DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155188	A. BUILDING -- B. WING	05/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD HEALTHCARE CENTER	200 GREEN MEADOWS DR GREENFIELD, IN 46140

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 05/04/21 Facility Number: 00099 Provider Number: 155188 AIM Number: 100291140 At this Emergency Preparedness survey, Greenfield Healthcare Center was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 163 certified beds. At the time of the survey, the census was 103. Quality Review completed on 05/07/21	E 0000	Greenfield Healthcare Center requests desk review and will attach documents and photos of all corrections made from survey. Thanks, Andrew	
E 0036 SS=F Bldg. --	403.748(d), 416.54(d), 418.113(d), 441.184(d), 482.15(d), 483.475(d), 483.73(d), 484.102(d), 485.625(d), 485.68(d), 485.727(d), 485.920(d), 486.360(d), 491.12(d), 494.62(d) EP Training and Testing §403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d). *[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	§441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. *[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section,			

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	and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years.			
	Based on record review and interview, the facility failed to maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. Findings include: Based on record review of the Emergency Preparedness Plan with the Executive Director (ED) on 05/04/21 at 10:37 p.m., the facility did not have an emergency preparedness training and testing program available for review. Based on interview at the time of record review, the ED stated a written Emergency Training and testing Plan could not be provided for review. This was discussed with the ED during the exit conference.	E 0036	**1. Initial training in emergency preparedness policies and procedures was given to all new and existing staff, consistent with their expected roles along with a post test to ensure staff knowledge of procedures and kept in a binder.** **2. All residents and staff members and visitors had the potential to be affected.** **3. The maintenance director/designee will give emergency preparedness training and a post test to all future new hires during orientation to ensure this does not recur.** **4. The maintenance**	06/03/2021

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			director/designee will report to QAPI on a monthly basis and keep record of all training for new/existing employees to ensure training is completed initially and annually in a binder. **5. The date of completion is June 3, 2021.**	
E 0037 SS=F Bldg. --	403.748(d)(1), 416.54(d)(1), 418.113(d)(1), 441.184(d)(1), 482.15(d)(1), 483.475(d)(1), 483.73(d)(1), 484.102(d)(1), 485.625(d)(1), 485.68(d)(1), 485.727(d)(1), 485.920(d)(1), 486.360(d)(1), 491.12(d)(1) EP Training Program §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of			

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	emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency			

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	preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually.			

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	(iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services			

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	under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years.			
	Based on record review and interview, the facility failed to ensure the emergency preparedness training and testing program includes a training program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles; (ii) Provide emergency preparedness training at least annually; (iii) Maintain documentation of the training; (iv) Demonstrate staff knowledge of emergency procedures in accordance with 42 CFR 483.73(d)(1). This deficient practice could affect all residents in the facility.	E 0037	**1. Initial training in emergency preparedness policies and procedures was given to all new and existing staff, consistent with their expected roles along with a posttest to ensure staff knowledge of procedures and kept in a binder.** **2. All residents and staff members and visitors had the potential to be affected.** **3. The maintenance director/designee will give emergency preparedness training and a**	06/03/2021

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	Findings include: Based on review of the Emergency Preparedness Disaster Manual dated 03/12/21 with the Executive Director (ED) on 05/04/21 at 10:40 a.m., there was no documentation to indicate facility staff were trained on the Emergency Preparedness Disaster Manual over the past year. Based on an interview with the ED, it was stated the facility has not trained the staff and documented the training on the Emergency Preparedness Disaster Manual and the facility does not have a testing program. This was confirmed and reviewed with the ED during the exit conference.		**post test to all future new hires during orientation to ensure this does not recur.** **4. The maintenance director/designee will report to QAPI on a monthly basis and keep record of all training for new/existing employees to ensure training is completed initially and annually in a binder.** **5. The date of completion is June 3, 2021.**	
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: 05/04/21 Facility Number: 00099 Provider Number: 155188 AIM Number: 100291140 At this Life Safety Code survey, Greenfield Healthcare Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.	K 0000	Greenfield Healthcare Center requests desk review and will attach documents and photos of all corrections made from survey. Thanks, Andrew	

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	This one story facility with a second story equipment area was determined to be of Type V (000) construction and fully sprinkled. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 163 and had a census of 103 at the time of this visit. All areas where residents have customary access were sprinkled and all areas providing facility services were sprinkled except for four outside sheds which were used for storage.. Quality Review completed on 05/07/21			
K 0291 SS=E Bldg. 01	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 Based on observation and interview, the facility failed to ensure 1 of 4 battery powered emergency lights were maintained in accordance with LSC 7.9. LSC 7.9.2.6 states battery operated emergency lights shall use only reliable types of rechargeable batteries provided with suitable facilities for maintaining them in properly charged condition. Batteries used in such lights or units shall be approved for their intended use and shall comply with NFPA 70 National Electric Code. LSC 7.9.2.7 states the emergency lighting system shall be either be continuously in operation or shall be capable of repeated automatic operation without manual intervention. This finding could only affect staff in Laundry.	K 0291	**1. The battery operated emergency light in the Laundry room has been replaced with a new light.** **2. This deficient practice could only affect staff in laundry.** **3. The maintenance director or designee will perform weekly rounds to ensure battery operated lights in the facility are in good working condition and to ensure compliance with LSC 7.9.2.6.** **4. The maintenance director or designee will perform weekly rounds. The Maintenance**	06/03/2021

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	Findings include: Based on observation on 05/04/21 at 1:09 p.m. with the Executive Director (ED), a Battery Operated Emergency Light located in Laundry on Service hall failed to function when tested. Based on an interview at the time of observation the ED indicated that Maintenance tests these monthly, and this one must have just stopped working. This was discussed with the ED during the exit conference. 3.1-19(b)		**Director will report to the QAPI Committee on a monthly basis for six months period of time the results.** **5. The date of completion was June 3, 2021.**	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms			

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	b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			
	Based on observation and interview, the facility failed to ensure 1 of 10 hazardous areas observed such as Storage rooms over 50 square feet, would latch in their frame and be provided with a self-closing device. This deficient practice could affect staff on first floor. Findings include: Based on observation on 05/04/21 at 11:35 a.m. with the Executive Director (ED), there were over 35 cardboard boxes stored in the Accounts Payable office adjacent to the Front entrance and there was no self closing device on the corridor door. Based on interview at the time of observation with the ED it was acknowledged the corridor door to the Accounts Payable office was not provided with a self closing device. It was further acknowledged the area was over 50 square feet. This was discussed with the ED during the exit conference. 3.1-19(b)	K 0321	**1. The accounts payable office was cleaned out and records were picked up by Iron Mountain. Maintenance Director also installed self-closing device on door.** **2. This deficient practice could affect staff on first floor.** **3. The maintenance director or designee will perform weekly rounds to ensure boxes are not stored in an area where the storage room is greater than 50 square feet and do not have a self-closing door.** **4. The maintenance director or designee will perform weekly rounds. The Maintenance Director will report to the QAPI Committee on a monthly basis for six months period of time the results.** **5. The date of completion was June 3, 2021.**	06/03/2021
K 0341 SS=F Bldg. 01	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			

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	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 Control Panel (FACP) was protected from unauthorized use. NFPA 72, National Fire Alarm and Signaling Code Section 10.10.1 states a means for turning off activated alarm notification appliance(s) shall be permitted only if it complies with 10.10.3 through 10.10.7. Section 10.10.3 states the means shall be key-operated or located within a locked cabinet, or arranged to provide equivalent protection against unauthorized use. This deficient practice could affect all occupants. Findings include: Based on observation on 05/04/21 during the tour between at 2:07 p.m. with the Executive Director (ED), the door to the Fire Alarm Control Panel (FACP) located next to the Front reception desk was locked with the key provided in the door lock. The key was removed at the time of observation. Based on interview at the time of observation, the ED was unaware the FACP door needed to remain locked with the key secured in another location protected from unauthorized use. This was discussed with the ED during the exit conference.	K 0341	**1. The ED was inserviced by the Divisional Facilities Manager. The key to the Fire Alarm Control Panel was removed and locked in a cabinet. 2. This deficient practice could affect all occupants. 3. The maintenance director or designee will perform weekly rounds to key remains in cabinet and secured. 4. The maintenance director or designee will perform weekly rounds. The Maintenance Director will report to the QAPI Committee on a monthly basis for six months period of time the results. 5. The date of completion was June 3, 2021.**	06/03/2021

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	3.1-19(b)			
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25			
	Based on observation and interview, the facility failed to maintain the ceiling construction in 2 of 2 areas observed 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 24 residents. Findings include: Based on observations on 05/04/21 during the tour between 12:05 p.m. to 2:30 p.m. with the Executive Director (ED), two sprinkler heads	K 0353	**1. The maintenance director performed a house wide sweep with no further concerns noted. SafeCare provided facility with missing escutcheons and maintenance director installed on 2 sprinkler heads.** **2. This deficient practice could affect staff and up to 24 residents.** **3. The maintenance director/designee will perform weekly rounds to ensure facility is in compliance with NFPA 13, 2010 edition, Section 6.2.7.1.** **4. The maintenance director or**	06/03/2021

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	located in resident room 34 were missing escutcheons and two sprinkler heads in the Sprinkler riser room were missing an escutcheon. Based on interview at the time of observations, the ED confirmed the escutcheons were missing. This finding was reviewed with the ED during the exit conference. 3.1-19(b)		**designee will perform weekly rounds. The Maintenance Director will report to the QAPI Committee on a monthly basis for six months period of time the results.** **5. The date of completion was June 3, 2021.**	
K 0354 SS=C Bldg. 01	NFPA 101 Sprinkler System - Out of Service Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined, recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) Based on record review and interview, the facility failed to provide a written policy containing procedures to be followed for the protection of 103 of 103 residents in the event the automatic sprinkler system has to be placed out-of-service for 10 hours or more in a 24-hour period in accordance with LSC, Section 9.7.5. LSC 9.7.5 requires sprinkler impairment procedures comply with NFPA 25, 2011 Edition, the Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 15.5.2 requires nine	K 0354	**1. Facilities Fire Watch Policy and Procedure has been updated to include "Once the sprinkler system has returned to normal service, ALL entities listed above will be contacted."** **2. This deficient practice could affect all occupants in the facility.** **3. The maintenance director/designee will update each binder in the facility and**	06/03/2021

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	procedures that the impairment coordinator shall follow. This deficient practice could affect all occupants in the facility. Findings include: Based on record review on 05/04/21 at 10:59 a.m. with the Executive Director (ED), the facility provided Fire Watch Policy and Procedure documentation but it was incomplete. The Fire Watch Policy and Procedure plan failed to include contacting all entities back once the Sprinkler system has returned to north service. This was confirmed by the ED and reviewed with the ED at the exit conference. 3.1-19(b)		**inform staff of policy change to ensure compliance with NFPA 25, 15.5.2.** **4. The maintenance director or designee will perform monthly rounds after updating binder and inservicing staff. The Maintenance Director will report to the QAPI Committee on a monthly basis for six months period of time the results.** **5. The date of completion was June 3, 2021.**	
K 0355 SS=D Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 1. Based on observation and interview, the facility failed to ensure 12 of 12 portable fire extinguishers were properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could possible affect 10 staff. Findings include: Based on observations on 05/04/21 during the tour between at 1:16 p.m. to 1:38 p.m. with the	K 0355	**1. SafeCare was contacted and picked up the 12 freestanding fire extinguishers in the maintenance office. The fire extinguisher in the Brookshire electrical room was removed and also the used fire extinguisher was removed and replaced to indicate a full reading.** **2. This deficient practice could only affect staff.** **3. The maintenance director/designee will perform**	06/03/2021

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	Executive Director (ED) there were 12 small ABC fire extinguishers freestanding on the floor in Maintenance room on Service hall. They were full and simply stored there, not awaiting servicing, there was one ABC fire extinguisher freestanding on the floor in the Brookshire electrical room. Based on interview concurrent with the observations it was confirmed by the ED the ABC portable fire extinguishers were full and not secured properly to prevent the cylinders from falling. This was discussed with the ED during the exit conference. 3.1-19(b) 2. Based on observation and interview the facility failed to ensure 1 of 1 fire extinguishers was maintained with the gauge indicator reading in the operable zone. NFPA 10, 2010 Edition states at 7.2 2 (3) pressure gauge reading or indicator in the operable range or position. This deficient practice could affect only staff. Findings include: Based on observation on 05/04/21 at 12:25 p.m. with the Divisional Facilities Manager (DFM), on the second floor above the Boiler room just inside the equipment utility room was an ABC portable fire extinguisher with the red indicator needle showing discharged. Based on interview at the time of observation, the (DFM) acknowledged the fire extinguisher was discharged and would have to be replaced. This was discussed with the Executive Director and the DFM during the exit conference. 3.1-19(b)		**weekly rounds to ensure facility is in compliance with NFPA 99, 2012 edition, Section 11.6.2.3(11) and also with NFPA 10, 2010 Edition states at 7.2 2 (3).** **4. The maintenance director or designee will perform weekly rounds. The Maintenance Director will report to the QAPI Committee on a monthly basis for six months period of time the results.** **5. The date of completion was June 3, 2021.**	

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K 0372 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.			
	Based on observation and interview, the facility failed to ensure 1 of 10 smoke barriers observed had a minimum of a 1/2 hour fire resistive rating and the penetrations caused by the passage of wire and/or conduit the smoke barrier walls were protected to maintain the smoke resistance of each smoke barrier. LSC Section 19.3.7.5 requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating. This deficient practice could affect 12 residents, visitors and staff. Findings include: Based on observation on 05/04/21 at 2:16 p.m. with the Executive Director (ED), the TCU smoke barrier wall had large opening around two, four inch diameter pipes to the right side of the wall which were left unsealed. Based on interview after physical observation by the ED it was confirmed the smokewall described on TCU had an unsealed openings which were not	K 0372	**1. The TCU smoke barrier wall that had large openings around two, four inch diameter pipes were sealed with fire caulk and fire putty to allow a ½ hour fire resistance rating.** **2. This deficient practice could affect 12 residents, visitors and staff.** **3. The maintenance director/designee will perform weekly rounds to ensure facility is in compliance with LSC Section 19.3.7.5 which requires smoke barriers to be constructed in accordance with LSC Section 8.5 and shall have a minimum ½ hour fire resistive rating.** **4. The Maintenance Director/designee will check the springs on a month basis that is part of our preventive**	06/03/2021

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	firestopped to maintain a 1/2 hour fire resistive rating. This finding was reviewed with the ED at the exit conference 3.1-19(b)		**maintenance plan. The maintenance will report to the QAPI committee on a monthly basis for six months.** **5. The completion date is June 3, 2021**	
K 0511 SS=E Bldg. 01	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 1. Based on observation and interview, the facility failed to ensure 1 of 10 areas observed, like above ceiling tiles at smokewall's, protected electrical wiring according to NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect only staff. Findings include: Based on observation on 05/04/21 at 2:15 p.m. with the Executive Director (ED), there were exposed electrical wires above the ceiling tiles at the TCU smokewall and were not within an electrical junction box with a cover. Based on interview at the time of observation, the ED acknowledged the aforementioned condition and confirmed that exposed wiring was visible. This finding was reviewed with the ED at the exit conference. 3.1-19(b)	K 0511	**1. The maintenance director installed an electrical junction box with a cover on the TCU smoke wall to ensure compliance NFPA 70, 2011 Edition. Article 406.5. The ED replaced the receptacle faceplate cover in the front lobby.** **2. This deficient practice could affect all residents, visitors and staff in the Front lobby.** **3. The maintenance director/designee will perform weekly rounds to ensure facility is in compliance with NFPA 70, 2011 Edition. Article 406.5.** **4. The Maintenance Director/designee will report on a monthly basis their findings as part of our preventive maintenance plan. The maintenance will report to the**	06/03/2021

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	2. Based on observation and interview, the facility failed to ensure 1 of 1 electrical receptacles were protected accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect all residents, visitors and staff in the Front lobby. Findings include: Based on observation on 05/04/21 at 10:15 a.m. with the Executive Director (ED), one electrical outlet adjacent to the Front entrance doors was cracked and open at the bottom of the cover plate. Based on interview at the time of observation, the ED acknowledged the damaged receptacle cover plate and this was discussed with the ED during the exit conference.		**QAPI committee on a monthly basis for six months.** **5. The completion date is June 3, 2021**	
K 0741 SS=E Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances,			

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	secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 1. Based on record review and interview, the facility failed to include in 1 of 1 smoking policies the designated location where smoking by residents and staff was permitted. This deficient practice could affect any resident and staff. Findings include: Based on record review on 05/04/21 at 10:11 p.m. with the Executive Director (ED), the smoking policy presented for review did not indicate where smoking by residents and staff was permitted. Based on interview concurrent with the record review the ED stated this current smoking policy only stated that smoking was allowed at designated areas, but did not specify where. This was discussed with the ED during the exit conference. 3.1-19(b) 2. Based on record review, observation and interview, the facility failed to ensure a non-combustible container into which cigarette	K 0741	**1. All cigarette butts were picked up where they were discarded on the ground outside the smoking court by the TCU area, outside the memory care area, and also outside by the diesel generator/ natural gas supply pipes. Containers of noncombustible material and safe design for the deposit of cigarette butts were added to the location where smoking is permitted.** **2. This deficient practice could affect any number of residents and staff who use the outside smoking locations.** **3. The maintenance director or designee will perform daily rounds as part of preventive maintenance to ensure staff is following smoking procedure. All staff to be in serviced on designated smoking areas.** **4. The maintenance director or**	06/03/2021

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	butts can be disposed of in 3 of 4 outdoor areas where evidence of smoking occurred. This deficient practice could affect any number of residents and staff who use the outside smoking locations. Findings include: Based on review of the facility's written smoking policy on 05/04/21 at 10:11 a.m. with the Executive Director (ED), resident and staff smoking is permitted on the premises at the designated locations. Based on observation with the ED on 05/04/21 during a tour of outside areas from 12:10 p.m. to 2:00 p.m., the following areas observed either did not have a non-combustible container or the cigarette butts were thrown on the ground. a. Outside smoking court by the TCU was provided with a large metal box with a self closing lid, but over 100 cigarette butts (TMC), too many to count, were thrown on the gravel ground. b. Outside Memory care there were numerous cigarette butts deposited in a plastic trash can with paper goods. c. Outside by the diesel generator there were cigarette butts thrown on the ground throughout the area and many were observed by the natural gas supply pipes. Based on interview during each incident observed the ED explained this has been a constant battle. This was discussed with the ED during the exit conference. 3.1-19(b)		**designee will perform daily rounds as part of the preventive maintenance program and will report to the QAPI committee on a monthly basis. The maintenance director will report the results for 6 months.** **5. The date of completion was June 3, 2021.**	
K 0753 SS=D Bldg. 01	NFPA 101 Combustible Decorations Combustible Decorations			

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	Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6			
	Based on observation and interview, the facility failed to ensure 1 of 1 areas observed was maintained in accordance with 19.7.5.6. LSC 19.7.5.6 prohibits combustible decorations unless an exception was met. This deficient practice could affect 1 staff and visitors. Findings include: Based on observation on 05/04/21 at 12:10 p.m. with the Executive Director (ED), in the Social service office on TCU there was a candle on display with a wick intact. Based on interview with the ED it was acknowledged a candle with wick was observed in the Social service office and explained to the Social service director that candles would be allowed as long as the wick was not exposed. This was discussed with the ED during the exit conference. 3.1-19(b)	K 0753	**1. The combustible decoration was removed from the Social Service office on TCU.** **2. This deficient practice could affect 1 staff and visitors.** **3. The maintenance director or designee will perform weekly rounds to ensure there are no combustible decorations in the building.** **4. The maintenance director or designee will perform weekly rounds. The Maintenance Director will report to the QAPI Committee on a monthly basis for six months period of time the results.** **5. The date of completion was June 3, 2021.**	06/03/2021

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K 0911 SS=E Bldg. 01	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 enclosures housing electrical apparatus in 1 of 2 electrical rooms. 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 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). Distances shall be measured from the live parts if such parts are exposed or from the enclosure front or opening if such are enclosed. Article 110.26(B) states the working space required by this section shall not be used for storage. This deficient practice could affect at least two staff. Findings include: Based on observation on 05/04/21 at 12:18 p.m. with the Divisional Facilities Manager (DFM), the Electric room located in the Boiler on Service hall had two large utility carts stored next to the high voltage electrical panels. Based on interview at the time of the observation, the DFM acknowledged the stored item were present	K 0911	**1. The maintenance director removed the two large utility carts next to the high voltage electric panels.** **2. This deficient practice could possibly affect at least two staff.** **3. The maintenance director/designee will perform weekly rounds as part of the preventive maintenance program to ensure compliance is made.** **4. The maintenance director/designee will perform weekly rounds as part of the preventive maintenance program. The maintenance director will report to the QAPI committee on a monthly basis regarding the results. The maintenance director will report the results for six months.** **5. The date of completion was June 3, 2021.**	06/03/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155188	A. BUILDING 01 B. WING	05/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD HEALTHCARE CENTER	200 GREEN MEADOWS DR GREENFIELD, IN 46140

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and acknowledged he knew they should not be there. This was discussed with the DFM and the Executive Director during the exit conference. 3.1-19(b)			
K 0916 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Alarm Annunciator A remote annunciator that is storage battery powered is provided to operate outside of the generating room in a location readily observed by operating personnel. The annunciator is hard-wired to indicate alarm conditions of the emergency power source. A centralized computer system (e.g., building information system) is not to be substituted for the alarm annunciator. 6.4.1.1.17, 6.4.1.1.17.5 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 emergency generator was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station. NFPA 99, 2012 Edition, Health Care Facilities Code, at 6.4.1.1.17 requires a remote annunciator that is storage battery powered shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall be hard-wired to indicate alarm conditions of the emergency or auxiliary power source as follows: (1) Individual visual signals shall indicate: a. When the emergency or auxiliary power source is operating to supply power to load. b. When the battery charger is malfunctioning. (2) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate:	K 0916	**1. A quote has been prepared and SafeCare is scheduled to come out to the facility and install an additional annunciator panel on our South East nurses station (Brookshire) unit on May 27th.** **2. This deficient practice could affect all residents, as well as visitors and staff in the facility.** **3. An additional annunciator panel was added to ensure this deficient practice does not recur.** **4. The maintenance director/designee will perform weekly rounds as part of the preventive maintenance program. The maintenance director will report to the QAPI**	06/03/2021

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	a. Low lubricating oil pressure. b. Low water temperature. c. Excessive water temperature. d. Low fuel when the main fuel storage tank contains less than a 4-hour operating supply. e. Overcrank (failed to start). f. Overspeed. 6.4.1.1.17.1 A remote, common audible alarm shall be provided as specified in 6.4.1.1.17.4 that is powered by the storage battery and located outside of the EPS service room at a work site observable by personnel. 6.4.1.1.17.4 Individual alarm indication to annunciate any of the conditions listed in Table 6.4.1.1.16.2 shall have the following characteristics: (1) It shall be battery powered. (2) It shall be visually indicated. (3) It shall have additional contacts or circuits for a common audible alarm that signals locally and remotely when any of the itemized conditions occurs (4) It shall have a lamp test switch(es) to test the operation of all alarm lamps. This deficient practice could affect all residents, as well as visitors and staff in the facility. Findings include: Based on observation on 05/04/21 at 12:03 p.m., with the Executive Director (ED) the annunciator panel for the generator was located in the TCU which has been vacated and the annunciator panel cannot be observed by staff. Based on interview at the time of observation it was stated by the ED the annunciator panel for the generator could not be observed where it was located and was pondering how to remedy the situation. This was		**committee on a monthly basis regarding the results. The maintenance director will report the results for six months.** **5. The date of completion was June 3, 2021.**	

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	discussed with the ED during the exit conference. 3.1-19(b)			
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5			
	Based on observation and interview, the facility failed to ensure proper use of extension cords and power strips in 4 of 4 area's observed. This deficient practice could affect 5 to 10 staff. Findings include:	K 0920	**1. The mini refrigerator in the director of therapy's office and in the housekeeping supervisor office was unplugged from power strip and plugged into outlet on wall. A power strip**	06/03/2021

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	Based on observations on 05/04/21 during the tour between 12:32 p.m. to 1:10 p.m. with the Executive Director (ED), the following area's misused extension cords and power strips. a. A mini refrigerator was connected to a power strip in the Director of Therapy's office. b. A power strip was connected to a power strip in the Program Director's office. c. A mini refrigerator was connected to a power strip in the Housekeeping Supply office in Laundry. d. On the second floor utility space above the Boiler room was a Kobalt air compressor connected to an extension cord. Based on interview concurrent with the observations with the ED, the misuse of the extension cord and power strips described was confirmed. This finding was reviewed with the ED at the exit conference. 3.1-19(b)		**was removed from the Program Director's office. An outlet was added by Underwood Construction on the second floor utility space for the air compressor and the extension cord was removed to ensure compliance. 2. This deficient practice could possibly affect 5-10 staff. 3. A house wide sweep was made with no other findings. The maintenance director/designee will perform weekly rounds as part of the preventive maintenance program to ensure compliance is made. 4. The maintenance director/designee will perform weekly rounds as part of the preventive maintenance program. The maintenance director will report to the QAPI committee on a monthly basis regarding the results. The maintenance director will report the results for six months. 5. The date of completion was June 3, 2021.**	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.			

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	>300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 2 of 2 cylinders of nonflammable gases such as Nitrogen was properly secured from falling. NFPA 99, Health Care Facilities Code, 2012 Edition, Section	K 0923	**1. The 2 nitrogen bottles were secured in a flammable storage cabinet.** **2. This deficient practice could possibly affect over 10 staff and**	06/03/2021

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	11.3.2 states storage for nonflammable gases greater than 8.5 cubic meters (300 cubic feet) but less than 85 cubic meters (3000 cubic feet) shall comply with 11.3.2.1 through 11.3.2.3. NFPA 99, Section 11.3.2.6 states cylinder or container restraints shall comply with 11.6.2.3. Section 11.6.2.3(11) states freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart. This deficient practice could possible affect 10 staff and visitors on Service hall. Findings include: Based on observation on 05/04/21 at 1:16 p.m. with the Executive Director (ED) there were two Nitrogen cylinders freestanding on the floor in the Maintenance room on Service hall. Based on interview concurrent with the observation it was confirmed by the ED the Nitrogen tanks were full and was not secured properly to prevent the cylinders from falling. 3.1-19(b)		**visitors on the service hall.** **3. A house wide sweep was made with no other findings. The maintenance director/designee will perform weekly rounds as part of the preventive maintenance program to ensure compliance is made with NFPA 99, Sections 11.3.2.** **4. The maintenance director/designee will perform weekly rounds as part of the preventive maintenance program. The maintenance director will report to the QAPI committee on a monthly basis regarding the results. The maintenance director will report the results for six months.** **5. The date of completion was June 3, 2021.**	
K 0927 SS=E Bldg. 01	NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99).			

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	11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 3 oxygen transfilling rooms with concrete or ceramic flooring maintained a one hour fire rating. NFPA 99 2012 edition, 11.5.2.3.1 (2) requires oxygen transfilling rooms to be mechanically ventilated, is sprinklered, and have ceramic or concrete flooring. This deficient practice could affect 20 residents, visitors and staff on Rosewood. Findings include: Based on observation on 05/04/21 at 12:44 p.m. with the Executive Director (ED), the oxygen transfilling room on Rosewood had carpet extend 2 1/2 inches into the oxygen room from the corridor. Based on interview concurrent with the observation it was verified by the ED at the time of observation. This finding was reviewed with the ED at the exit conference 3.1-19(b)	K 0927	**1. The maintenance director cut back the carpet and a transition piece was added in the oxygen transfilling room on Rosewood. 2. This deficient practice could affect 20 residents, visitors, and staff on Rosewood. 3. All other oxygen rooms in the facility were checked with no findings. The maintenance director/designee will perform weekly rounds as part of the preventive maintenance program to ensure compliance is made with NFPA 99 2012 edition, 11.5.2.3.1 (2). 4. The maintenance director/designee will perform weekly rounds as part of the preventive maintenance program. The maintenance director will report to the QAPI committee on a monthly basis regarding the results. The maintenance director will report the results for six months. 5. The date of completion was June 3, 2021.**	06/03/2021