STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155759	A. BUILDING -- B. WING	07/05/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
GLEN OAKS HEALTH CAMPUS	601 W CR 200 S NEW CASTLE, IN 47362

(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: 07/05/23 Facility Number: 011187 Provider Number: 155759 AIM Number: 200838150 At this Emergency Preparedness survey, Glen Oaks Health Campus was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 68 certified beds. At the time of the survey, the census was 58. Quality Review completed on 07/07/23	E 0000		
E 0041 SS=F Bldg. --	482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tammy Nelson	Executive Director	07/21/2023

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

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	forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below.			

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	You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and			

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	Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. Based on record review and interview, the facility failed to implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect all occupants. Findings include: Based on observations and interview during a facility tour with the Plant Operations Director, Plant Operations Director from another facility and Facilities Support Representative on 07/05/23 between 12:10 p.m. and 2:15 p.m., the generator's annunciator panel had the "Low Power" (yellow) light illuminated. The Plant Operations Director stated the light on the generator annunciator panel was illuminated because the micro switch needed to be replaced and the part is on order. The Plant Operations Director stated the generator operates without it, but does not automatically transfer, requiring manual transfer. He stated that he has trained several people on how to accomplish this maneuver. The generator does start and run when tested. The facility does not have any residents relying on life support equipment. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Plant Operations Director, Plant Operations Director from another facility and Facilities Support Representative present.	E 0041	Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of noncompliance cited during the survey visit with exit on July 5th, 2023. **E 041** **Hospital CAH and LTC Emergency Power** **Immediate intervention** The bad microprocessor was replaced by an outside contractor and function was verified. This deficient practice could affect all occupants. **Exhibit A – Documentation** **Compliance date** **7 -21-23** The director of plant operations	07/21/2023

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			and the executive director were educated by Regional Facilities Support on processes and procedures listed for emergency operations as they pertain to CFR 483.73 **Exhibit B – Inservice** The director of plant operations will ensure proper function of the emergency generator and its subsequent systems weekly as our policy provides. **Exhibit C – Audit tool** Executive Director will present results of inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
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: 07/05/23 Facility Number: 011187 Provider Number: 155759 AIM Number: 200838150	K 0000		

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	At this Life Safety Code survey, Glen Oaks Health Campus 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. This one-story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, hard wired smoke detectors in all resident rooms in the building. The facility has a capacity of 68 and had a census of 58 at the time of this visit. All areas where residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 07/07/23			
K 0100 SS=E Bldg. 01	NFPA 101 General Requirements - Other General Requirements - Other List in the REMARKS section any LSC Section 18.1 and 19.1 General 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. Based on observation and interview, the facility failed to ensure 1 of 1 attic gas fired furnace had safe exhaust. LSC 19.1.1.3.1 states all health care facilities shall be designed, constructed, maintained and operated to minimize the possibility of a fire emergency requiring the	K 0100	**K 100** **General Requirements** **Immediate intervention**	07/21/2023

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	evacuation of occupants and to maximize the confinement of the effects of fire. This deficient practice could affect 15 staff and residents. Findings include: Based on observations and interview during a facility tour with the Plant Operations Director, Plant Operations Director from another facility and Facilities Support Representative on 07/05/23 between 12:10 p.m. and 2:15 p.m., the attic gas furnace near the Therapy Area had an exhaust vent which was rotted out at the elbow and would not confine the furnace exhaust allowing it to flow into the attic. The Plant Operations Director agreed the elbow in the vent was rotted out. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Plant Operations Director, Plant Operations Director from another facility and Facilities Support Representative present. 3.1-19(b)		The attic gas fired furnace exhaust vent that was damaged was replaced to meet the requirement of K100 this deficient practice could affect 15 staff and residents. **Exhibit D – photo** **Compliance Date** **7/21/23** The Director of plant operations was educated by the regional facilities Support as to the requirements for all healthcare facilities shall be designed, constructed, maintained and operated to minimize the possibility of fire as stated in LSC 19.1.1.3.1 **Exhibit B – Inservice** Visual inspections of the furnace exhaust shall happen monthly x3 then quarterly thereafter. **Exhibit E – Audit tool** Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved	

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K 0211 SS=E Bldg. 01	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. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of over 6 exit discharges were continuously maintained free of obstructions. LSC 7.3.4.1 states the width of any means of egress, unless otherwise provided in 7.3.4.1.1 through 7.3.4.1.3, shall be as follows: (1) Not less than that required for a given egress component in this chapter or Chapters 11 through 43 (2) Not less than 36 in. (915 mm) where another part of this chapter and Chapters 11 through 43 do not specify a minimum width. This deficient practice affects 18 residents in the facility. Findings include: Based on observations and interview during a facility tour with the Plant Operations Director, Plant Operations Director from another facility and Facilities Support Representative on 07/05/23 between 12:10 p.m. and 2:15 p.m., the exit discharge sidewalk on the 300 Hall was obstructed with a large transformer and generator located in the path of exit discharge which restricted the width of the exit discharge before arriving at a level ramp to the public way. The Facilities Support Representative agreed that the exit discharge extended past the transformer and generator before arriving a level ramp to the public	K 0211	**K 211 – Means of Egress** **Immediate intervention** Contacted a contractor to quote and install a curb for building exit discharge to continuously maintain pathway is free of obstructions. As this could possibly affect 18 residents in the facility to meet the deficiency K211 **Completion Date** **8/16/23** The Director of Plant Operations was educated by the Regional Facilities Support on means of Egress, Aisles, passageways, corridors, exit discharges, exit locations and accesses in accordance with Chapter 7 of the LSC 7.3.4.1, 7.3.4.1.1, 7.3.4.1.3. **Exhibit B – Inservice**	08/16/2023

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	way. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Plant Operations Director, Plant Operations Director from another facility and Facilities Support Representative present. 3.1-19(b)		The director of plant Operations with Conduct a monthly Visual inspection of all exit discharges. **Exhibit F – Audit tool** Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved	
K 0363 SS=E Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have 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			

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	release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.			
	Based on observation and interview, the facility failed to ensure 1 of over 30 corridor doors had no impediment to closing and latching into the door frame and would resist the passage of smoke. This deficient practice could affect 4 staff and residents. Findings include: Based on observations and interview during a facility tour with the Plant Operations Director, Plant Operations Director from another facility and Facilities Support Representative on 07/05/23 between 12:10 p.m. and 2:15 p.m., the corridor door to the Spa on the 200 Hall failed to self-close close and latch positively into the door frame. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Plant Operations Director, Plant Operations Director from another facility and Facilities Support	K 0363	**K363 – Corridor – Doors** **Immediate intervention** Adjusted the closer attached to the door that would have prevented keeping closed, had no impediment to closing, latching and would resist the passage of smoke that could affect 4 staff and residents to meet K363 deficiency. **Compliance date** **7/21/23**	07/21/2023

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	Representative present. 3.1-19(b)		The Director of Plant Operations was educated by Regional Support on K363 corridor – doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas to resist the passage of smoke as it pertains NFPA 101 in compliance with 7.2.1.9, 19.3.6.3.6, 8.3, 19.3.6.3, 42 CFR parts 403,418,460,482,483 and 485. **Exhibit B – Inservice** The Director of Plant Operations or assigned party will visually inspect the corridor doors weekly. **Exhibit G _ Audit tool** Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
K 0374 SS=E Bldg. 01	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height			

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	are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9			
	Based on observation and interview, the facility failed to ensure 1 of 5 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC 19.3.7.8 requires doors in smoke barriers shall comply with LSC Section 8.5.4. LSC 8.5.4.1 requires doors in smoke barrier shall close the opening leaving only the minimum clearance necessary for proper operation. This deficient practice could affect 30 residents and staff. Findings include: Based on observations and interview during a facility tour with the Plant Operations Director, Plant Operations Director from another facility and Facilities Support Representative on 07/05/23 between 12:10 p.m. and 2:15 p.m., the set of smoke/fire barrier doors near the kitchen, in the facilities fire wall, did not close completely and latch. Based on interview during the time of observations, the Plant Operations Director acknowledged these barrier doors did not close completely and latch. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Plant Operations Director, Plant Operations Director from another facility and Facilities Support Representative present. 3.1-19(b)	K 0374	**K374 – Subdivision of building Spaces – Smoke barriers** **Immediate intervention** Adjusted the speed of the closure for the opening providing the necessary latching for proper operation that could affect 30 residents in two compartments to meet deficiency K374. **Compliance date** **7/21/23** The Director of Plant Operations was educated by Regional Support on K374 smoke barrier doors would restrict the movement of smoke for at least 20 minutes as it pertains to NFPA 101 2012 19.3.7.6, 19.3.7.8, 19.3.7.9 in Compliance with LSC Section 8.5.4, LSC 8.5.4.1	07/21/2023

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			Exhibit B – Inservice The Director of plant Operations or assigned party will visually inspect the corridor doors weekly. **Exhibit H – Audit tool** Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved	
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 micro switch was in proper operating condition. This deficient practice could affect all the residents, as well as staff and visitors in the facility.	K 0916	**K 916 Electrical systems – Essential Electric Systems**	07/21/2023

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	155759	A. BUILDING 01 B. WING	07/05/2023

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GLEN OAKS HEALTH CAMPUS	601 W CR 200 S NEW CASTLE, IN 47362

(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
	Findings include: Based on observations and interview during a facility tour with the Plant Operations Director, Plant Operations Director from another facility and Facilities Support Representative on 07/05/23 between 12:10 p.m. and 2:15 p.m., the generator's annunciator panel had the "Low Power" (yellow) light illuminated. The Plant Operations Director stated the light on the generator annunciator panel was illuminated because the micro switch needed to be replaced and the part is on order. The Plant Operations Director stated the generator operates without it, but does not automatically transfer, requiring manual transfer. He stated that he has trained several people on how to accomplish this maneuver. The generator does start and run when tested. The facility does not have any residents relying on life support equipment. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Plant Operations Director, Plant Operations Director from another facility and Facilities Support Representative present. 3.1-19(b)		**Immediate intervention** The bad microprocessor was replaced by an outside contractor and function was verified. This deficient practice could affect all occupants. **Exhibit A - Documentation** **Compliance date** **7 -21-23** The director of plant operations and the executive director were educated by Regional Facilities Support on essential electrical systems as it pertains to NFPA 101 6.4.1.1.17, 6.4.1.1.17.5 (NFPA99) **Exhibit B – Inservice** The director of plant operations will visually inspect the function of the emergency generator and its subsequent systems weekly. **Exhibit I – Audit Tool** Executive Director will present results of inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	

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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 2 of 2 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. Section 10.2.4.2.3 states the cabling shall comply with 10.2.3. Section 10.2.3.5.1 states cord strain relief shall be provided at the attachment of the power cord to the appliance so that mechanical stress, either pull, twist, or bend, is not transmitted to internal connections. This deficient practice could	K 0920	**K920 Electrical equipment – Power cords and extension cords** **Immediate Intervention** Removed the additional power strip and plugged both device directly into the wall. Thus, removing the substitute for fixed	07/21/2023

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	affect 2 residents and 1staff. Findings include: Based on observations and interview during a facility tour with the Plant Operations Director, Plant Operations Director from another facility and Facilities Support Representative on 07/05/23 between 12:10 p.m. and 2:15 p.m., in Resident Room #205 a (1) power strip was being used to power equipment and was daisy chained into a second power strip. And (2) one of the aforementioned power strips was powering a combination of medical and non-medical devices. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Plant Operations Director, Plant Operations Director from another facility and Facilities Support Representative present. 3.1-19(b)		wiring that could affect up to 3 residents and two staff members in the salon. **Compliance Date** **7/21/23** Director of plant operations was educated by Regional Support on K920 NFPA101 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 UL60601-1. 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. As it pertains to 10.2.4, 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70 - 2011), 590.3 (D) (NFPA70), TIA 12-5. **Exhibit B– Inservice** The Director of Plant Operations and Executive Director will verify non approved devices are not in use once per week X 3 months	

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			followed by once per month X 3. **Exhibit J – Audit tool** Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	
K 0927 SS=F 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). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage/transfer rooms was provided with a sign indicating that transferring is occurring. NFPA 99 11.5.2.3.1(3) states, the area is posted with signs indicating that trans-filling is occurring and that smoking in the immediate area is not permitted. This deficient practice could affect all residents. Findings include:	K 0927	**K 927 Gas Equipment – Transfilling Cylinders** **Immediate Intervention** Signage that was missing indicating transfilling is currently occurring and area in use or open was ordered and will be installed	08/16/2023

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	Based on observations and interview during a facility tour with the Plant Operations Director, Plant Operations Director from another facility and Facilities Support Representative on 07/05/23 between 12:10 p.m. and 2:15 p.m., the oxygen storage/transfer room did not have a posted sign making a clear distinction between when transferring of oxygen is occurring in this location and when it is not. Based on interview at the time of observation, the Plant Operations Director stated there was not a sign stating when trans-filling oxygen is occurring and when it is not. This finding was acknowledged by the Maintenance Director at the time of discovery and again at the exit conference with the Plant Operations Director, Plant Operations Director from another facility and Facilities Support Representative present. 3.1-19(b)		once it arrives to the campus to prevent the practice that could affect all residents in one smoke compartment to meet deficiency K 927. **Compliance Date** **8/16/23** The Director of Plant Operations was educated by Regional Support on K 927 Gas Equipment – Transfilling Cylinders in accordance with CGA P2.5, Transfilling to liquid oxygen containers or to portable containers over 50 PSI in compliance under 11.5.2.3.1 (NFPA 99), 11.5.2.3.2 (NFPA 99), 11.5.2.2 (NFPA 99). **Exhibit B– Inservice** The Director of plant Operations will visually inspect signage of Hazardous areas to ensure appropriate indicators are present. This will be completed weekly x3 months then monthly thereafter. **Exhibit K – Audit tool**	

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			Executive Director will present results of visual inspection thru the QAPI committee for further recommendations and will continue until QAPI team determines substantial compliance has been achieved.	