STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155752	A. BUILDING 01 B. WING	05/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORNINGSIDE NURSING AND MEMORY CARE CENTER	18325 BAILEY AVE SOUTH BEND, IN 46637

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/05/17 Facility Number: 004732 Provider Number: 155752 AIM Number: 200808300 At this Life Safety Code survey, Morningside Nursing and Memory Care Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(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 automatic smoke detection in the corridors, in areas open to the corridors, and battery operated smoke alarms in all resident rooms except the hard wired smoke detectors in	K 0000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	

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

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	resident room 112, 113, 115 and 116. The facility has a capacity of 40 and had a census of 32 at the time of this survey. All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered with the exception of a wood shed. Quality Review completed on 05/11/17 - DA			
K 0291 SS=F Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on record review and interview; the facility failed to ensure battery operated emergency lights in 3 of 3 corridors were tested properly on a monthly basis and annually for 90 minutes over the past year to ensure the light would provide lighting during periods of power outages and a written record of visual inspections and tests was provided. Section 7.9.3.1.1 (1) requires functional testing shall be conducted monthly, with a minimum of 3 weeks and a maximum of 5 weeks between tests, for not less than 30 seconds, (3) Functional testing shall be conducted annually for a minimum of 1 1/2 hours if the emergency	K 0291	*The Facility requests paper compliance for this citation* *1. No residents were affected by this practice* *2. Due to the nature of the violation all residents in the facility had the potential to be affected.* *3. A 90 minute load test is scheduled for 5/25. Maintenance technician was instructed in the length of time the monthly test should last.* *4. Length of test has been added to Maintenance test records. 90 minute annual test has been added to scheduled tests from vendor.* *5. Date of compliance: May 30th, 2017*	05/30/2017

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	lighting system is battery powered and (5) Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. This deficient practice could affect all occupants because the facility does not have generator. Findings include: Based on observation with the Administrator and the Maintenance Technician #1 on 05/05/17 at 10:17 a.m., the battery operated emergency light documentation had check boxes in the monthly columns. No documentation was available for an annual 90 minute test. Additionally, at 11:11 a.m., the Dining room exit discharge battery operated emergency light failed to illuminate when tested. Based on interview at the time of observation, the Administrator and the Maintenance Technician #1 confirmed that the lights were just pressed for five seconds to indicate that the light will turn on and confirmed no annual test was performed. 3.1-19(b)			
K 0321 SS=F Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING			

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	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. 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 Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops 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 K3220)			
	1. Based on observation and interview, the facility failed to maintain protection of 1 of 1 popcorn popper in the Sun room. This deficient practice could affect all occupants open to the Main Dining room. Findings include:	K 0321	The Facility requests paper compliance for this citation 1. No residents were affected by this practice 2. Due to the nature of the violation all residents in the facility had the potential to be affected. 3. A. Popcorn machine storage location has been changed to be	05/30/2017

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	Based on observation with the Administrator and the Maintenance Technician #1 on 05/05/17 at 10:41 a.m., the Sun room contained a popcorn popper. Based on interview at the time of observation, the Administrator and the Maintenance Technician #1 confirmed the popcorn popper uses oil and is popped in the Main Dining room which is open to the corridor. 3.1-19(b) 2. Based on observation and interview, the facility failed to maintain protection of 1 of 1 fuel-fired Mechanical Room #1 in accordance of 19.3.2. LSC 19.3.2, Protection from Hazards, requires doors to be self-closing or automatic closing. This deficient practice could affect all occupants open to the Main Dining room. Findings include: Based on observation with the Administrator and the Maintenance Technician #1 on 05/05/17 at 11:17 a.m., the Mechanical Room #1 contained fuel-fire equipment. The corridor door did not have a self-closing device installed. Based on interview at the time of observation, the Administrator and the Maintenance Technician #1		stored behind a door with a self-closing mechanism B. A self-closing mechanism has been added to the Mechanical Room #1 door 4. The self-closing mechanism for these doors will be added to the preventative maintenance schedule for functionality check. Administrator to audit monthly for 3 months. Results from these audits will be brought to QA for review 5. Date of compliance: May 30th, 2017	

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	acknowledged the aforementioned condition. 3.1-19(b)			
K 0351 SS=D 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. 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 1 of 1 complete automatic sprinkler system was installed in accordance with 19.3.5.1. NFPA 13, 2010 Edition, Standard for the Installation of Sprinkler Systems, Section 9.1.1.7, Support of Non-System Components, requires sprinkler piping or hangers shall not be used to support non-system components. This deficient	K 0351	The Facility requests paper compliance for this citation 1. No residents were affected by this practice. 2. Due to the nature of the violation all residents in the facility had the potential to be affected. 3. Facility will visually inspect and uncover sprinkler heads found to be covered in the attic during scheduled repair on 5/25/17	05/30/2017

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	practice could affect staff only. Findings include: Based on observations with the Administrator and the Maintenance Technician #1 on 05/05/17 at 11:48 a.m., at least 5 sprinkler heads were covered in insulation in the attic near the smoke barrier. Based on interview at the time of observation, the Administrator and the Maintenance Technician #1 acknowledged the aforementioned condition. 3.1-19(b)		4. Maintenance department will inspect sprinkler heads in the attic after any maintenance done in the attic to ensure compliance. 5. Date of completion May 30th, 2017	
K 0353 SS=F 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.			

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	9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review and interview, the facility failed to maintain 1 of 1 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. This deficient practice could affect all occupants. Findings include: Based on record review with the Administrator and the Maintenance Technician #1 on 05/05/17 at 9:34 a.m., no documentation was available for the monthly control valves and monthly dry system gauge. Additionally, no documentation for the quarterly inspection for the second and third quarter of 2016. Based on interview at the time of record review, the Administrator and the Maintenance Technician #1 acknowledged the aforementioned condition. 3.1-19(b) 2. Based on observation and interview,	K 0353	*The Facility requests paper compliance for this citation* *1. No residents were affected negatively from this practice.* *2. Due to the nature of the violation all residents in the facility had the potential to be affected.* *3. A. Valve and gauge inspection have been added to the preventative maintenance records.* *B. The box mentioned on the report has been removed along with all other possible obstructions.* *C. The paint covered sprinkler head will be removed and replaced on 5/25/17.* *4. A monthly audit of the valve and gauge records will be conducted by the administrator for 3 months to ensure compliance. The results from these audits will be brought to QA meeting for review. Checking of the clearance in the sun room will be made part of the preventative maintenance records.* *5. Date of compliance May 30th, 2017*	05/30/2017

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	the facility failed to maintain a clearance of 1 of 1 sprinkler head in the Sun Closet #1 accordance with LSC 9.7.5. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, 5.2.1.2 requires the minimum clearance required by the installation standard shall be maintained below all sprinkler deflectors. This deficient practice could affect all occupants in the Main Dining room. Findings include: Based on observation with the Administrator and the Maintenance Technician #1 on 05/05/17 at 10:41 a.m., one cardboard box was two inches away from the sprinkler head deflector. Based on interview at the time of observation, the Administrator and the Maintenance Technician #1 acknowledged the aforementioned condition and provided the measurement. 3.1-19(b) 3. Based on observation and interview, the facility failed to replace 1 of 1 painted sprinkler head in the Dietary office in accordance with LSC 9.7.5. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire			

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	Protection Systems. NFPA 25, 2011 edition, 5.2.1.1.2 requires any sprinkler shall be replaced that show signs of leakage, corrosion, physical damage, loss of fluid in the glass bulb heat responsive element, loading, or painting unless painted by the sprinkler manufacturer. This deficient practice could affect staff only. Findings include: Based on observation with the Administrator and the Maintenance Technician #1 on 05/05/17 at 11:01 a.m., one sprinkler head was covered in paint in the Dietary office. Based on interview at the time of observation, the Administrator and the Maintenance Technician #1 acknowledged the aforementioned condition. 3.1-19(b)			
K 0363 SS=F Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided			

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	with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. 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 maintain protection of corridor doors in 2 of 3 corridors in accordance of 19.3.6.3. This deficient practice could affect all occupants open to the Main Dining room. Findings include: Based on observation with the Administrator and the Maintenance	K 0363	The Facility requests paper compliance for this citation 1. No residents were affected negatively from this practice. 2. Due to the nature of the violation all residents in the facility had the potential to be affected. 3. The door to the medication room will be replaced on 5/24/17 with a door that provides proper gap coverage. All doors in the facility have been inspected for proper compliance	05/30/2017

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	Technician #1 on 05/05/17 at 10:46 a.m. then again at 11:32 a.m., the Medication room door left a half inch gap along the top of the door when closed. Then again, the "Restroom next to the Beauty Shop" contained a quarter inch gap around the door knob. Based on interview at the time of each observation, the Administrator and the Maintenance Technician #1 acknowledged each aforementioned condition. 3.1-19(b)		4. An audit of door compliance will be conducted by the administrator for 3 months. The results from these audits will be brought to QA meeting for review. 5. Date of compliance May 30th, 2017	
K 0372 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Based on observation and interview, the facility failed to ensure the penetrations caused by the passage of wire and/or conduit through 1 of 1 smoke barrier walls were protected to maintain the	K 0372	*The Facility requests paper compliance for this citation* *1. No residents were affected negatively from this practice.* *2. Due to the nature of the*	05/30/2017

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	smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect all occupants. Findings include: Based on observations with the Administrator and the Maintenance Technician #1 on 05/05/17 at 12:05 p.m., a four foot by two and a half foot penetration in the smoke barrier. Based on interview at the time of observation, the Administrator and the Maintenance Technician #1 acknowledged the aforementioned condition. 3.1-19(b)		*violation all residents in the facility had the potential to be affected.* *3. The smoke barrier penetration is scheduled to be repaired on 5/25/17 .* *4. No further follow up is necessary at this time. Maintenance department will visually inspect the smoke barrier compartment after any maintenance done in the attic to ensure smoke barrier integrity.* *5. Date of completion May 30th, 2017*	
K 0374 SS=F Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel.			

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	Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 Based on observation and interview, the facility failed to maintain annual testing of 1 of 1 rolling fire door in accordance of 19.3.6.3.3. LSC 19.3.6.3.3 requires compliance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. NFPA 80 5.2.1 requires fire door assemblies shall be inspected and tested not less than annually, and a written record of the inspection shall be signed and kept for inspection by the AHJ. This deficient practice could affect all occupants in the Main Dining room. Findings include: Based on observation with the Administrator and the Maintenance Technician #1 on 05/05/17 at 11:12 a.m., the tag on the rolling fire door indicated the last annual test was performed in 2015. Based on interview at the time of observation, the Administrator and the Maintenance Technician #1 acknowledged the aforementioned condition. 3.1-19(b)	K 0374	The Facility requests paper compliance for this citation 1. No residents were affected negatively from this practice. 2. Due to the nature of the violation all residents in the facility had the potential to be affected. 3. The door will be inspected by a qualified technician on 5/29/17 for proper functionality . 4. After the inspection, no further follow up will be required at the time. Next test will be scheduled after completion on 5/29/17. 5. Date of compliance: May 30th, 2017	05/30/2017
K 0712 SS=C	NFPA 101 Fire Drills			

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	155752	A. BUILDING 01 B. WING	05/05/2017

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Bldg. 01	Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure 7 of 12 fire drills included the verification of transmission of the fire alarm signal to the monitoring station in fire drills conducted between 6:00 a.m. and 9:00 p.m. for the last 4 quarters. This deficient practice affects all residents in the facility as well as staff and visitors. Findings include: Based on record review of titled "Fire Drill Report" with the Administrator and the Maintenance Technician #1 on 05/05/17 at 9:22 a.m., the documentation for fire drills for seven of the past twelve months lacked verification of the transmission of the signal for drills. Based on interview at the time of record review, the Administrator and the	K 0712	The Facility requests paper compliance for this citation 1. No residents were affected by this practice. 2. Due to the nature of the violation all residents in the facility had the potential to be affected. 3. Maintenance Technician was re-educated on the need to verify transmission of signal to the monitoring company according to code. 4. Fire drill records will be audited for completion by administrator for 3 months. The results of these audits will be brought to QA meeting for review. 5. Date of compliance May 30th, 2017	05/30/2017

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	Maintenance Technician #1 confirmed no documentation was available showing the times when the monitoring company received the fire alarm signal. 3.1-19(b) 3.1-51(c)			
K 0920 SS=F Bldg. 01	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 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 4 of 4 flexible cords were not used as a substitute for	K 0920	The Facility requests paper compliance for this citation 1. No residents were affected by	05/30/2017

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	fixed wiring according to 9.1.2. LSC 9.1.2 requires electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect all occupants open to the Main Dining room. Findings include: Based on observation with the Administrator and the Maintenance Technician #1 on 05/05/17 between 10:32 a.m. and 10:53 a.m., the following was discovered: a) a surge protector was powering a bed in resident room 6. Additionally, the surge protector was not UL 60601-1 rated when installed within six feet of the patient b) a surge protector was powering another surge protector powering the telephone system in the Telephone Room c) a surge protector was powering a refrigerator in the Director of Nursing office. Based on interview at the time of each observation, the Administrator and the Maintenance Technician #1 acknowledged each aforementioned		this practice. 2. Due to the nature of the violation all residents in the facility had the potential to be affected. 3. All rooms in the facility have been inspected for proper use of surge protectors. Any surge protectors used inappropriately have been removed. 4. Appropriate surge protector use has been added to preventative maintenance records. Administrator will audit these records monthly for 3 months. The results from these audits will be brought to QA meeting for review. 5. Date of completion May 30th, 2017	

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	condition. 3.1-19(b)			
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to protect 3 of 3 oxygen cylinders and 3 of 3 liquid oxygen cylinders in the oxygen transfill outdoor storage area. 2012 NFPA 99, Health Care Facilities Code, 11.6.2.3(11) requires freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect staff only. Findings include: Based on observation with the Administrator and the Maintenance Technician #1 on 05/05/17 at 11:04 a.m., the outdoor oxygen transfill area	K 0927	The Facility requests paper compliance for this citation 1. No residents were affected by this practice. 2. Due to the nature of the violation all residents in the facility had the potential to be affected. 3. Facility will receive stands for all oxygen tanks from oxygen provider on 5/25/17. 4. Oxygen stand inspection has been added the preventative maintenance schedule Administrator will audit these inspections monthly for 3 months and the results from these audits will be brought to QA meeting for review. 5. Date of completion May 30th, 2017	05/30/2017

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	contained three oxygen cylinders and three oxygen tanks that were freestanding on the floor. Based on interview at the time of observation, the Administrator and the Maintenance Technician #1 acknowledged the aforementioned condition. 3.1-19(b)			