| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | X2) MULTIPLE CONSTRUCTION | X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155502 | A. BUILDING -- B. WING | 09/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| TRANSCENDENT HEALTHCARE OF OWENSVILLE | 7336 W STATE ROAD 165 OWENSVILLE, IN 47665 |

| (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 |
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| E 0000<br><br>Bldg. -- | An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.<br><br>Survey Date: 09/27/22<br><br>Facility Number: 000328<br>Provider Number: 155502<br>AIM Number: 100287960<br><br>At this Emergency Preparedness survey, Transcendent Healthcare of Owensville was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73<br><br>The facility has 68 certified beds. At the time of the survey, the census was 52.<br><br>Quality Review completed on 09/29/22 | E 0000 | | |
| K 0000<br><br>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).<br><br>Survey Date: 09/27/22<br><br>Facility Number: 000328<br>Provider Number: 155502<br>AIM Number: 100287960<br><br>At this Life Safety Code survey, Transcendent | K 0000 | | |

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

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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| | Healthcare of Owensville 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.<br><br>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 68 and had a census of 52 at the time of this survey.<br><br>All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered.<br><br>Quality Review completed on 09/29/22 | | | |
| K 0353<br>SS=C<br>Bldg. 01 | NFPA 101<br>Sprinkler System - Maintenance and Testing<br>Sprinkler System - Maintenance and Testing<br>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.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____ | | | |

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| | Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>Based on record review, observation, and interview; the facility failed to document sprinkler system inspections in accordance with NFPA 25 for 1 of 1 dry sprinkler systems during 40 of the past 52 weeks. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.2.4.2 states gauges on dry pipe sprinkler systems shall be inspected weekly to ensure that normal air and water pressures are being maintained. Section 4.3.1 states records shall be made for all inspections, tests, and maintenance of the system and its components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility.<br><br>Findings include:<br><br>Based on record review on 09/27/22 between 9:45 a.m. and 12:00 p.m. with the Director of Environmental Services and Administrator present, there was documentation available to show the facility's sprinkler system gauges were inspected, however, the documentation only indicated the inspections were performed monthly instead of weekly as required for dry pipe sprinkler systems. Based on interview at the time of record review, the Administrator said he inspects the gauges and control valves almost daily but only documents the gauge readings on a monthly basis. Based on observations with the Director of Environmental Services during a tour of the facility between 12:00 p.m. and 2:00 p.m. the facility had two pressure gauges at the sprinkler | K 0353 | By submitting the enclosed materials, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective 10/14/2022 to the state findings of the Life Safety Code Recertification and Emergency Preparedness Survey conducted on September 27, 2022.<br>K 353<br>*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. The facility is now documenting their weekly inspections of the facility's sprinkler system including documenting the air and water pressure of all gages on the facility's dry pipe sprinkler system.<br>*The corrective action taken for the other residents that have the* | 10/14/2022 |

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| | riser.<br><br>This finding was reviewed with the Administrator and Maintenance Supervisor during the exit conference.<br><br>3.1-19(b) | | *potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility is now documenting their weekly inspections of the facility's sprinkler system including documenting the air and water pressure of all gages on the facility's dry pipe sprinkler system.<br>*The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the maintenance supervisor on the facility's policy related to the weekly inspection of the facility's dry pipe sprinkler system, which includes documenting the weekly inspection of all gages on the facility's sprinkler system.<br>*The corrective action taken to monitor to ensure the deficient practice will not recur is that* the maintenance supervisor will submit weekly to the Executive Director all documentation required related to the inspection of the sprinkler system to ensure that all required sprinkler system inspections are being completed and documented in accordance with the regulation. | |
| K 0500<br>SS=F | NFPA 101<br>Building Services - Other | | | |

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| Bldg. 01 | Building Services - Other<br>List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.<br>Based on observation and interview, the facility failed to ensure 4 of 4 fuel-fired boiler had a current inspection certificate to ensure the boiler was in safe operating condition. NFPA 101, Section 19.1.1.3.1 requires all health facilities to be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect all residents, staff and visitors.<br><br>Findings include:<br><br>Based on observations on 09/27/22 between 12:00 p.m. and 2:00 p.m. during a tour of the facility with the Director of Environmental Services, the four fuel-fired boilers in the Mechanical Room had certificates with an expiration date of 05/2020. Based on interview at the time of observation and during the exit conference, the Director of Environmental Services and Administrator confirmed the expiration dates of the four fuel-fired boilers.<br><br>This finding was reviewed with the Director of Environmental Services and Administrator during the exit conference.<br><br>3.1-19(b) | K 0500 | K 500<br>*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has contacted their boiler inspection vendor and has scheduled an inspection of the facility's four fuel-fired boilers and will retain a copy of this inspection in the facility's maintenance prevention manual. These inspections will continue to be scheduled and copies of the certificates maintained in accordance with Life Safety Code requirements.<br>*The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has contacted their boiler inspection vendor and has scheduled an inspection of the facility's four fuel-fired boilers and will retain a | 10/14/2022 |

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| | | | copy of this inspection in the facility's maintenance prevention manual. These inspections will continue to be scheduled and copies of the certificates maintained in accordance with Life Safety Code requirements.<br>*The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the maintenance supervisor on the required inspections and certification of the facility's boiler system. The maintenance supervisor was educated on their responsibility to ensure that these inspections/certifications were completed in accordance with Life Safety Code and a copy of the certifications maintained in the maintenance prevention manual.<br>*The corrective action taken to monitor to ensure the deficient practice will not recur is that* the maintenance supervisor will submit to the Executive Director a copy of the inspection certificates of all four of the fuel-fired boilers to validate that the inspections are current and in compliance with the regulation as part of the facility preventative maintenance program. | |

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| K 0712<br>SS=F<br>Bldg. 01 | NFPA 101<br>Fire Drills<br>Fire Drills<br>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.<br>19.7.1.4 through 19.7.1.7<br>1. Based on record review and interview, the facility failed to provide quarterly fire drill documentation for 2 of 3 shifts during 2 of 4 quarters. This deficient practice could affect all residents in the facility.<br><br>Findings include:<br><br>Based on review of the facility's fire drill reports on 09/27/22 between 9:45 a.m. and 12:00 p.m. with the Director of Environmental Services and Administrator present, the facility lacked fire drill documentation for the following shifts and quarters:<br>a. Second shift (evening) of the third quarter (July, August, and September) of 2021 and so far in 2022, and the fourth quarter (October, November, and December) of 2021.<br>b. Third shift (night) of the fourth quarter (October, November, and December) of 2021.<br>Based on interview at the time of record review, the Administrator confirmed the lack of a fire drill report for the second and third shifts of the third and fourth quarters of 2021. | K 0712 | K 712<br>*1 a). The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents, staff and visitors could be affected by this deficient practice. A fire drill has now been conducted on second shift and the results of the fire drill documented in the maintenance supervisor's fire drill binder.<br>*1 b.) The corrective action taken for those residents found to have been affected by the deficient practice is that* all residents, staff and visitors could be affected by this deficient practice. A fire drill has now been conducted on the third shift and the results of the fire drill documented in the maintenance supervisor's fire drill binder.<br>2.) *The corrective action taken for those residents found to have* | 10/14/2022 |

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| | 3.1-19(b)<br><br>2. Based on record review and interview, the facility failed to ensure 12 of 12 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents.<br><br>Findings include:<br><br>Based on review of the facility's fire drill reports on 09/27/22 between 9:45 a.m. and 12:00 p.m. with the Director of Environmental Services and Administrator present, all 10 fire drill reports performed during the past 12 month period did not include documentation for the transmission of the alarm to the monitoring company. Based on interview at the time of record review, the Administrator acknowledged there was no information on all 10 fire drill reports to verify that transmission of the alarm was received by the monitoring company.<br><br>3-1.19(b) | | *been affected by the deficient practice is that* all residents, staff and visitors could be affected by this deficient practice. The facility has now revised their fire drill log to include the documentation verifying that the facility's monitoring company/fire department received transmission of the facility's fire alarm signal at the time of the fire drill.<br>*The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now conducted a fire drill on each shift and the results of the fire drill have been documented in the maintenance supervisor's fire drill binder. The documentation also includes verification that the fire alarm signal was received at the facility's monitoring company/fire department at the time of each fire drill conducted. A schedule has also been established to ensure that fire drills are conducted on each shift at least quarterly in accordance with Life Safety Code.<br>*The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been conducted for the maintenance supervisor on their responsibility to ensure that fire drills are completed on each shift | |

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| | | | at least quarterly and the results of those fire drills documented in the maintenance supervisor's fire drill binder. The maintenance supervisor was also instructed on the required documentation of verifying that the fire alarm signal was successfully received by the monitoring company/fire department and that this verification is being documented on the fire drill log.<br>*The corrective action taken to monitor to ensure the deficient practice will not recur is that* the maintenance supervisor will submit to the Executive Director monthly documentation on the fire drills conducted, including documentation that the fire alarm signal was successfully received by the monitoring company/fire department to validate compliance with the regulation. | |
| K 0761<br>SS=C<br>Bldg. 01 | Based on observation, record review, and interview; the facility failed to ensure an annual inspection and testing of 1 of 1 oxygen room fire door assembly was completed in accordance with LSC 19.1.1.4.1.1. Communicating openings in dividing fire barriers required by 19.1.1.4.1 shall be permitted only in corridors and shall be protected by approved self-closing fire door assemblies. (See also Section 8.3.) LSC 8.3.3.1 Openings required to have a fire protection rating by Table 8.3.4.2 shall be protected by approved, listed, labeled fire door assemblies and fire window | K 0761 | K 761<br>*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now inspected and tested the fire door assembly on the door of the | 10/14/2022 |

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| | assemblies and their accompanying hardware, including all frames, closing devices, anchorage, and sills in accordance with the requirements of NFPA 80, Standard for Fire Doors and Other Opening Protectives, except as otherwise specified in this Code. NFPA 80 5.2.1 states 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. NFPA 80, 5.2.4.1 states fire door assemblies shall be visually inspected from both sides to assess the overall condition of door assembly.<br><br>NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified:<br>(1) No open holes or breaks exist in surfaces of either the door or frame.<br>(2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped.<br>(3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage.<br>(4) No parts are missing or broken.<br>(5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.<br>(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position.<br>(7) If a coordinator is installed, the inactive leaf closes before the active leaf.<br>(8) Latching hardware operates and secures the door when it is in the closed position.<br>(9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame.<br>(10) No field modifications to the door assembly have been performed that void the label. | | oxygen room storage. No concerns were identified during this inspection.<br>*The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The facility has now inspected and tested the fire door assembly on the door of the oxygen room storage. No concerns were identified during this inspection.<br>*The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been conducted for the maintenance supervisor on the required annual inspection and testing of all fire door assemblies in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives as well as the documentation of these inspections/testings. This inspection/testing shall include the door to the oxygen storage area.<br>*The corrective action taken to monitor to ensure the deficient practice will not recur is that* the maintenance supervisor will submit at least annually to the Executive Director the documentation of the annual inspection of fire door assemblies to validate compliance in accordance with the regulation. | |

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| | (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity.<br>This deficient practice could affect all residents, as well as staff, and visitors.<br><br>Findings include:<br><br>Based on record review on 09/27/22 between 9:45 a.m. and 12:00 p.m. with the Director of Environmental Services and Administrator present, the facility was unable to provide documentation for an annual inspection of the oxygen transfilling room fire door assembly.<br>Based on interview at the time of record review, the Administrator said there was no documentation of an annual inspection of the oxygen transfilling room fire door assembly.<br>Based on observations during a tour of the facility with the Director of Environmental Services between 12:00 p.m. and 2:00 p.m., there was one oxygen transfilling room fire door assembly noted in the facility.<br><br>This finding was reviewed with the Director of Environmental Services and Administrator during the exit conference.<br><br>3.1-19(b) | | | |
| K 0920<br>SS=D<br>Bldg. 01 | NFPA 101<br>Electrical Equipment - Power Cords and Extens<br>Electrical Equipment - Power Cords and Extension Cords<br>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 | | | |

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| | 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<br>Based on observation and interview, the facility failed to ensure a power strip was not used as a substitute for fixed wiring in 1 of 1 Beauty Shop. LSC 19.5.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code, 2011 Edition. NFPA 70, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect one resident and staff.<br><br>Findings include:<br><br>Based on observations on 09/27/22 between 12:00 p.m. and 2:00 p.m. during a tour of the facility with the Director of Environmental Services, there were four curling irons and one hand held hair dryer plugged into a power strip in the Beauty Shop. Based on interview at the time of observation, the Director of Environmental Services acknowledged the use of the power strip in the Beauty Shop. | K 0920 | K 920<br>*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified, any resident and staff member in the beauty shop has the potential to be affected by this deficient practice. The power strip was immediately removed from the beauty shop at the time of the survey. The facility has now installed an additional hard wired electrical outlet in the beauty shop providing additional electrical outlets for the beautician's use.<br>*The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* any resident utilizing the beauty shop along with the beautician have the | 10/14/2022 |

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| | 155502 | A. BUILDING 01<br>B. WING | 09/27/2022 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP COD |
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| TRANSCENDENT HEALTHCARE OF OWENSVILLE | 7336 W STATE ROAD 165<br>OWENSVILLE, IN 47665 |

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| | This finding was reviewed with the Director of Environmental Services and Administrator during the exit conference.<br><br>3.1-19(b) | | potential to be affected by this deficient practice. The facility has now installed an additional hard wired electrical outlet in the beauty shop providing additional electrical outlets for the beautician's use.<br>*The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for the beautician to instruct them on the need to ensure that all electrical devices are plugged into a hard-wired electrical outlet and that power strips are not permitted to be used.<br>*The corrective action taken to monitor to ensure the deficient practice will not recur is that* as part of the facility's preventative maintenance program the maintenance supervisor will check the beauty shop monthly to ensure that all electrical devices are plugged into a hard-wired electrical outlet and that power strips are not being used. | |
| K 0923<br>SS=F<br>Bldg. 01 | NFPA 101<br>Gas Equipment - Cylinder and Container Storag<br>Gas Equipment - Cylinder and Container | | | |

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| | Storage<br>Greater than or equal to 3,000 cubic feet<br>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.<br>>300 but <3,000 cubic feet<br>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.<br>Less than or equal to 300 cubic feet<br>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.<br>Cylinders must be handled with precautions as specified in 11.6.2.<br>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."<br>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.<br>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) | | | |

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| | Based on observation and interview, the facility failed to ensure cylinders of nonflammable gases such as oxygen were properly secured from falling in 1 of 1 oxygen transfilling/storage room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.3.3 states storage for nonflammable gases with a total volume equal to or less than greater than 8.5 cubic meters (300 cubic feet) shall comply with 11.3.3.1 and 11.3.3.2. NFPA 99, Section 11.3.3.2 states precautions in handling cylinders specified in 11.3.3.1 shall be in accordance with 11.6.2. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect all residents, staff and visitors since the oxygen room is across from the dining room.<br><br>Findings include:<br><br>Based on observations on 09/27/22 between 12:00 p.m. and 2:00 p.m. during a tour of the facility with the Director of Environmental Services, there was one of four E size oxygen cylinders in the oxygen transfilling/storage room freestanding on the floor and was not supported in a proper cylinder stand or otherwise secured from falling. Based on interview at the time of the observation, the Director of Environmental Services acknowledged the E size oxygen cylinder in the oxygen transfilling/storage room was not supported in a cylinder stand or otherwise secured from falling.<br><br>This finding was reviewed with the Director of Environmental Services and Administrator during the exit conference.<br><br>3.1-19(b) | K 0923 | K 923<br>*The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. The E size oxygen cylinder identified during the survey was immediately placed in a secure oxygen cylinder stand to ensure that the cylinder was secure and free of the potential of falling over.<br>*The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The E size oxygen cylinder identified during the survey was immediately placed in a secure oxygen cylinder stand to ensure that the cylinder was secure and free of the potential of falling over. All oxygen cylinders are securely stored to prevent them from falling over.<br>*The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all nursing, housekeeping and maintenance staff on the facility's policy related to secure oxygen storage. All | 10/14/2022 |

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| | | | staff members were instructed on the proper means to secure oxygen cylinders.<br>*The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been developed and implemented to monitor the secure storage of oxygen cylinders. This tool will be completed by the maintenance supervisor and/or their designee, weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted. | |
| K 0927<br>SS=F<br>Bldg. 01 | NFPA 101<br>Gas Equipment - Transfilling Cylinders<br>Gas Equipment - Transfilling Cylinders<br>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).<br>11.5.2.2 (NFPA 99)<br>Based on observation and interview, the facility | K 0927 | K 927 | 10/14/2022 |

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| | failed to ensure 1 of 1 oxygen storage location where transfilling occurs had proper distance from combustible items. NFPA 99, Health Care Facilities Code 2012 Edition, Section 11.5.2.3.1 states oxygen transfilling locations shall include the following:<br>(1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire resistive construction.<br>(2) The area is mechanically vented, is sprinklered, and has ceramic or concrete flooring.<br>(3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted.<br>(4) The individual transfilling the container(s) has been properly trained in the transfilling procedures.<br>NFPA 99, 11.3.2.3 requires oxidizing gases such as oxygen shall be separated from combustibles by one of the following: (1) a minimum distance of 20 feet. (2) a minimum distance of 5 feet if the required storage location is protected by an automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour.<br>This deficient practice could affect all residents, as well as staff and visitors since the oxygen room is across from the dining room.<br><br>Findings include:<br><br>Based on observations on 09/27/22 between 12:00 p.m. and 2:00 p.m. during a tour of the facility with the Director of Environmental Services, the oxygen transfilling and storage room where three liquid oxygen tanks and four oxygen cylinders were being stored had four cardboard boxes, plus | | *The corrective action taken for those residents found to have been affected by the deficient practice is that* although no specific residents were identified during the survey, all residents, staff and visitors have the potential to be affected by this deficient practice. All the cardboard boxes, papers and plastic items were immediately removed from the oxygen storage area at the time of the survey. No combustible items are left in the oxygen storage area.<br>*The corrective action taken for the other residents that have the potential to be affected by the same deficient practice is that* all residents, staff and visitors have the potential to be affected by this deficient practice. The oxygen storage area is free of any combustible items, such as cardboard, paper or plastic items.<br>*The measures that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all nursing, housekeeping and maintenance staff on the facility policy related to oxygen storage. The staff was re-educated on ensuring that no combustible items are placed in the oxygen storage area.<br>*The corrective action taken to monitor to ensure the deficient practice will not recur is that* a Quality Assurance tool has been | |

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| | paper and plastic items stored on a rack that was within three feet of the liquid oxygen tanks.<br>Based on interview at the time of observation, the Director of Environmental Services acknowledged the cardboard boxes, plus paper and plastic items stored within three feet of the three liquid oxygen tanks.<br><br>This finding was reviewed with the Director of Environmental Services and Administrator during the exit conference.<br><br>3.1-19(b) | | developed and implemented to monitor the oxygen storage areas to ensure that the oxygen storage area is free of any combustible items. This tool will be completed by the maintenance supervisor and/or their designee, weekly for four weeks, then monthly for three months and then quarterly for three quarters. The outcome of this tool will be reviewed at the facility's Quality Assurance meetings to determine if any additional action is warranted. | |