STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155628	A. BUILDING -- B. WING	06/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CREEKSIDE HEALTH AND REHABILITATION CENTER	3114 EAST 46TH STREET INDIANAPOLIS, IN 46205

(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: 06/08/21 Facility Number: 009569 Provider Number: 155628 AIM Number: 200139920 At this Emergency Preparedness survey, Creekside Health and Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 120 certified beds. At the time of the survey, the census was 104. Quality Review completed on 06/10/21	E 0000	We hereby respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a Post Survey Revisit. All necessary corrections have been completed by June 18, 2021 as we hereby allege compliance as of that date. We are willing to submit any and all supporting documentation as requested to assure our credible compliance with the deficiencies noted in the CMS form 2567. We are providing our plan of correction. Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth, affects, alleged or corrections set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	
K 0000 Bldg. 02	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/08/21	K 0000	We hereby respectfully requesting this agency consider paper compliance for the following plan of correction as opposed to a Post Survey Revisit. All necessary corrections have been completed by June 18, 2021 as we hereby	

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

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	Facility Number: 009569 Provider Number: 155628 AIM Number: 200139920 At this Life Safety Code survey, Creekside Health and Rehabilitation Center was found not in compliance with Requirements for Participation 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 18, New 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 smoke detection in the corridors and in all areas open to the corridor. The facility has smoke detectors hard wired to the fire alarm system in all resident sleeping rooms. The facility has a capacity of 120 and had a census of 104 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered except for a single detached storage garage that was unsprinklered. Quality Review completed on 06/10/21		allege compliance as of that date. We are willing to submit any and all supporting documentation as requested to assure our credible compliance with the deficiencies noted in the CMS form 2567. We are providing our plan of correction. Submission of this plan of correction does not constitute an admission or an agreement by the provider of the truth, affects, alleged or corrections set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirements under state and federal law. Please accept this plan of correction as our credible allegation of compliance.	
K 0211 SS=E Bldg. 02	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11.			

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	18.2.1, 19.2.1, 7.1.10.1 Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in 2 of 8 corridors within the facility. LSC 19.2.3.4(4) states, projections into the required width shall be permitted for wheeled equipment, provided that all of the following conditions are met: (a) The wheeled equipment does not reduce the clear unobstructed corridor width to less than 60 in. (1525 mm.) (b) The health care occupancy fire safety plan and training program address the relocation of the wheeled equipment during a fire or similar emergency. (c) The wheeled equipment is limited to the following: i. Equipment in use and carts in use ii. Medical emergency equipment not in use iii. Patient lift and transport equipment This deficient practice could affect approximately 16 residents, 4 staff and 2 visitors. Findings include: Based on observation on 06/08/21 during a tour of the facility between 11:21 a.m. and 1:58 p.m. with the Director of Plant Operations, the following was noted: a) resident room # 117 had a three-drawer cart outside of it used to store isolation supplies that was not on wheels. b) resident room # 328 had a three-drawer cart outside of it used to store isolation supplies that was not on wheels. c) resident room # 329 had a three-drawer cart outside of it used to store isolation supplies that was not on wheels. Based on interview with the Director of Plant Operations at the time of the observation, he	K 0211	**K211** **Corrective Actions:** No residents were negatively affected. All three drawer carts have been corrected with wheels and/or placed on a movable device. **How other residents have the potential to be affected and what actions will be taken:** All other carts in the facility have been inspected with no other findings. All other objects that would require to have wheels and/or placed on a movable device have been corrected. All carts have been corrected. **Systematic changes:** All carts or movable objects that may be in use are now wheeled and inspected upon placement. **How corrections actions will be monitored:** All three drawer carts will be inspected weekly, and concerns will be noted in the TELS system. All concerns and findings will be forwarded by the maintenance director to the health facility administrator and the QAA committee for further response and monitoring **What date corrections will be completed:** All corrections were completed before June 18, 2021	06/18/2021

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	acknowledged the items in the corridor were not on wheels and added that he would get different carts or add wheels to the current carts as soon as he was able to do so. During the exit conference with the Executive Director and the Director of Plant Operations at 3:15 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)			
K 0293 SS=E Bldg. 02	NFPA 101 Exit Signage Exit Signage 2012 NEW Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1 Based on observation and interview, the facility failed to install exit signage on 1 of 1 Central supply office door in the facility in accordance with LSC 7.10. LSC 7.10.1.2.1 exits, other than main exterior exit doors that obviously and clearly are identifiable as exits, shall be marked by an approved sign that is readily visible from any direction of exit access. LSC 7.10.1.2.2 states horizontal components of the egress path within an exit enclosure shall be marked by approved exit or directional exit signs where the continuation of the egress path is not obvious. This deficient practice could affect staff and at least 3 staff. Findings include: Based on observation on 06/08/21 during a tour of the facility at 11:32 a.m. with the Director of Plant Operations, there was a door with a frosted window that led directly outside located within	K 0293	**K293** **Corrective Actions:** No residents were negatively affected. The affected door was placed with the proper signage indicating “No Exit.” **How other residents have the potential to be affected and what actions will be taken:** All doors in the facility have been observed with no findings of incorrect exit signage. **Systematic changes:** Auditing and inspection of door signage will continue on a weekly basis. **How corrections actions will be monitored:** The maintenance director or designee will audit and inspect all	06/18/2021

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	the Central Supply office. This door was not provided with signage as to whether it was an exit or not an exit. Based on interview at the time of observation, the Director of Plant Operations acknowledged that the door could be thought of as a facility exit in case of an emergency and stated that he would have signage affixed to the door to identify it as an exit or not an exit as soon as he was able to do so. During the exit conference with the Executive Director and the Director of Plant Operations at 3:15 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		doors on a weekly basis and noted in the TELS Monitoring system. All concerns and findings will be forwarded by the maintenance director to the health facility administrator and the QAA committee for further response and monitoring **What date corrections will be completed** All corrections were completed before June 18, 2021	
K 0341 SS=E Bldg. 02	NFPA 101 Fire Alarm System - Installation Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 Based on observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was installed in accordance with 19.3.4.1. NFPA 72, 17.7.4.1 requires in spaces served by air handling systems, detectors shall not be located where air flow prevents operation of the detectors.	K 0341	**K341** **Corrective Actions:** No residents have been negatively affected. The affected smoke detector was moved to a correct location.	06/18/2021

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	(Annex A is not a part of the requirements but is included for informational purposes only.) A.17.7.4.1 states detectors should not be located in a direct airflow or closer than 36 inches from an air supply diffuser or return air opening. This deficient practice could affect staff and up to 15 residents in the therapy hall. Findings include: Based on observation on 06/08/21 during a tour of the facility at 12:25 p.m. with the Director of Plant Operations, the smoke detector located outside the Honey Creel hall outside the facility Laundry room was approximately 10 inches of an air outlet / return. Based on interview at the time of record review, the Director of Plant Operations acknowledged the smoke detector and provided the measurements of the distance between the smoke detector and the air outlet / return. During the exit conference with the Executive Director and the Director of Plant Operations at 3:15 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		**How other residents have the potential to be affected and what actions will be taken:** All residents have the potential to be affected. All smoke detectors in the facility have been inspected and audited. No other concerns were noted. **Systematic changes:** All smoke detectors will not be installed or placed within 36 inches of air handling systems or an air supply diffuser. **How corrections actions will be monitored:** All air handling systems are currently being inspected monthly and noted in the TELS monitoring system. All concerns and findings will be forwarded by the maintenance director to the health facility administrator and the QAA committee for further response and monitoring **What date corrections will be completed:** All corrections were completed before June 18, 2021.	
K 0351 SS=E Bldg. 02	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 NEW Buildings are to be 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			

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	areas where state and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed six square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10			
	Based on observation and interview, the facility failed to maintain the ceiling construction in 2 of 8 corridors in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 2010 edition, Section 6.2.7.1 states plates, escutcheons, or other devices used to cover the annular space around a sprinkler shall be metallic or shall be listed for use around a sprinkler. This deficient practice could affect staff and up to 18 residents, 3 staff and 1 visitor. Findings include: Based on observation on 06/08/21 during a tour of the facility between 11:21 a.m. and 1:58 p.m. with the Director of Plant Operations, the following was noted: a) the Environmental services room in the Kitchen nearest exit #6 had a missing escutcheon leaving a 3/8ths inch gap around the sprinkler head leading up into the attic space. b) the Medicine room located on the 200 hall within the Nurses Station had a loose escutcheon with a ½ inch gap of annular space around the sprinkler head. Based on an interview at the time of each	K 0351	**K351** **Corrective Actions:** No residents were negatively affected. All escutcheons and gaps around sprinkler heads have been corrected. **How other residents have the potential to be affected and what actions will be taken:** All residents have the potential to be affected. No other missing escutcheons or gaps around sprinkler heads were identified. **Systematic changes:** During quarterly pipe inspections and weekly sprinkler system inspections, all necessary corrections will be made if missing escutcheons or gaps are identified. **How corrections actions will be monitored:** The maintenance director or designee will inspect building for loose or missing escutcheons and noted in the TELS monitoring	06/18/2021

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	observation, the Director of Plant Operations acknowledged the missing escutcheon and annular space of the sprinklers stating that he would have them replaced and caulk added. During the exit conference with the Executive Director and the Director of Plant Operations at 3:15 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		System. All concerns and findings will be forwarded by the maintenance director to the health facility administrator and the QAA committee for further response and monitoring **What date corrections will be completed:** All corrections were completed before June 18, 2021	
K 0363 SS=E Bldg. 02	NFPA 101 Corridor - Doors Doors protecting corridor openings shall be constructed to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have self-latching and positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 18.3.6.3.6 are permitted. 18.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatic closing			

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	devices, etc. Based on observation and interview, the facility failed to ensure 1 of 1 physical therapy room door sets were provided with positive latching hardware. This deficient practice could affect over 10 residents, 5 staff and visitors in the vicinity of Therapy Room by the main entrance lobby. Findings include: Based on observation on 06/08/21 during a tour of the facility at 12:25 p.m. with the Director of Plant Operations, the corridor door set serving as the entrance to the Therapy Room was not equipped with positive latching devices to latch the door set into the door frame. The south door in the door set was equipped with a thumb twist deadbolt lock on the therapy room side of the door and required a key to unlock the door on the corridor side of the door. The north door set had only manual locking pins that had to be engaged at the top and the bottom of the door set and therefore would not automatically positively latch into the doorframe. Based on interview at the time of the observations, the Director of Plant Operations agreed that the Therapy Room corridor door set by the main entrance lobby was not equipped with automatic positive latching door devices. During the exit conference with the Executive Director and the Director of Plant Operations at 3:15 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)	K 0363	**K363** **Corrective Actions:** No residents were negatively affected. The affected door on the therapy gym has been repaired with the required latching mechanism. **How other residents have the potential to be affected and what actions will be taken:** All other doors in the facility have been inspected with no other findings completed. All other doors that would have positive latching hardware been inspected with no further issues. All doors are working properly. **Systematic changes:** All doors are inspected weekly as a part of the TELS preventative maintenance inspection and are found to be working properly. **How corrections actions will be monitored:** All facility doors will be inspected weekly, and concerns will be noted in the TELS system. All concerns and findings will be forwarded by the maintenance director to the health facility administrator and the QAPI committee for further response and monitoring **What date corrections will be completed** All corrections were completed before June 18, 2021.	06/18/2021

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K 0511 SS=D Bldg. 02	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 attic junction box was maintained in a safe operating condition. LSC 19.5.1 requires utilities 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, 2011 Edition, Article 314.28(c) requires all junction boxes shall be provided with covers compatible with the box. This deficient practice could affect as many as 16 residents, 2 staff and 1 visitor within the facility. Findings include: Based on observation on 06/08/21 during a tour of the facility at 12:25 p.m. with the Director of Plant Operations, two sets (four wires) protruding from an electronic flow switch located within the facility riser room that were exposed only being attached to each other by wire nuts. Based on an interview at the time of the observation, the Director of Plant Operations acknowledged the exposed wires and stated that he would add junction boxes with cover plates to the wires safely encasing them. During the exit conference with the Executive Director and the Director of Plant Operations at 3:15 p.m., no additional information or evidence could be provided contrary to this deficient finding.	K 0511	**K511** **Corrective Actions:** No residents were negatively affected. The wires protruding from an electronic flow switch have been corrected. **How other residents have the potential to be affected and what actions will be taken:** All other electric boxes for the potential of exposed or protruding wire have been inspected and corrected. **Systematic changes:** All exposed or protruding wires are inspected on an annual basis as a part of the TELS preventative maintenance inspections and found to be in compliance. **How corrections actions will be monitored:** All junction boxes will be inspected on an annual basis and noted in the TELS monitoring system. All concerns and findings will be forwarded by the maintenance director to the health facility administrator and the QAPI committee for further response and monitoring	06/18/2021

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	3.1-19(b)		**What date corrections will be completed** All corrections were completed before June 18, 2021.	
K 0911 SS=E Bldg. 02	NFPA 101 Electrical Systems - Other Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems 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. Chapter 6 (NFPA 99) Based on observation and interview, the facility failed to ensure access and working space was maintained in 1 of 1 electrical panel in the housekeeping storage closet. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.3.2.1 states electrical installation shall be in accordance with NFPA 70, National Electric Code. NFPA 70, 2011 Edition, Article 110.26 states access and working space shall be provided and maintained about all electrical equipment to permit ready and safe operation and maintenance of such equipment. Working space for equipment operating at 600 volts, nominal, or less and likely to require examination, adjustment, servicing, or maintenance while energized shall comply with the dimensions of 110.26(A) (1), (2) and (3). 110.26(A) (1) states the depth of the working space in the direction of live parts shall not be less than that specified in Table 110.26(A)(1) which the minimum clear distance is 3feet. 110.26(A) (2) states the width of the working space in front of the electrical equipment shall be the width of the equipment or 762 mm (30 in.), whichever is greater.	K 0911	**K911** **Corrective Actions:** No residents were negatively affected. The kitchen/food transportation carts have been removed from blocking the electrical panels. **How other residents have the potential to be affected and what actions will be taken:** All other areas with electrical panels have been inspected for items blocking access with no findings. **Systematic changes:** Kitchen staff have been reeducated on not having food transportation equipment blocking electrical panels. The minimum distance to be clear of the electrical panels have been identified and marked. **How corrections actions will be**	06/18/2021

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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
	In all cases, the workspace shall permit at least a 90-degree opening of equipment doors or hinged panels. 110.26(A)(3) states the workspace shall be clear and extend from the grade, floor, or platform to a height of 6 and 1/2 feet or the height of the equipment, whichever is greater. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect 5 staff in the kitchen. Findings include: Based on observation on 06/08/21 during a tour of the facility at 12:25 p.m. with the Director of Plant Operations, there were two electrical panels located within the kitchen marked K1 and K2. Located immediately in front of these two electrical panels were food transportation carts completely blocking their access. When asked if these food transportation carts normally occupied these areas, the Director of Plant Operations stated that he was unsure. He then went to a kitchen employee and explained that the carts could not block the electric panels and moved the carts to an acceptable location within the kitchen. Based on interview at the time of the observations, the Director of Plant Operations stated that he would help educate the kitchen employees and have them keep the space immediately in front of the electric panels free and clear of any items. This deficiency was taken care of prior to my exiting of the facility and also discussed during the exit conference with the Executive Director at 3:15 p.m. 3.1-19(b)		**monitored:** The affected area in the kitchen is to be inspected and audited monthly and noted in the TELS monitoring system. All concerns and findings will be forwarded by the maintenance director to the health facility administrator and the QAPI committee for further response and monitoring **What date corrections will be completed** All corrections were completed before June 18, 2021.	
K 0927 SS=E Bldg. 02	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155628	A. BUILDING 02 B. WING	06/08/2021

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	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 ensure 1 of 4 oxygen storage rooms where oxygen transferring takes place, was provided with properly working mechanical ventilation. NFPA 99, Health Care Facilities, 2012 edition, Section 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated. Section 9.3.7.5.3.1 requires mechanical exhaust to maintain a negative pressure in the space continuously. This deficient practice could affect up to 21 residents, as well as staff and visitors in main hall two and main hall three. Findings include: Based on observation on 06/08/21 during a tour of the facility at 12:13 p.m. with the Director of Plant Operations, the oxygen storage / transfer room had three large liquid oxygen tanks. Furthermore, there was a mechanically ventilated exhaust fan in the ceiling of this room, but it was not working. This was verified by holding a piece of paper up to the vent louver to see if the vent fan was creating suction, which it was not. There was an air outlet vent located within the oxygen storage / transfer room, and an exterior vent, but no mechanical ventilation. Based on an interview at	K 0927	**K927** **Corrective Actions:** No residents were negatively affected. All oxygen tanks requiring mechanical ventilation have been placed in the correct oxygen room. **How other residents have the potential to be affected and what actions will be taken:** All other oxygen rooms have been inspected for liquid oxygen tanks exceeding the maximum capacity requirements with no issues noted. **Systematic changes:** All oxygen tanks requiring mechanical ventilation have been moved. The contracted oxygen company has been informed this deficiency and instructions for future oxygen delivery has been requested to remain compliant. The Respiratory Therapist of this campus has also been informed of this requirement and oxygen delivery instructions moving	06/18/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	the time of the observation, the Director of Plant Operations stated that he thought the air outlet and outside ventilation were enough to meet the code. During the exit conference with the Executive Director and the Director of Plant Operations at 3:15 p.m., no additional information or evidence could be provided contrary to this deficient finding. 3.1-19(b)		forward. **How corrections actions will be monitored:** All oxygen rooms will be inspected monthly and noted in the TELS monitoring system. Additional concerns noted by the maintenance director or designee and forwarded to the QAPI committee for further response and monitoring. **What date corrections will be completed** All corrections were completed before June 18, 2021. -	