had dropped down is makeup air ductwork for the natural gas fired water heater and agreed the kitchen was not separated from other spaces with smoke resistant partitions and doors. These findings were reviewed with the Executive Director, the Maintenance Director and the Facilities Management Support during the exit conference. 3.1-19(b)		then 1 X monthly on latch and gap inspection. B. Ductwork above natural gas fired water heater/smoke penetration to attic. 1. The Director of Plant Operations reinstalled the vent through the attic penetration and secured it so that it would no longer fall down. The Director of Plant Operations also fire sealed the duct work to the ceiling. See Pictures Labeled K321B in file 2. All occupants had the potential to be affected by the deficient practice. 3. The Director of Plant Operations is now knowledgeable that all smoke penetrations are to be sealed. 4. As a quality measure, the Director of Plant Operations will ensure all smoke penetrations are sealed.	
K 0351 SS=F Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.			

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	In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure only new sprinklers were available to be utilized for its sprinkler system. NFPA 13, Standard for the Installation of Sprinkler Systems, 2010 Edition; Section 6.1.2.2 states reconditioned sprinklers shall not be permitted to be utilized on any new or existing system and Section 6.2.1 states only new sprinklers shall be installed. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on observations with the Executive Director, the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 12:25 p.m. to 2:30 p.m. on 03/21/24, the spare sprinkler cabinets located in the sprinkler riser room contained one sidewall spare sprinkler which had pipe grout on the threads and was stamped as a quick response sprinkler manufactured in 1999. One additional sidewall spare sprinkler also had a manufacture date of 1999 stamped on the sprinkler by the manufacturer. Based on interview at the time of observation, the DPO and the Facilities	K 0351	K351 Sprinkler System – Installation 2012 EXISTING 1. The Director of Plant Operations replaced out-of-date replacement sprinkler heads. See Pictures Labeled K351 in file 2. All occupants had the potential to be affected by the deficient practice. 3. The Director Plant Operations is now knowledgeable that all replacement sprinkler heads must be in date. 4. As a quality measure, the Director of Plant Operations will ensure that all replacement sprinkler heads are visually inspected both in house and by a qualified fire sprinkler contractor at least quarterly. Any findings will be reviewed at least quarterly and ongoing in the campus Quality	04/01/2024

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	Management Support agreed both quick response sprinklers were more than 20 years old with one of them previously installed in sprinkler systems. These findings were reviewed with the Executive Director, the DPO and the Facilities Management Support during the exit conference. 3.1-19(b)		Assurance Performance Improvement meetings.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 1 ceiling smoke barriers. 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	K 0353	K353 Sprinkler System – Maintenance and Testing / Drop ceiling penetration 1. The Director of Plant Operations repaired all penetrations. See Pictures Labeled K353 in file 2. All occupants had the potential to be affected by the deficient	03/26/2024

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	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 over 10 residents, staff and visitors in the vicinity of the kitchen. Findings include: Based on observations with the Executive Director, the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 12:25 p.m. to 2:30 p.m. on 03/21/24, a four inch by three inch hole was noted in one suspended ceiling tile in the water heater room in the kitchen for the passage of two natural gas pipes. Based on interview at the time of the observations, the DPO and the Facilities Management Support agreed the hole in the ceiling did not maintain the ceiling construction in the room. These findings were reviewed with the Executive Director, the DPO and the Facilities Management Support during the exit conference. 3.1-19(b)		practice. 3. The Director of Plant Operations is now knowledgeable that all drop ceilings must be in place and free from open penetration. 4. As a quality measure, the Director of Plant Operations will ensure ceiling tiles are free from penetration by visual inspection. Any findings will be reviewed at least quarterly and ongoing in the campus Quality Assurance Performance Improvement meetings.	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or			

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	combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of over 70 corridor doors would resist the passage of smoke. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the kitchen. Findings include: Based on observations with the Executive Director, the Director of Plant Operations (DPO)	K 0363	K363 Corridor – Doors 1. The Director of Plant Operations repaired the door from the service hall corridor door to the kitchen, and it is now latching properly, resisting the passage of smoke. See Pictures Labeled K363 & Audit Tool Labeled Tag 363 in file	03/22/2024

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	and the Facilities Management Support during a tour of the facility from 12:25 p.m. to 2:30 p.m. on 03/21/24, the corridor door to the kitchen by the corridor door set to the service hall was equipped with a latching mechanism to latch the door into the door frame but the door failed to latch into the door frame when tested to close multiple times. Based on interview at the time of the observations', the DPO stated the kitchen door frame and the bottom hinge on the door were loose which caused the latching mechanism to not latch the door into the door frame and agreed the aforementioned corridor door would not resist the passage of smoke. These findings were reviewed with the Executive Director, the DPO and the Facilities Management Support during the exit conference. 3.1-19(b)		2. All occupants had the potential to be affected by the deficient practice. 3. The Director of Plant Operations is now knowledgeable that all doors must latch properly to ensure ability resist the passage of smoke. 4. As a quality measure, the Director of Plant Operations/ designee will ensure that all doors are latching properly when completing rounding of all doors 5 X times a week for 4 weeks, then 3 X a week for 4 weeks, then 2 X a Week for 8 Weeks, then 1X monthly on latch and gap inspection.	
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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 01 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	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. 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 1 of 1 storage locations of nonflammable gases equal to or greater than 3000 cubic feet were secured against unauthorized entry. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.2.1 states storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room by Room 204.	K 0923	K923 Gas Equipment – Cylinder and Container Storage 1. The Director of Plant Operations installed a lock mechanism to the door of the oxygen cylinder storage room. See Pictures Labeled K923 & Audit Tool Labeled Tag K923 in file 2. All occupants had the potential to be affected by the deficient practice.	03/22/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155681	A. BUILDING 01 B. WING	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
AUTUMN WOODS HEALTH CAMPUS	2911 GREEN VALLEY RD NEW ALBANY, IN 47150

(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
	Findings include: Based on observations with the Executive Director, the Director of Plant Operations (DPO) and the Facilities Management Support during a tour of the facility from 12:25 p.m. to 2:30 p.m. on 03/21/24, the corridor entry door to the oxygen storage and transfilling room at the end of the hall by Room 204 was not equipped with a lock or other means to secure against unauthorized entry. The room contained six liquid oxygen containers and eleven 'E' type cylinders. Based on interview at the time of the observations, the DPO agreed the corridor entry door to the oxygen storage and transfilling room was not equipped with a lock or other means to secure against unauthorized entry. These findings were reviewed with the Executive Director, the DPO and the Facilities Management Support during the exit conference. 3.1-19(b)		3. The Director of Plant Operations is now knowledgeable the oxygen cylinder storage room must be secured. 4. As a quality measure, the Director of Plant Operations/ designee will ensure that the door into the Oxygen room is latched and secured 5 X times a week for 4 weeks, then 3 X times a week for 4 weeks, then 2 X a Week for 8 Weeks, then 1 X monthly on latch and gap inspection.	