STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155203	A. BUILDING -- B. WING	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HILLCREST VILLAGE	203 SPARKS AVE JEFFERSONVILLE, IN 47130

(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: 02/20/25 Facility Number: 000110 Provider Number: 155203 AIM Number: 100271120 At this Emergency Preparedness survey, Hillcrest Village was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 149 certified beds. At the time of the survey, the census was 117. Quality Review completed on 02/25/25	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 Date: 02/20/25 Facility Number: 000110 Provider Number: 155203 AIM Number: 100271120 At this Life Safety Code survey, Hillcrest Village was found not in compliance with Requirements	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Mark Bowman	Executive Director	03/06/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	for 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. Hillcrest Village is a three story building. The building was constructed at two different times. The original building was built in 1966 and constructed with mixed construction consisting of a two and one-half inch thick concrete decks separating each floor, one hour fire rated smoke barrier walls, two fire barrier walls constructed of two hour construction on each level, brick exterior walls with metal studs and one-half hour rated drywall, a mix of concrete and metal stud interior walls with one-half hour rated drywall, and metal trusses and wooden rafters in the roof assembly. Based on the lowest construction type, the facility construction type was classified as Type V (111) construction. The original building was built with an open column foundation exposed at the entire south length of the facility. In 1974, a two story addition including the level 1 Transcare Unit and level 2 East Wing was constructed to the southeast of the original building and the column foundation was converted into a poured finished physical therapy area and is also of Type V (111) construction. Because the original building and the addition are the same type of construction, the facility was surveyed as one building. The facility is fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including the corridors, spaces open to the corridors, and has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 149 and had a census of 117 at the time of this survey.			

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	All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except the detached laundry building and storage shed. Quality Review completed on 02/25/25			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General 1. Based on observation and interview, the facility failed to ensure 1 of over 10 corridor means of egresses were continuously maintained free of obstructions. LSC 19.2.3.4 (4) states projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in.(1525 mm). (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c)The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice affects 25 residents in the facility. Findings include: Based on observations and interview with the Maintenance Supervisor (MS) during a tour of the facility from 11:55 a.m. to 2:45 p.m. on 02/20/25, in the corridor outside Resident Room # 146 a stationary pedestal fan was in use. Based on	K 0211	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** 12 residents, staff and visitors could have the potential to be affected by the alleged deficient practice during an emergency event. On 2/20/25, the Maintenance director removed the pedestal fan from the corridor by room 146 and the lift and wheelchair from the corridor by room 301. **What measure will be put into**	03/14/2025

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	interview at the time of observations, the MS stated the aforementioned fan would need to be removed and replaced with one that hung up on the wall. This finding was acknowledged by the MS at the time of discovery and again at the exit conference with the MS and AD present. 2. Based on observation and interview, the facility failed to ensure 1 of over 8 means of egress was continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect over 12 residents, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview with the Maintenance Supervisor (MS) during a tour of the facility from 11:55 a.m. to 2:45 p.m. on 02/20/25, the exit door by Resident Room # 301, marked a facility exit was obstructed with a lift and wheelchair positioned directly in front of the exit door. The MS stated that staff know better than to park things in front of the exit doors. This finding was acknowledged by the MS at the time of discovery and again at the exit conference with the MS and AD present. 3.1-19(b)		**place or what systemic changes will be made to ensure that the deficient practice does not occur?** On 3/3/25, CEN and Maintenance Director began in-servicing nursing staff on the egress door and corridor requirements of LSC section 19.2.3.4 whereas the corridors and means of egress shall be free from obstruction. On 3/3/25, a life safety compliance audit on egress doors was performed by the Administrator and Maintenance Director using the K 211 Means of Egress audit tool, all areas met compliance standards as they were free from obstruction. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** The Maintenance Director or designee will be responsible for the completion of the life safety compliance audit on means of egress. The audits will be completed weekly times 4 weeks, monthly times 6 months and semiannually thereafter to ensure compliance. The results of the audits will be reviewed monthly by the QAPI committee overseen by the Administrator. If 100% is not achieved an action plan will be	

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			developed. All systemic changes will be completed by 3/14/25	
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Based on observation and interview, the facility failed to ensure the means of egress through the reception main exit was readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could affect over 24, staff and visitors if needing to exit the facility. Findings include: Based on observations and interview with the Maintenance Supervisor (MS) during a tour of the facility from 11:55 a.m. to 2:45 p.m. on 02/20/25, the exit door from the main reception area was marked as a facility exit, was magnetically locked and could be opened by entering a four digit code but the code was not posted at the exit. The MS stated that someone had removed the code recently. This condition was observed when the surveyor entered the facility and again during the tour. This finding was acknowledged by the MS at the time of discovery and again at the exit conference with the MS and AD present. 3.1-19(b)	K 0222	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** 24 residents, staff and visitors could have the potential to be affected by the alleged deficient practice during an emergency not related to fire or loss of power. On 2/20/25, the Maintenance Director posted the missing code hint at the main lobby entrance by the receptionist desk. The hint posted is the same throughout all facility egress doors. **What measure will be put into place or what systemic changes will be made to**	03/14/2025

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			ensure that the deficient practice does not occur? On 3/4/25, Maintenance staff was educated on egress door requirements of LSC section 19.2.2.2.5.2 and a K-222 life safety compliance audit tool for egress doors whereas all egress doors shall have a code hint posted. On 3/4/24, a life safety compliance audit on egress doors was performed by the Administrator and Maintenance Director using the egress door audit tool, all areas met compliance standards as they all provide a hint sign that could be known by anyone that enters the facility. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** The Maintenance Director or designee will be responsible for the completion of the life safety compliance audit of egress doors. The audits will be completed weekly times 4 weeks, monthly times 6 months and semiannually thereafter to ensure compliance. The results of the audits will be reviewed monthly by the QAPI committee overseen by the Administrator. If 100% is not achieved an action plan will be	

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			developed. All systemic changes will be completed by 3/14/25	
K 0223 SS=E Bldg. 01	NFPA 101 Doors with Self-Closing Devices Based on observation and interview, the facility failed to ensure 2 of over 30 corridor doors to hazardous area enclosures are self-closing and kept in the closed position, unless held open by a release device complying with 7.2.1.8.2. This deficient practice could affect 15 occupants. Findings include: Based on observations and interview with the Maintenance Supervisor (MS) during a tour of the facility from 11:55 a.m. to 2:45 p.m. on 02/20/25, Rooms #201 and #202 being used for storage, greater than 50 square feet, contained a number of combustible items, such as paper, plastic, and cardboard boxes. The corridor door to these rooms were equipped with self-closing devices but would not release by fire alarm activiation due the doors being held open with chairs and carts wedged into the doors. This finding was acknowledged by the MS at the time of discovery and again at the exit conference with the MS and AD present. 3.1-19(b)	K 0223	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** 15 residents, staff and visitors could have the potential to be affected by the alleged deficient practice during an emergency related to fire. On 2/20/25, the Maintenance Director removed the items obstructing door closure from rooms 201 and 202. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur?**	03/14/2025

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			On 3/5/25, Maintenance and Nursing staff was educated on Doors with Self-closing device requirements of LSC section 7.2.1.8.2, whereas, all doors with a self-closing device shall remain closed and not propped open. On 3/5/24, a life safety compliance audit on doors with self-closing devices was performed by the Administrator and Maintenance Director. All areas met compliance standards as all storage room doors equipped with a self-closing device were shut. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** The Maintenance Director or designee will be responsible for the completion of the life safety compliance audit of egress doors. The audits will be completed weekly times 4 weeks, monthly times 6 months and semiannually thereafter to ensure compliance. The results of the audits will be reviewed monthly by the QAPI committee overseen by the Administrator. If 100% is not achieved an action plan will be developed. All systemic changes will be completed by 3/14/25	

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K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Based on observation and interview, the facility failed to ensure 4 of over 15 hazardous area doors, such as storage rooms, were provided with properly working self-closing devices. This deficient practice could affect more than 30 residents, staff and visitors. Findings include: Based on observations and interview with the Maintenance Supervisor (MS) during a tour of the facility from 11:55 a.m. to 2:45 p.m. on 02/20/25, the following was noted: A) Room #207 labeled Activities Storage, greater than 50 square feet, contained a number of combustible items, such as paper, plastic, and cardboard boxes. The corridor door to this room equipped with a self-closing device, failed to self-close and latch due to large amounts of storage in the door way. B) The Business Office, greater than 50 square feet, contained a number of combustible items, such as paper and cardboard boxes. The door to this office was not equipped with a self-closing device. The aforementioned office opens into a common area of reception which is open to the corridor near the main reception entrance. The MS agreed the hazardous area was open to the main corridor. These findings were acknowledged by the MS at the time of discovery and again at the exit conference with the MS and AD present. 3.1-19(b)	K 0321	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** 30 residents, staff and visitors could have the potential to be affected by the alleged deficient practice during an emergency. On 2/20/25 the obstructed items preventing positive closure and latching in room 207 was removed, the door closure and latching is positive. On 3/4/25, the Business office manager completed the annual file purge process which led to the noted combustible material in the business office. These items have been removed and properly stored. **What measure will be put into place or what systemic changes will be made to ensure that the deficient**	03/14/2025

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			practice does not occur? On 3/5/25, Maintenance and Administrative Staff were educated on Hazardous Areas storage requirments related to K-321. On 3/5/24, a life safety compliance audit on hazardous storage area's was performed by the Administrator and Maintenance Director. All areas met compliance standards as all storage room doors were free from obstruction, equipped with a self-closing device that properly latched. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** The Maintenance Director or designee will be responsible for the completion of the life safety compliance audit on hazardous areas storage. The audits will be completed weekly times 4 weeks, monthly times 6 months and semiannually thereafter to ensure compliance. The results of the audits will be reviewed monthly by the QAPI committee overseen by the Administrator. If 100% is not achieved an action plan will be developed. All systemic changes will be	

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			completed by 3/14/25	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Based on observation and interview, the facility failed to maintain the ceiling construction of 1 of 1 Therapy Storage Closet. The ceiling tiles trap hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.11 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice affects 5 residents and staff. Findings include: Based on observations and interview with the Maintenance Supervisor (MS) during a tour of the facility from 11:55 a.m. to 2:45 p.m. on 02/20/25, the suspended ceiling in the Therapy Storage Closet was missing ceiling tile. This condition could delay the activation of the sprinklers. Based on interview at the time of the observations, the MS agreed there were missing ceiling tile stating that a helper had removed them to address an issue but had forgot to replace the tile. This finding was acknowledged by the MS at the time of discovery and again at the exit conference with the MS and AD present. 3.1-19(b)	K 0353	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** 5 residents, staff and visitors could have the potential to be affected by the alleged deficient practice during an emergency. On 2/21/25 the missing ceiling in the therapy closet was replaced. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur?** On 3/5/25, Maintenance Staff was educated on sprinkler system – maintenance and testing related to the missing ceiling tile in the therapy closet. On 3/5/24, a life	03/14/2025

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			safety compliance audit on sprinkler system maintenance and testing was performed by the Administrator and Maintenance Director. All areas met compliance standards as there were no missing ceiling tiles or ceiling breaches in the 44 storage area's audited. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** The Maintenance Director or designee will be responsible for the completion of the life safety compliance audit on sprinkler system – maintenance and testing. The audits will be completed weekly times 4 weeks, monthly times 6 months and semiannually thereafter to ensure compliance. The results of the audits will be reviewed monthly by the QAPI committee overseen by the Administrator. If 100% is not achieved an action plan will be developed. All systemic changes will be completed by 3/14/25	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on records review, observation, and interview, the facility failed to conduct the	K 0921	Facility filed ad Life safety Code Temporary Waiver.	05/28/2025

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	required maintenance and maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and 10.5 states the physical integrity, resistance, leakage current, and touch current tests for fixed and portable PCREE is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice affects all residents. The findings include: Based on records review, interview and facility tour with the Maintenance Supervisor (MS) and Administrator (AD) on 02/20/25 between 9:15 a.m. and 2:45 p.m., no documentation was available for review for the testing of the PCREE in use throughout the facility, as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Observation during the building tour revealed that			

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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
	the facility provided electric beds for all residents. The AD stated that PCREE such as beds, nebulizers, oxygen concentrators, vital signs monitors, and other electrical medical equipment was present and in use at the facility. Both the MS and AD stated that the facility was not aware that the PCREE was required to be tested. This finding was acknowledged by the MS and AD at the time of discovery and again at the exit conference with each present. 3.1-19(b)			
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Based on observation and interview, the facility failed to ensure 1 of 1 indoor oxygen storage locations was provided with a precautionary sign indicating that smoking in the immediate area is not permitted. NFPA 99 Health Care Facilities Code, 2012 Edition, Section 11.3.4 states oxygen cylinder and storage locations shall be provided with a precautionary sign readable from a distance of 5 feet shall be posted on each door or gate of the storage room or enclosure. Section 11.3.4.2 states the sign shall include following wording as a minimum: "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observations and interview with the Maintenance Supervisor (MS) during a tour of the facility from 11:55 a.m. to 2:45 p.m. on 02/20/25, the oxygen storage/transfilling room was not	K 0923	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** 10 residents, staff and visitors could have the potential to be affected by the alleged deficient practice in the event of a fire emergency. On 2/20/25 a precautionary sign “No Smoking	03/14/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155203	A. BUILDING 01 B. WING	02/20/2025

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	provided with the necessary signage prohibiting smoking in the immediate area. Liquid oxygen containers and 'E' type oxygen cylinders were observed stored in the room. Based on interview at the time of the observations, the MS agreed the oxygen storage/transfilling room was not provided with the necessary signage prohibiting smoking. The MS searched for the missing magnetic signage but was unable to locate any sign. The MS stated that they might need to post a permanent sign instead of the magnetic sign they were using. This finding was acknowledged by the MS at the time of discovery and again at the exit conference with the MS and AD present. 3.1-19(b)		O2 in use" was secured to the door frame of the only facility O2 storage area across from room 319. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur?** On 3/5/25, Maintenance staff was educated on NFPA 99 section 11.3.4 whereas oxygen cylinder and storage locations shall be provided with a precautionary sign readable from a distance of 5 feet shall be posted on the door. On 3/5/25, a life safety compliance audit for precautionary signage "No Smoking O2 in use" in place on Oxygen storage room door was performed by the ED and Maintenance director. The sign was observed in place on the Oxygen storage room door. No new issues were identified, and the affected area identified during survey has been corrected. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** The Maintenance Director or designee will be responsible for	

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	155203	A. BUILDING 01 B. WING	02/20/2025

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			the completion of the life safety compliance audit on precautionary signage. The audits will be completed weekly times 4 weeks, monthly times 6 months and semiannually thereafter to ensure compliance. The results of the audits will be reviewed monthly by the QAPI committee overseen by the Administrator. If 100% is not achieved an action plan will be developed. All systemic changes will be completed by: 3/14/25	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Based on observation and interview, the facility failed to ensure 1 of 1 oxygen transfilling locations was provided with a precautionary sign indicating that smoking in the immediate area is not permitted. NFPA 99 Health Care Facilities Code, 2012 Edition, Section 11.5.2.3.1(3) states the transfilling of liquid oxygen area shall be posted with a sign indicating that transfilling is occurring and that smoking in the immediate area is not permitted. This deficient practice could affect over 10 residents, staff and visitors in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observations and interview with the Maintenance Supervisor (MS) during a tour of the facility from 11:55 a.m. to 2:45 p.m. on 02/20/25, the oxygen storage/transfilling room was not	K 0927	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents, staff or visitors were affected by the alleged deficient practice. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** 10 residents, staff and visitors could have the potential to be	03/14/2025

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	provided with the necessary signage prohibiting smoking in the immediate area. Liquid oxygen containers and 'E' type oxygen cylinders were observed stored in the room. Based on interview at the time of the observations, the MS agreed the oxygen storage/transfilling room was not provided with the necessary signage prohibiting smoking. The MS searched for the missing magnetic signage but was unable to locate any sign. The MS stated that they might need to post a permanent sign instead of the magnetic sign they were using. This finding was acknowledged by the MS at the time of discovery and again at the exit conference with the MS and AD present. 3.1-19(b)		affected by the alleged deficient practice in the event of a fire emergency. On 2/20/25 a precautionary sign “No Smoking O2 in use” was secured to the door frame of the only facility O2 storage area across from room 319. **What measure will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur?** On 3/5/25, Maintenance staff was educated on NFPA 99 section 11.3.4 whereas oxygen cylinder and storage locations shall be provided with a precautionary sign readable from a distance of 5 feet shall be posted on the door. On 3/5/25, a life safety compliance audit for precautionary signage “No Smoking O2 in use” in place on Oxygen storage room door was performed by the ED and Maintenance director. The sign was observed in place on the Oxygen storage room door. No new issues were identified, and the affected area identified during survey has been corrected. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, ie., what quality**	

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			assurance program will be put into place? The Maintenance Director or designee will be responsible for the completion of the life safety compliance audit on precautionary signage. The audits will be completed weekly times 4 weeks, monthly times 6 months and semiannually thereafter to ensure compliance. The results of the audits will be reviewed monthly by the QAPI committee overseen by the Administrator. If 100% is not achieved an action plan will be developed. All systemic changes will be completed by: 3/14/25	