STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155840	A. BUILDING -- B. WING	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
IGNITE MEDICAL RESORT DYER LLC	1532 CALUMET AVENUE DYER, IN 46311

(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: 05/15/2025 Facility Number: 013462 Provider Number: 155840 AIM Number: 201330210 At this Emergency Preparedness survey, Ignite Medical Resort Dyer LLC, was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 100 certified beds. At the time of the survey, the census was 93. Quality Review completed on 05/19/25	E 0000	Ignite Medical Resorts Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. This facility respectfully requests a desk review for the given citations in this survey. Please see all attached documentation for your consideration.	
E 0024 SS=F Bldg. --	403.748(b)(6), 416.54(b)(5), 418.113(b)(Policies/Procedures-Volunteers and Staffing Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency in accordance with 42 CFR 483.73(b)(6). This deficient practice could affect all residents, staff and visitors. Findings include:	E 0024	**E-024 Policies/Procedures – Volunteers and Staffing** It is the facility's policy to comply with all applicable federal and state regulations regarding emergency preparedness policies and procedures, specifically 42 CFR 483.73(b)(6), concerning the use of volunteers and emergency staffing strategies during	06/06/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Megan Matula	General Manager	06/06/2025

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	Based on record review with the Director of Environmental Services at 10:40 a.m. on 05/15/2025, the facility's Emergency Preparedness Policies and Procedures did not address the use of volunteers in an emergency, emergency staffing strategies, or the process and role for integration of State or Federally designated health care professionals to address surge needs during an emergency. Based on interview with the Director of Environmental Services at 10:40 a.m. on 05/15/2025, he acknowledged no policy was available to address volunteers in and emergency, staffing strategies, or the process and role for integration of State or Federally designated health care professionals. This finding was reviewed with the General Manager, Regional General Manager, and the Director of Environmental Services at the exit conference.		emergencies. **Corrective Action Taken:** The facility developed and implemented a comprehensive Emergency Preparedness Policy addressing the use of volunteers and emergency staffing strategies. The policy includes: Volunteer Support, Policy Implementation, Establishing Volunteer Resources, and Arrangements with other Facilities. The facility developed and implemented a policy to provide an understanding and guidance of typical Medical Surge Capacity and Capability plan that can be implemented for a mass casualty incident, pandemic, or other large scale incident that requires beds, staffing, and other support from our local regional healthcare coalition. The Director of Environmental Services and Emergency Preparedness Committee reviewed and approved the policy on 5/27/2025. **Identification of Other Areas with Potential to be Affected:** The Emergency Preparedness Committee conducted a facility-wide assessment to identify all areas requiring emergency staffing considerations. This included: - Review of all departments' staffing needs during emergencies - assessment of potential surge capacity requirements and evaluation of current emergency staffing protocols	

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			Systemic Changes and Measures Implemented: The following systemic changes have been implemented: Created a Volunteer Management Program (5/27/2025) Developed procedures for emergency credentialing of healthcare professionals (5/27/2025) **Monitoring and Quality Assurance:** The Director of Environmental Services/Designee will conduct monthly audits of: Volunteer Management Policy and Staffing and Surge Capacity to ensure no changes to policy/procedures/resources have changed or need updated. Results will be reported monthly to the Quality Assurance Performance Improvement (QAPI) Committee. The QAPI Committee will review findings and make necessary adjustments to ensure ongoing compliance. Monitoring will continue until substantial compliance is achieved and maintained for six consecutive months. Date of Completion: 6/6/2025	
E 0030 SS=F Bldg. --	403.748(c)(1), 416.54(c)(1), 418.113(c)(Names and Contact Information Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (1) Names and contact information for the following: (i) Staff (ii)	E 0030	**E-030 Names and Contact Information** It is the facility's policy to comply	06/06/2025

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	Entities providing services under arrangement (iii) Residents' physicians (iv) Other LTC facilities (v) Volunteers in accordance with 42 CFR 483.73(c)(1). This deficient practice could affect all occupants. Findings include: Based on record review with the Director of Environmental Services at 10:42 a.m. on 05/15/2025, the facility's communication plan did not include (1) Names and contact information for the following: (i) Staff (ii) Entities providing services under arrangement (iii) Residents' physicians (iv) Other LTC facilities (v) Volunteers. Based on interview with the Director of Environmental Services at 10:42 a.m. on 05/15/2025, he was not able to provide a list of the contact information. This finding was reviewed with the General Manager, Regional General Manager, and the Director of Environmental Services at the exit conference.		with all applicable federal and state regulations regarding emergency preparedness communication plans as outlined in 42 CFR 483.73(c)(1). **Corrective Action Taken:** The Director of Environmental Services developed and implemented a comprehensive emergency preparedness communication plan that includes contact information for: (i) all facility staff members, including their names, positions, and current contact information; (ii) entities providing services under arrangements, (iii) all residents attending physicians; (iv) other long term care facilities; and (v) all facility volunteers. This information has been compiled in both electronic and hard copy formats, with backup copies stored in multiple secure locations within the facility. **Identification of Other Areas with Potential to be Affected:** The Director of Environmental services conducted a facility-wide assessment to identify any other emergency preparedness documentation or communication systems that could be affected by similar deficiencies. This review included all emergency response protocols and communication procedures throughout the facility. **Systemic Changes and Measures Implemented:** Implemented a new policy and procedure for maintaining and	

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			updating the emergency preparedness communication plan annually Created an electronic database system to store and maintain all required contact information Scheduled mandatory in-service training for all department heads on 05/29/2025 regarding the new communication plan maintenance procedures. Created redundant systems for accessing contact information during emergencies, including both electronic and hard copy formats. **Monitoring and Quality Assurance:** The Director of Environmental Services/Designee will conduct monthly audits of the communication plan to ensure all contact information remains current and complete. Results of these audits will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly for six consecutive months, then annually thereafter. The QAPI Committee will analyze the data for patterns and trends and make additional recommendations as needed until substantial compliance is achieved and maintained. Date of Completion: 6/6/2025	
E 0031 SS=F Bldg. --	403.748(c)(2), 416.54(c)(2), 418.113(c)(Emergency Officials Contact Information			

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	Based on record review and interview, the facility failed to ensure the Emergency Preparedness Communication Plan includes: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman (iv) Other sources of assistance in accordance with 42 CFR 483.73(c)(2). This deficient practice could affect all occupants. Findings include: Based on record review with the Director of Environmental Services at 10:45 a.m. on 05/15/2025, the Emergency Preparedness Communication Plan included contact information for the Illinois Department of Health, but did not include Gateway.isdh.in.gov or incidents@isdh.in.gov as contact information for contacting the Indiana Department of Health (IDOH). Based on interview with the Director of Environmental Services at 10:45 a.m. on 05/15/2025, he acknowledged the emergency officials contact information did not include the contact information for IDOH. This finding was reviewed with the General Manager, Regional General Manager, and the Director of Environmental Services at the exit conference.	E 0031	**E-031 Emergency Officials Contact Information** It is the facility's policy to comply with all applicable federal and state regulations regarding emergency preparedness communication plans as outlined in 42 CFR 483.73(c)(2). **Corrective Action Taken:** The Director of Environmental Services updated the Emergency Preparedness Communication Plan to include the required contact information for the Indiana Department of Health (IDOH), specifically adding Gateway.isdh.in.gov. The Emergency Preparedness Communication Plan was reviewed in its entirety to ensure all required contact information is included and current for Federal, State, tribal, regional, and local emergency preparedness staff, the State Licensing and Certification Agency, the Office of the State Long-Term Care Ombudsman, and other sources of assistance. **Identification of Other Areas with Potential to be Affected:** The Director of Environmental Services conducted a comprehensive review of all emergency contact lists and communication protocols throughout the facility to ensure completeness and accuracy. This	06/06/2025

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			review included all emergency preparedness documentation, posted contact information, and electronic records maintained by the facility. **Systemic Changes and Measures Implemented:** A new policy has been implemented requiring annual verification of all emergency contact information by the Director of Environmental Services. The facility's Emergency Preparedness Committee will review the communication plan during monthly meetings to ensure ongoing compliance. Staff training on the updated Emergency Preparedness Communication Plan will be conducted by 05/30/2025. **Monitoring and Quality Assurance:** The Director of Environmental Services/Designee will conduct monthly audits of the Emergency Preparedness Communication Plan to ensure all required contact information remains current and accurate. Results of these audits will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for six months. Any identified deficiencies will be immediately corrected and may result in additional monitoring as determined by the QAPI Committee. Date of Compliance: 6/6/2025	

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E 0032 SS=F Bldg. --	403.748(c)(3), 416.54(c)(3), 418.113(c)(Primary/Alternate Means for Communication Based on record review and interview, the facility failed to ensure the emergency preparedness communication plan includes (3) Primary and alternate means for communicating with the following: (i) LTC facility's staff (ii) Federal, State, tribal, regional, or local emergency management agencies in accordance with 42 CFR 483.73(c) (3). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Director of Environmental Services at 10:50 a.m. on 05/15/2025, the emergency preparedness communication plan provided did not address primary and alternate means for communication. Based on interview with the Director of Environmental Services at 10:50 a.m. on 05/15/2025, he acknowledged the emergency communication plan did not address primary and alternate communication. This finding was reviewed with the General Manager, Regional General Manager, and the Director of Environmental Services at the exit conference.	E 0032	**E-032 Primary and Alternate Means for Communication** It is the facility's policy to comply with all applicable federal and state regulations regarding emergency preparedness communication plans as outlined in 42 CFR 483.73(c)(3). **Corrective Action Taken:** The Director of Environmental Services revised the facility's Emergency Preparedness Communication Plan to include specific primary and alternate means of communication. The plan now explicitly details communication protocols with both facility staff and Federal, State, tribal, regional, and local emergency management agencies. **Identification of Other Areas with Potential to be Affected:** The Emergency Preparedness Committee conducted a facility-wide assessment on 05/16/2025 to identify all areas requiring communication capability during emergencies. **Systemic Changes and Measures Implemented:** Updated Emergency Preparedness Communication Plan to include detailed primary and alternate communication	06/06/2025

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			methods Conducted staff training on revised communication plan and use of emergency communication equipment **Monitoring and Quality Assurance:** The Director of Environmental Services/Designee will conduct monthly audits of the emergency communication systems and equipment to ensure functionality and compliance. Results will be documented using the Emergency Communications Audit Tool. The Director of Environmental Services/Designee will report monitoring results to the monthly Quality Assurance and Performance Improvement (QAPI) committee for six consecutive months. Date of Compliance: 6/6/2025	
E 0039 SS=F Bldg. --	403.748(d)(2), 416.54(d)(2), 418.113(d)(EP Testing Requirements Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The LTC facility must do the following: (i) Participate in an annual full-scale exercise that is community-based; or a. When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. b. If the LTC facility experiences an actual natural or man-made emergency that requires activation	E 0039	**E-039 EP Testing Requirements** It is the facility's policy to comply with all applicable federal and state regulations regarding emergency preparedness testing requirements under 42 CFR 483.73(d)(2). **Corrective Action Taken:** The Director of Environmental Services, in collaboration with the facility Administrator, developed	06/06/2025

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	of the emergency plan, the LTC facility is exempt from engaging its next required full-scale community-based or individual, facility-based full-scale functional exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: a. A second full-scale exercise that is community-based or an individual, facility-based functional exercise. b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a facilitator that includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Director of Environmental Services at 11:08 a.m. on 05/15/2025, the facility failed to provide documentation of any exercises to test the emergency preparedness plan. Based on interview at 11:08 a.m. on 05/15/2025, the Director of Environmental Services was not aware of any exercises that were conducted in the last year. This finding was reviewed with the General Manager, Regional General Manager, and the Director of Environmental Services at the exit conference.		and implemented a comprehensive emergency preparedness testing schedule. The facility has scheduled a community-based full-scale exercise for 7/9/2025 in coordination with CHUG. Additionally, a facility-based mock disaster drill was completed on 5/29/2025. Documentation templates have been created to record and analyze all emergency preparedness exercises. **Identification of Other Areas with Potential to be Affected:** The Director of Environmental Services conducted a facility-wide assessment to identify all areas requiring emergency preparedness testing. This review included evaluation of current emergency procedures, staff knowledge of emergency protocols, and documentation systems for recording exercises. **Systemic Changes and Measures Implemented:** The facility implemented a new Emergency Preparedness Testing Program that includes: May 29, 2025: Facility-based disaster drill June 5, 2025: Full Scale Exercise - Active Shooter July 9, 2025: Community – based full-scale exercise Quarterly unannounced staff drills beginning July 1, 2025 Staff training on emergency procedures will be conducted:	

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			Initial training: May 26 – May 30 Quarterly updates thereafter New hire orientation **Monitoring and Quality Assurance:** The Director of Environmental Services/Designee will maintain an Emergency Preparedness Testing Log to track all exercises, participation, and outcomes. Results will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly for six consecutive months. Date of Compliance: 6/6/2025	
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). This visit was in conjunction with the Life Safety Code Preoccupancy Survey that exited on 05/15/25. Survey Date: 05/15/2025 Facility Number: 013462 Provider Number: 155840 AIM Number: 201330210 At this Life Safety Code survey, Ignite Medical Resort Dyer LLC, was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 483.90(a), Life Safety from Fire and the 2012 Edition of the National Fire	K 0000	Ignite Medical Resorts Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. This facility respectfully requests a desk review for the given citations in this survey. Please see all attached documentation for your consideration.	

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	Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies. This two-story facility was determined to be of Type V (111) construction and fully sprinklered. A 2-hour fire wall is provided to divide the facility into two separate buildings. Each separate building is subdivided into two smoke compartments. Separation between the first-floor healthcare occupancy and the second-floor residential occupancy is divided by a 2-hour horizontal floor/ceiling assembly and fire barriers. The rated floor/ceiling system is supported by 2-hour rated construction. The facility has a fire alarm system with hard-wired smoke detection in resident rooms, in corridors and in spaces open to the corridors. The building is partially protected by a 175-kW diesel powered generator. The facility has a capacity of 100 and had a census of 93 at the time of this survey. Quality Review completed on 05/19/25			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Based on observation and interview, the facility failed to ensure flexible cords and adapters were not used as a substitute for fixed wiring in 1 of 10 smoke compartments. 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 staff in 1 of 10 smoke compartments.	K 0920	**K-920 Electrical Equipment – Power Cords and Extens** It is the facility's policy to comply with all applicable federal and state regulations regarding electrical equipment safety, specifically NFPA 70 National Electrical Code Article 400.8 and NFPA 99 sections 10.2.3.6 and 10.2.4, concerning the proper use	06/06/2025

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	Findings include: Based on observation with the Director of Environmental Services at 11:48 a.m. on 05/15/2025, a power strip that was plugged directly into a wall receptacle was supplying power to two other power strips. One of the two power strips provided power to television equipment and the other power strip provided power to a fourth power strip that also provided power to television equipment. The television equipment was in a closet located in the administrative office area behind the receptionist's desk. Director of Environmental Services at 11:48 a.m. on 05/15/2025, he acknowledged the three power strips were plugged into a fourth power strip providing power to them. This finding was reviewed with the General Manager, Regional General Manager, and the Director of Environmental Services at the exit conference. 3.1-19(b)		of power strips and extension cords. **Corrective Action Taken:** On 05/28/2025, the Director of Environmental Services removed the daisy-chained power strips in the administrative office area closet and replaced them with a single UL-listed power strip appropriate for the equipment load. All equipment is now directly connected to appropriate wall outlets or a single approved power strip. **Identification of Other Areas with Potential to be Affected:** The Director of Environmental Services and Maintenance Staff conducted a facility-wide audit of all power strips and extension cord usage in facility, including patient care and non-patient care areas to ensure no additional power strips are connected. **Systemic Changes and Measures Implemented:** The Director of Environmental Services conducted mandatory in-service training for all maintenance staff and department heads regarding proper use of power strips and electrical safety requirements. **Monitoring and Quality Assurance:** The Director of Environmental Services/Designee will conduct weekly audits of all electrical connections and power strip usage. Results will be documented on the electrical	

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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
			safety inspection checklist. The Director of Environmental Services/Designee will review all findings and immediately address any identified issues. Audit results will be reported monthly to the Quality Assurance Performance Improvement (QAPI) Committee for six consecutive months. Date of Completion: 6/6/2025	
K 0921 SS=F Bldg. 01	NFPA 101 Electrical Equipment - Testing and Maintenanc Based on record review and interview, the facility failed to conduct the 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	K 0921	**K-921Electrical Equipment – Testing and Maintenance** It is the facility's policy to comply with all applicable federal and state regulations regarding Patient Care Related Electrical Equipment (PCREE) testing and maintenance requirements as specified in NFPA 99 (2012 edition), sections 10.3 and 10.5. **Corrective Action Taken:** The Director of Environmental Services initiated a comprehensive inventory of all PCREE in the facility. Testing includes physical integrity, resistance, leakage current, and touch current tests as required by section 10.3. The facility has established a centralized documentation system for maintaining records of all PCREE testing, repairs, and modifications.	06/06/2025

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	155840	A. BUILDING 01 B. WING	05/15/2025

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	facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Director of Environmental Services at 11:10 a.m. on 05/15/2025, the facility failed to provide documentation of testing of Patient Care Related Electrical Equipment (PCREE) in use in the facility as required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Based on interview with the Director of Environmental Services at 11:10 a.m. on 05/15/2025, he provided several documents including but not limited to HVAC inspections, and room inspection check lists; however, none of the documents contained testing of PCREE, stated he was not aware of the testing requirements of PCREE. This finding was reviewed with the General Manager, Regional General Manager, and the Director of Environmental Services at the exit conference. 3.1-19(b)		**Identification of Other Areas with Potential to be Affected:** The Director of Environmental Services conducted a facility-wide assessment to identify all areas where PCREE is in use. This included patient rooms, therapy areas, and all clinical spaces. An inventory database was created to track all PCREE equipment, including manufacturer specifications, maintenance requirements, and testing schedules. **Systemic Changes and Measures Implemented:** The facility developed and implemented a new PCREE Testing and Maintenance Policy that includes: Testing intervals for all PCREE equipment Documentation requirements for all tests, repairs, and modifications Procedures for testing new equipment before putting it into service Requirements for maintaining manufacturer service manuals and instructions By 6/1/2025, the facility will implement a computerized maintenance management system to track all PCREE testing schedules and maintenance records – TELS **Monitoring and Quality Assurance:** The General Manager/Designee will conduct	

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			monthly audits of PCREE testing records to ensure compliance with established testing intervals and documentation requirements. Results of these audits will be reported to the Quality Assurance and Performance Improvement (QAPI) committee monthly for six months The Director of Environmental Services/Designee will maintain a testing and maintenance record that includes: - Equipment inventory and location - Testing dates and results - Maintenance and repair records The facility's QAPI committee will monitor compliance with these measures until substantial compliance with all PCREE testing and maintenance requirements is achieved and maintained for a minimum of six consecutive months. Date of compliance: 6/6/2025	
K 0927 SS=F Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer location was used properly and in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.5.2.3.1(1) states, (transfilling shall occur in) 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. This deficient practice could affect all residents, staff and visitors.	K 0927	**K-927 Gas Equipment – Transfilling Cyclinders** It is the facility's policy to comply with all applicable federal and state regulations regarding oxygen storage and transfilling operations, specifically NFPA 99, Health Care	06/06/2025

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	Findings include: Based on observation with the Director of Environmental Services at 11:57 a.m. on 05/15/2025, the oxygen storage/transfill room on the "C" side of the Kendall hall of the facility contained 5 liquid oxygen containers, 3 portable refillable tanks, and five "E" tank oxygen carts. The oxygen storage/transfill room did not have space for a person to enter the room. A LPN was asked if they could demonstrate entering the room to fill a portable refillable tank. The LPN was not able to enter the room to perform the task and held the door open with his body. Based on interview with the Director of Environmental Services at 11:57 a.m. on 05/15/2025, when asked if staff normally leave the door open to perform transfilling, he indicated it was not and stated "Usually only have two tanks." This finding was reviewed with the General Manager, Regional General Manager, and the Director of Environmental Services at the exit conference. 3.1-19(b)		Facilities Code, 2012 Edition, Section 11.5.2.3.1(1). **Corrective Action Taken:** On 05/15/2025, the Director of Environmental Services reorganized the oxygen storage/transfill room on the “C” side of Kindle hall to ensure adequate space for staff to safely enter and perform transfilling operations. Excess oxygen containers and tanks were relocated to the facility’s secondary oxygen storage area. **Identification of Other Areas with Potential to be Affected:** The Director of Environmental Services conducted a facility-wide assessment of all oxygen storage areas to ensure compliance with NFPA 99 requirements. This included verification of proper fire barrier construction, ventilation, and adequate space for safe operation. **Systemic Changes and Measures Implemented:** Revised oxygen storage and transfilling policy to include specific requirements for maximum room capacity and safe operating procedures Implemented daily oxygen storage room inspection checklist to monitor compliance with storage limits and accessibility requirements. Conducted mandatory in-service training for all nursing staff and environmental services	

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			personnel on proper oxygen storage and transfilling procedures **Monitoring and Quality Assurance:** The Director of Environmental Services/Designee will conduct weekly inspections of the oxygen storage/transfill room to ensure proper storage capacity and accessibility are maintained as well as daily oxygen storage inspection log is being completed. The Director of Nursing/Designee will conduct 5 random observations of transfilling procedures on alternating shifts to ensure staff compliance with safety protocols. The Director of Environmental Services/Designee will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee monthly for six consecutive months. Date of Completion: 06/06/2025	