STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155672	A. BUILDING -- B. WING	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN 46552

(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: 06/03/2025 Facility Number: 000427 Provider Number: 155672 AIM Number: 100275150 At this Emergency Preparedness survey, Hamilton Grove was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 85 beds dually certified for Medicare and Medicaid. At the time of the survey, the census was 59. Quality Review completed on 06/05/25	E 0000		
E 0022 SS=F Bldg. --	403.748(b)(4), 416.54(b)(3), 418.113(b)(Policies/Procedures for Sheltering in Place Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include a means to shelter in place for residents, staff, and volunteers who remain in the LTC facility in accordance with 42 CFR 483.73(b)(4). This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Lead Maintenance Technician on 06/03/2025 at 10:39	E 0022	Facility will implement a policy to establish a means to shelter in place for residents, staff, and volunteers who remain in the facility. The Leadership Team of Facility will receive in-service training of the policy. The policy and agreement will be kept with all emergency disaster preparedness manuals. The in-service training will be provided by the Executive	07/15/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Catherine McClure	Executive Director	06/24/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
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	a.m., no policy or procedure was found regarding sheltering in place. Based on interview with the Lead Maintenance Technician on 06/03/2025 at 10:39 a.m., he stated he was not aware of and not able to locate a policy or procedure regarding sheltering in place. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.		Director/designee. The Quality Assurance and Performance Improvement (QAPI) Committee will evaluate the effectiveness of the implementation of the policy for a period of six months. The policy will be reviewed and updated as needed annually. Any deviation from the policy will be addressed through the preparation and execution of a performance improvement plan which will be further monitored by the QAPI Committee.	
E 0025 SS=F Bldg. --	403.748(b)(7), 418.113(b)(5), 441.184(b) Arrangement with Other Facilities Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the development of arrangements with other LTC facilities and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility residents. This deficient practice could affect all residents and staff. Findings include: Based on record review with the Lead Maintenance Technician on 06/03/2025 at 10:45 a.m., the facility provided of facilities they planned to evacuate to if necessary; however, no documentation of agreements was available for review. Based on interview with the Lead Maintenance Technician on 06/03/2025 at 10:45 a.m., he stated he was not aware of any	E 0025	E025 Arrangements with other LTC facilities to receive residents in the event of limitations or cessation of operations to maintain the continuity of service to facility residents will be established. The arrangements will be documented and added to the emergency preparedness plan. The Leadership Team of Facility will receive in-service training of these transfer arrangements with other LTC facilities. The in-service training will be provided by the Executive Director/designee. The QAPI Committee will evaluate the effectiveness of the transfer arrangements for a period of six months. Then, the arrangements	07/15/2025

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	agreements. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.		will be reviewed and updated as needed annually. Any issues identified regarding the transfer arrangements in relation to the requirements of this regulation will be addressed by the QAPI Committee.	
E 0026 SS=F Bldg. --	403.748(b)(8), 416.54(b)(6), 418.113(b)(Roles Under a Waiver Declared by Secretary Based on record review and interview, the facility failed to ensure emergency preparedness policies and procedures include the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials in accordance with 42 CFR 483.73(b)(8). This deficient practice could affect all residents and staff. Findings include: Based on record review with the Lead Maintenance Technician on 06/03/2025 at 10:48 a.m., the facility failed to provide a policy or procedure for the role of the LTC facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act. Based on interview with the Lead Maintenance Technician on 06/03/2025 at 10:48 a.m., he stated he was not familiar with and not able to locate a policy regarding the facility's role under a waiver declared by the Secretary in accordance with section 1135 of the Act. This finding was reviewed with the Executive	E 0026	Facility will implement a policy to establish roles for providing care and services under a waiver declared by the Secretary in accordance with Section 1135 of the Act. The Leadership Team of Facility will receive in-service training of the policy. The policy will be kept with all emergency disaster preparedness manuals. The in-service training will be provided by the Executive Director/designee. The Quality Assurance and Performance Improvement (QAPI) Committee will evaluate the effectiveness of the implementation of the policy for a period of six months. Then, the policy will be reviewed and updated as needed annually. Any deviation from the policy will be addressed through the preparation and execution of a performance improvement plan which will be further monitored by the QAPI Committee.	07/15/2025

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	Director and Maintenance Director at the exit conference.			
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 of the emergency plan, the LTC facility is exempt from engaging its next required full-scale in a 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).	E 0039	Facility will provide documentation to satisfy the requirements of the annual individual facility-based functional exercises to test the emergency plan. Facility will update the annual in service emergency preparedness binder with all documentation of the one full scale drill and the table top drill including face sheets and staff signatures. These exercises will be led by the Director of Maintenance and Executive Director. The Director of Maintenance will receive in-service training covering regulatory requirements under E039 related to Emergency Plan testing requirements for long-term care facilities. The in-service training will be provided by the Executive Director/designee. The QAPI Committee will incorporate an ongoing review of emergency planning testing processes to ensure that testing meets regulatory requirements of E039. Any deviation from the regulatory requirements will be addressed through the preparation and execution of a performance improvement plan which will be further monitored by the QAPI Committee.	07/15/2025

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	This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Lead Maintenance Technician on 06/03/2025 at 10:55 a.m., the facility was unable to provide documentation of any exercises of the Emergency Preparedness Plan. Based on interview with the Lead Maintenance Technician on 06/03/2025 at 10:55 a.m., documentation of a fire watch was provided; however, the documentation did not state if activation of the emergency plan occurred and there was no documentation to show the facility response was analyzed. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference.			
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/03/2025 Facility Number: 000427 Provider Number: 155672 AIM Number: 100275150 At this Life Safety Code survey, Hamilton Grove was not found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire, the 2012 edition of the	K 0000		

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	National Fire Protection Association (NFPA) 101, Life Safety Code (LSC) and 410 IAC 16.2 and was surveyed with Chapter 19 Existing Health Care Occupancies. This one-story facility was determined to be of Type V (111) construction and was fully sprinkled. The facility has a monitored fire alarm system with smoke detection in corridors, areas open to the corridor, and hardwired smoke detectors in all resident rooms. A 2-hour occupancy barrier separates the assisted living portion and a business occupancy section from the healthcare part of the building. A bathing area and physical therapy for healthcare residents both are located outside of the 2-hour wall located within the business area of the building which was then surveyed as part of healthcare. The facility has a capacity of 85 and had a census of 59 at the time of this survey. All areas where the residents have customary access were sprinkled and all areas providing facility services were sprinkled. Quality Review completed on 06/05/25			
K 0341 SS=E Bldg. 01	NFPA 101 Fire Alarm System - Installation 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. 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 residents, staff and	K 0341	The smoke detector located on the ceiling outside of resident room 1138 will be relocated so that it is at least 36 inches from the return air opening. All other smoke detectors in Facility will be checked to ensure they are at least 36 inches from any return air opening. Any other smoke detector found to be within 36	07/15/2025

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	visitors in 1 of 7 smoke compartments. Findings include: Based on observation with the Lead Maintenance Technician on 06/03/2025 at 12:47 p.m., a smoke detector located on the ceiling outside of resident room 1138 measured 12 inches of a return air opening. Based on interview with the Lead Maintenance Technician on 06/03/2025 at 12:47 p.m., he acknowledged the close proximity and agreed the smoke detector was 12 inches from the return air opening. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)		inches of a return air opening will be relocated to meet the requirements under K341. These corrections will be made by Facility's fire detection system contractor. The Director of Maintenance will receive in-service training covering the regulatory requirements of K341. The in-service training will be provided by the Executive Director/designee. Monitoring of the placement of any new smoke detectors in relation to return air openings will be incorporated into the Maintenance Department's maintenance program. The QAPI Committee will review progress with this plan of correction for a period of six months. Any deviation from this regulatory requirement will be addressed through the preparation and execution of a performance improvement plan which will be further monitored by the QAPI Committee.	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Based on observation and interview, the facility failed to ensure 6 of 6 electrical receptacles located within 6 feet of a sink was provided with ground fault circuit interrupter (GFCI) protection against electric shock. LSC 19.5.1.1 requires utilities comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault	K 0511	The six electrical receptacles identified in the report that are located within six feet of a sink will be corrected to ensure they are provided with ground fault circuit interrupter (GFCI) protection against electrical shock. All electrical receptacles located within six feet of a sink will be	07/15/2025

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	Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel. (1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical		reinspected to ensure they are provided with properly functioning ground fault circuit interrupter (GFCI) protection against electrical shock. The Director of Maintenance will receive in-service training covering the regulatory requirements of K511. The in-service training will be provided by the Executive Director/designee. Yearly audit to include healthcare related areas of electrical receptacles requiring ground fault circuit interrupter (GFCI) protection will be incorporated into Facility's preventive maintenance program. The QAPI Committee will review progress with this plan of correction for a period of six months. Any deviation from this regulatory requirement will be addressed through the preparation and execution of a performance improvement plan which will be further monitored by the QAPI Committee.	

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	care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools, or portable lighting equipment are to be used. This deficient practice could affect residents, staff and visitors in 1 of 7 smoke compartments. Findings include: Based on observation with the Lead Maintenance Technician on 06/03/2025 at 1:54 p.m., the following electrical receptacles failed to provide ground fault circuit interrupter (GFCI) protection against electric shock when tested: 1. A GFCI type electrical receptacle located on the wall behind a sink near the Therapy area desk. 2. A standard type electrical receptacle on the wall 34 inches from the sink located in Therapy area restroom. 3. A GFCI type electrical receptacle located on the wall behind a sink in Exam room 1 in the Therapy area. 4. A GFCI type electrical receptacle located on the wall behind a sink in Exam room 2 in the Therapy area. 5. A GFCI type electrical receptacle located on the wall behind a sink in Exam room 3 in the Therapy area. 6. A GFCI type electrical receptacle located on the wall behind a sink in the Speech Therapy room in the Therapy area. When tested, the GFCI type electrical receptacle located near the Therapy area desk started to smoke. The Lead Maintenance Technician			

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	immediately disconnected the power at the circuit breaker. The Lead Maintenance 1 started to replace the above mentioned receptacles during the survey. This finding was reviewed with the Executive Director and Maintenance Director during the exit conference. 3.1-19(b)			
K 0712 SS=F Bldg. 01	NFPA 101 Fire Drills Based on record review and interview, the facility failed to conduct quarterly fire drills for 1 of 3 shifts in 1 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions. This deficient practice affects all residents, staff and visitors. Findings include: Based on record review with the Lead Maintenance Technician on 06/03/2025 at 10:53 a.m., there was no documentation for a first shift fire drill in the first quarter of 2025. Based on interview with the Lead Maintenance Technician on 06/03/2025 at 11:23 a.m., he stated "The January fire drill was supposed to be first shift." Based on record review with the Lead Maintenance Technician on 06/03/2025 at 10:53 a.m., the January fire drill conducted on 1/30/2025 was done at 4:45 p.m. during the second shift. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)	K 0712	An annual schedule of fire drills involving the execution of quarterly drills on each shift under varied conditions will be created and administered. The Director of Maintenance will receive in-service training covering the requirements of fire drills under K712. This training will be provided by the Executive Director/designee. The QAPI Committee will review progress with this plan of correction for a period of six months. Routine monitoring of fire drills will be conducted on an ongoing basis by the QAPI Committee. Any deviation from this regulatory requirement will be addressed through the preparation and execution of a performance improvement plan which will be further monitored by the QAPI Committee.	07/15/2025

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K 0761 SS=F Bldg. 01	3.1-51(c) NFPA 101 Maintenance, Inspection & Testing - Doors Based on record review and interview, the facility failed to ensure annual inspection and testing of fire door assemblies were completed in accordance with LSC 8.3.3.1. LSC 8.3.3.1 states 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 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. NFPA 80, 5.2.4.2 states as a minimum, the following items shall be verified: (1) No open holes or breaks exist in surfaces of either the door or frame. (2) Glazing, vision light frames, and glazing beads are intact and securely fastened in place, if so equipped. (3) The door, frame, hinges, hardware, and noncombustible threshold are secured, aligned, and in working order with no visible signs of damage. (4) No parts are missing or broken. (5) Door clearances do not exceed clearances listed in 4.8.4 and 6.3.1.7.	K 0761	The preventive maintenance documentation of fire door assembly inspections will be corrected to include identifying information of the doors inspected. The assembly of all fire doors will be inspected and properly identified to ensure compliance with NFPA 80. The Director of Maintenance will receive in-service training covering the requirements of maintenance, inspection, and testing of doors with fire doors assemblies. This training will be provided by the Executive Director/designee. The QAPI Committee will review progress with this plan of correction for a period of six months. Any deviation from this regulatory requirement will be addressed through the preparation and execution of a performance improvement plan which will be further monitored by the QAPI Committee.	07/15/2025

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	(6) The self-closing device is operational; that is, the active door completely closes when operated from the full open position. (7) If a coordinator is installed, the inactive leaf closes before the active leaf. (8) Latching hardware operates and secures the door when it is in the closed position. (9) Auxiliary hardware items that interfere or prohibit operation are not installed on the door or frame. (10) No field modifications to the door assembly have been performed that void the label. (11) Gasketing and edge seals, where required, are inspected to verify their presence and integrity. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review with the Lead Maintenance Technician on 06/03/2025 at 10:53 a.m., the facility provided documentation of fire door assembly inspections; however, it did not identify the location of the doors inspected. Based on interview with the Lead Maintenance Technician on 06/03/2025 at 10:53 a.m., he acknowledged the documentation did not identify the doors that were inspected and could not determine from the documentation if all fire doors were inspected. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)			
K 0921 SS=F	NFPA 101 Electrical Equipment - Testing and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155672	A. BUILDING 01 B. WING	06/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
HAMILTON GROVE	31869 CHICAGO TRAIL NEW CARLISLE, IN 46552

(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
Bldg. 01	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 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 records review with the Lead Maintenance Technician on 06/03/2025 at 12:16 p.m., the facility failed to provide documentation of testing of Patient Care Related Electrical Equipment (PCREE) in use in the facility as	K 0921	Patient Care Related Electrical Equipment (PCREE) in use at Facility will be tested and documented as required. The Director of Maintenance will receive in-service training covering the regulatory requirements of K341. The in-service training will be provided by the Executive Director/designee. The Director of Maintenance will receive in-service training covering the requirements for testing and documentation of testing of PCREE as required. Routine testing and documentation of testing of PCREE will be incorporated into the Maintenance Department's preventive maintenance program. The QAPI Committee will review progress with this plan of correction for a period of six months. Any deviation from this regulatory requirement will be addressed through the preparation and execution of a performance improvement plan which will be further monitored by the QAPI Committee.	07/15/2025

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	required by section 10.5.6.2 of NFPA 99, Health Care Facilities Code. Based on interview with the Lead Maintenance Technician on 06/03/2025 at 12:16 p.m., he stated "We do check wires and the Brain Box on beds."; however, no documentation of any testing was available. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)			
K 0927 SS=F Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Based on record review and interview, the facility failed to ensure staff was properly trained on trans-filling procedures in 1 of 1 oxygen storage room where oxygen transferring takes place. NFPA 99 2012 edition, Section 11.5.2.3.1 (4) and Section 11.5.2.3.2 (3) requires the individual transfilling the container(s) has been properly trained in the transfilling procedures. Sections 11.5.2.1.1 thru 11.5.2.1.3 require personnel concerned with the application and maintenance of medical gases and others who handle medical gases and the cylinders that contain the medical gases shall be trained on the risks associated with their handling and use. Health care facilities shall provide programs of continuing education for their personnel. Continuing education programs shall include periodic review of safety guidelines and usage requirements for medical gases and their cylinders. This deficient practice could affect all residents, staff and visitors. Findings include:	K 0927	Facility will implement a policy addressing routine training, including documentation thereof, related to the transfilling of liquid oxygen. All staff who transfill liquid oxygen will receive in-service training on the proper procedure for transfilling liquid oxygen. This education will be provided by the Director of Maintenance/designee and it will be documented. The QAPI Committee will review progress with this plan of correction for a period of six months. The policy will be reviewed and updated as needed annually. Any deviation from this regulatory requirement will be addressed through the preparation and execution of a performance improvement plan which will be further monitored by the QAPI Committee.	07/15/2025

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	Based on records review with the Lead Maintenance Technician on 06/03/2025 at 11:19 a.m., the facility failed to provide a policy or evidence of a program of continuing education and no documentation was available for review to indicate that staff who transfill liquid oxygen was properly trained. Based on interview with the Lead Maintenance Technician on 06/03/2025 at 11:19 a.m., he stated a facility used the "Little green and grey tanks." Based on observation with the Lead Maintenance Technician on 06/03/2025 at 1:31 p.m., Liquid oxygen containers and refillable portable tanks were present in the Oxygen storage and transfill room. This finding was reviewed with the Executive Director and Maintenance Director at the exit conference. 3.1-19(b)			