STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155502	A. BUILDING -- B. WING	03/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
TRANSCENDENT HEALTHCARE OF OWENSVILLE	HWY 165 W PO BOX 369 OWENSVILLE, IN 47665

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E 0000 Bldg. --	. An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 03/06/18 Facility Number: 000328 Provider Number: 155502 AIM Number: 100287960 At this Emergency Preparedness survey, Transcendent Healthcare of Owensville, LLC was found 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 57. Quality Review completed on 03/07/18 - DA	E 0000	March 16, 2018 Matthew Foster, Director Long Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 RE: Transcendent Healthcare of Owensville Survey Event ID TK9R21 Dear Mr. Foster; By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective March16, 2018 to the state findings of the Life Safety Code and Emergency Preparedness Survey conducted on March 6, 2018. On March 6, 2018 a Life Safety Code with Emergency	

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

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			Preparedness Survey was conducted at our facility. By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective March 16, 2018 to the State findings of the Life Safety Code with Emergency Preparedness Survey conducted on March 6, 2018. We respectfully request a desk review to validate the facility's compliance to the findings of the Life Safety Code with Emergency Preparedness Survey conducted on March 6, 2018. We CAN submit supportive documentation to validate facility compliance supporting this plan of correction for your review. Transcendent Healthcare of Owensville annual Licensure survey was Jan 28th through Feb 1st with a date of alleged compliance being March 2nd and PSR March 8th. Although all citations were cleared the WINDOW remains open due to Life Safety survey March 6th with a date of alleged compliance being	

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			March 16th. Please feel free to contact the facility is any additional information is needed. Respectfully submitted, Robert O'Niones, HFA Executive Director Transcendent Healthcare of Owensville	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 03/06/18 Facility Number: 000328 Provider Number: 155502 AIM Number: 100287960 At this Life Safety Code survey, Transcendent Healthcare of Owensville, LLC 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 (000) construction and was fully sprinklered. The facility has a fire alarm system	K 0000	March 16, 2018 Matthew Foster, Director Long Term Care Division Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 RE: Transcendent Healthcare of Owensville Survey Event ID TK9R21 Dear Mr. Foster; By submitting the enclosed material, we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of	

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	with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke alarms in all resident sleeping rooms. The facility has a capacity of 68 and had a census of 57 at the time of this survey. All areas where the residents have customary access were sprinklered and all areas providing facility services were sprinklered. Quality Review completed on 03/07/18 - DA		any proceedings and submit these responses pursuant to our regulatory obligations. The facility requests the plan of correction be considered our allegation of compliance effective March16, 2018 to the state findings of the Life Safety Code and Emergency Preparedness Survey conducted on March 6, 2018. On March 6, 2018 a Life Safety Code with Emergency Preparedness Survey was conducted at our facility. By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request that the plan of correction be considered our allegation of compliance effective March 16, 2018 to the State findings of the Life Safety Code with Emergency Preparedness Survey conducted on March 6, 2018. We respectfully request a desk review to validate the facility's compliance to the findings of the Life Safety Code with Emergency Preparedness Survey conducted on March 6, 2018. We CAN submit supportive documentation	

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			to validate facility compliance supporting this plan of correction for your review. Transcendent Healthcare of Owensville annual Licensure survey was Jan 28th through Feb 1st with a date of alleged compliance being March 2nd and PSR March 8th. Although all citations were cleared the WINDOW remains open due to Life Safety survey March 6th with a date of alleged compliance being March 16th. Please feel free to contact the facility is any additional information is needed. Respectfully submitted, Robert O'Niones, HFA Executive Director Transcendent Healthcare of Owensville	
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2			

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	* cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on record review, observation and interview; the facility failed to ensure 1 of 1 kitchen range hood extinguishing system was maintained in proper working order. This deficient practice was not in a resident area but could affect kitchen staff. Findings include: Based on review of the semi annual kitchen range hood inspection reports on 03/06/18 at 10:00 a.m. with the Maintenance Supervisor present, the 12/08/17 report stated "Need swivel on nozzle for deep fryer". Based on observation of the kitchen range hood at 12:08 p.m. during a tour of the facility with the Maintenance Supervisor, the extinguishing nozzle in the range hood dedicated to the deep fryer was not properly positioned over the deep fryer, but, pointing to the left of the deep fryer. Based on interview at the time of observation, the Maintenance Supervisor agreed the nozzle was not properly positioned over the deep fryer. 3.1-19(b)	K 0324	K 324 *The corrective action taken for those residents found to be affected by the deficient practice is that* no specific residents were identified however the kitchen staff could be affected by the deficient practice, therefore the extinguishing nozzle in the range hood dedicated to the deep fryer has now been properly positioned over the deep fryer. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* no residents have the potential to be affected by the deficient practice however the kitchen staff could be affected by the deficient practice, therefore the extinguishing nozzle in the range hood dedicated to the deep fryer has now been properly positioned	03/16/2018

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			over the deep fryer. *The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that* the facility has hired a new Maintenance Supervisor. The new Maintenance Supervisor has been in-serviced on the facility's expectation of compliance in accordance with NFPA 96 Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* as part of the facility Preventative Maintenance Program the Maintenance Supervisor will check the kitchen range hood monthly to ensure that the extinguishing nozzles are in good working order and properly positioned. Any identified areas of concern will be promptly corrected to ensure on-going compliance.	
K 0353 SS=E 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.			

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	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			
	1. Based on observation and interview, the facility failed to ensure the ceiling in 2 of 4 sprinklered smoke compartments was maintained to allow sprinkler heads to function to their full capability. This deficient practice could affect residents, as well as staff and visitors while in the Physical Therapy gym and the Social Services office. Findings include: Based on observations on 03/06/18 between 11:15 a.m. and 1:30 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted: a. There was a four inch circular hole in the ceiling attic access panel in the Social Services office b. There was a one inch gap around a wire bundle that penetrated the ceiling into the attic space in the Physical Therapy gym storage area hall above the electrical panel Based on interview at the time of observations, the Maintenance Supervisor acknowledged the four inch hole in the attic access panel in the Social Services office and the one inch gap in the ceiling of the Physical Therapy gym.	K 0353	K 353 *1 a) The corrective action taken for those residents found to be affected by the deficient practice is that* no specific residents were identified however all residents, visitors and staff could be affected by the deficient practice. The four-inch circular hole in the ceiling attic access panel in the social service office has been repaired. *1 b) The corrective action taken for those residents found to be affected by the deficient practice is that* no specific residents were identified however all residents, visitors and staff could be affected by the deficient practice. The one-inch gap around the wire bundle that penetrated the ceiling into the attic space in the physical therapy gym storage area hall above the electrical panel has been repaired/sealed.	03/16/2018

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	3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of over 200 sprinkler heads in the facility was free of corrosion. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems at 5.2.1.1.1 requires sprinklers to be free of paint and corrosion. 5.2.1.1.2 requires any sprinkler that shows signs of paint or corrosion shall be replaced. This deficient practice could mostly kitchen staff plus all residents, as well as staff and visitors while in the adjacent dining room. Findings include: Based on observation on 03/06/18 at 12:14 p.m. during a tour of the facility with the Maintenance Supervisor, one sprinkler head above the dishwashing machine in the kitchen was covered with green corrosion. Based on interview at the time of observation, the Maintenance Supervisor agreed the sprinkler head was covered with green corrosion. 3.1-19(b)		*2) The corrective action taken for those residents found to be affected by the deficient practice is that* no specific residents were identified however all residents, visitors and staff could be affected by the deficient practice. The sprinkler head above the dish washing machine in the kitchen has been replaced and is free of signs of paint and corrosion. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* a housewide audit of all ceiling areas in the facility and all sprinkler heads has been conducted to ensure that all ceiling areas are maintained to allow sprinkler heads to function to their full capacity and that all sprinkler heads in the facility were free of corrosion. No other deficiencies were identified during this housewide audit. *The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that* the facility has hired a new Maintenance Supervisor. The new Maintenance Supervisor has been in-serviced on the facility's expectation of compliance in accordance with NFPA 25, Standard for the Inspection, Testing and Maintaining of	

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			Water-based Fire Protection Systems. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* as part of the facility Preventative Maintenance Program the Maintenance Supervisor will inspect all ceiling areas and sprinkler heads to ensure that all sprinkler heads are able to function to their full capacity and that all sprinkler heads in the facility are free of corrosion. Any identified areas of concern will be promptly corrected to ensure on-going compliance.	
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 2 smoke barrier walls was protected to maintain the smoke resistance of the	K 0372	K 372	03/16/2018

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	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 up to 32 residents, as well as staff and visitors in the west hall. Findings include: Based on observation on 03/06/18 at 12:49 p.m. during a tour of the facility with the Maintenance Supervisor, the smoke barrier wall in the attic above the smoke barrier doors in the west hall had a 2 to 3 inch gap through the wall on the bottom half of the four inch sprinkler main that was not properly fire stopped. Based on interview at the time of observation, the Maintenance Supervisor said he just started the job and was not aware of the gap that penetrated the smoke barrier wall in the west hall. 3.1-19(b)		*The corrective action taken for those residents found to be affected by the deficient practice is that* no specific residents were identified however 32 residents on the west hall as well as staff and visitors could be affected by the deficient practice. The smoke barrier wall in the attic above the smoke barrier doors in the west hall which had the 2 – 3 inch gap through the wall on the bottom half of the four-inch sprinkler main has now been repaired and meets the ½ hour fire resistive rating. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* a housewide audit of all smoke barrier walls has been conducted to ensure that there are no other breaches in the smoke barrier walls. No other areas were identified. *The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that* the facility has hired a new Maintenance Supervisor. The new Maintenance Supervisor has been in-serviced on the facility's expectation of compliance in accordance with LSC Section 19.3.7.5 related to smoke barrier walls being maintained to ensure a minimum of ½ hour fire resistive	

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			rating. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* as part of the facility's Preventative Maintenance Program the Maintenance Supervisor will inspect all smoke barrier walls monthly to ensure on-going compliance. Any areas of concern identified will be promptly corrected.	
K 0511 SS=C 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 Based on record review and interview the facility failed to ensure 1 of 1 emergency generator had a current letter from their gas company to ensure a reliable source of fuel in accordance with the requirements of NFPA 101 - 2012 edition, Section 19.5.1.1, 9.1, 9.1.3.1 and NFPA 110, 2010 Edition, 5.1. LSC section 9.1.3.1 states emergency generators shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition. Section 5.1.1 states the following energy sources shall be permitted to be used for the emergency power supply (EPS): (1) Liquid petroleum products at atmospheric pressure (2) Liquefied petroleum gas (liquid or vapor	K 0511	K 511 *The corrective action taken for those residents found to be affected by the deficient practice is that* no specific residents were identified however all residents, visitors and staff could be affected by the deficient practice. A letter signed by the gas company representative with a current date was obtained by the Executive Director during the Life Safety Survey and is maintained in the emergency generator log information.	03/16/2018

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	withdrawal) (3) Natural or synthetic gas Exception: For Level 1 installations in locations where the probability of interruption of off-site fuel supplies is high, on-site storage of an alternate energy source sufficient to allow full output of the EPSS to be delivered for the class specified shall be required, with the provision for automatic transfer from the primary energy source to the alternate energy source. A.5.1.1 states examples of probability of interruption could include the following: earthquake, flood damage, or a demonstrated utility unreliability. This deficient practice could affect all residents, staff and visitors. Findings include: Based on record review on 03/06/18 at 10:50 a.m. with the Administrator present, the emergency generator log information identified the fuel source for the emergency generator was natural gas. Additionally, the facility did have a letter from their natural gas provider indicating the natural gas was from a reliable source, however, the date on the letter was 09/23/14, and furthermore, the letter was not signed by the gas company representative, and was not current within the past twelve months. Based on interview at the time of record review, the Administrator said the letter presented was the most recent letter on file at the facility. 3.1-19(b)		*The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* all residents, visitors and staff have the potential to be affected by the deficient practice. A letter signed by the gas company representative with a current date was obtained by the Executive Director during the Life Safety Survey and is maintained in the emergency generator log information. *The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that* the facility has developed a calendar whereby the natural gas provider will be contacted by the Maintenance Supervisor to obtain a letter from the natural gas provider which is dated at least annually and signed by a gas company representative. The letter will be maintained in the emergency generator log. The facility has hired a new Maintenance Supervisor and he has been in-serviced on the new facility practice. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* a Quality Assurance tool has been developed and	

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			implemented to ensure that a current and valid letter from the natural gas provider is on file in the emergency generator log. This tool will be completed by the Executive Director every three months which and will be on-going to ensure continued compliance. Any areas of concern will be immediately addressed with the Maintenance Supervisor.	
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to ensure fire drills were held at varied times for 3 of 3 employee shifts during 4 of 4 quarters. LSC 19.7.1.6 requires drills to be conducted quarterly on each shift under varied conditions, furthermore, the facility failed to conduct fire drills at unexpected times under varying conditions for 10 of 12 fire drills. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drills on	K 0712	K 712 *The corrective action taken for those residents found to be affected by the deficient practice is that* no specific residents were identified however all residents could be affected by this deficient practice. The facility has prepared a fire drill calendar which staggers the week, day of the week and time of the fire drills to ensure that	03/16/2018

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	03/06/18 at 10:15 a.m. with the Maintenance Supervisor present, ten of twelve fire drills performed during the past twelve months were conducted during the last four days of the month. During an interview at the time of record review, the Maintenance Supervisor acknowledged that 10 of 12 fire drills were performed during the last four days of the month. 3-1.19(b)		the fire drills are being conducted at unexpected times and under varying conditions. A new calendar will be developed annually to ensure the week, day of the week and time varies each year. Only the Maintenance Supervisor and the Executive Director will have knowledge of the fire drill calendar. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* all residents have the potential to be affected by this deficient practice. The facility has prepared a fire drill calendar which staggers the week, day of the week and time of the fire drills to ensure that the fire drills are being conducted at unexpected times and under varying conditions. A new calendar will be developed annually to ensure the week, day of the week and time varies each year. Only the Maintenance Supervisor and the Executive Director will have knowledge of the fire drill calendar. *The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that* the facility has hired a new Maintenance Supervisor. The Executive Director has in-serviced the new Maintenance Supervisor	

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			of the facility's new practice in the development of a fire drill calendar and his responsibility in conducting fire drills in accordance with the facility calendar. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* the Executive Director will be responsible for reviewing/monitoring the monthly fire drill logs to ensure that the facility fire drill calendar is being followed. Any areas of concern identified will be immediately addressed with the Maintenance Director for additional action if warranted.	
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			

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	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 record review, observation, and interview; the facility failed to ensure power strips, extension cords, and multi plug adapters were not used as a substitute for fixed wiring in at least 5 of 32 resident rooms, plus one other area. LSC 19.5.1.1 requires utilities to comply with Section 9.1. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. NFPA 70, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect over 10 residents in sleeping room, plus residents as well as staff and visitors while in the southwest sitting area. Findings include: Based on observations on 03/06/18 between 11:15 a.m. and 1:30 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted: a. There were two vending machines and a wall mounted light plugged into a multi plugged adapter in the southwest sitting area outside the Beauty Shop. b. Room 13 had a bed plugged into an extension cord c. Room 9 had a refrigerator and fan plugged into an extension cord d. Room 5 had a TV and bed air mattress plugged into two separate power strips	K 0920	K 920 *a). The corrective action taken for those residents found to be affected by the deficient practice is that* no specific residents were identified however all residents, visitors and staff have the potential to be affected by the deficient practice. The vending machines on the southwest sitting area outside the Beauty Shop are now plugged into the appropriate electrical outlet in accordance with NFPA 101 power cord and extensions safety code requirements. *b). The corrective action taken for those residents found to be affected by the deficient practice is that* no specific residents were identified however all residents, visitors and staff have the potential to be affected by the deficient practice. Room 13 has had additional hard wired electrical outlet installed and/or an upgraded power strip added in accordance with the regulation. *c). The corrective action taken for*	03/16/2018

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	e. Room 3 had a refrigerator and lamp plugged into a power strip f. Room 19 had a TV and lamp plugged into a power strip Furthermore, the UL rating on the power strips mentioned did not meet the power strip requirements of UL 1363A or UL 60601-1 for medical equipment, or UL 1363 for resident care rooms. This was acknowledged by the Maintenance Supervisor at the time of each observation. 3.1-19(b)		*those residents found to be affected by the deficient practice is that* no specific residents were identified however all residents, visitors and staff have the potential to be affected by the deficient practice. Room 9 has had additional hard wired electrical outlet installed and/or an upgraded power strip added in accordance with the regulation. *d). The corrective action taken for those residents found to be affected by the deficient practice is that* no specific residents were identified however all residents, visitors and staff have the potential to be affected by the deficient practice. Room 5 has had additional hard wired electrical outlet installed and/or an upgraded power strip added in accordance with the regulation. *e). The corrective action taken for those residents found to be affected by the deficient practice is that* no specific residents were identified however all residents, visitors and staff have the potential to be affected by the deficient practice. Room 3 has had additional hard wired electrical outlet installed and/or an upgraded power strip added in accordance with the regulation. *f). The corrective action taken for those residents found to be*	

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			affected by the deficient practice is that no specific residents were identified however all residents, visitors and staff have the potential to be affected by the deficient practice. Room 19 has had additional hard wired electrical outlets installed and/or an upgraded power strip added in accordance with the regulation. *The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* a housewide audit has been conducted to identify any other areas in need of fixed electrical outlets. In addition, all power strips and/or extension cords that do not meet the requirements of UL 1363A, or UL 60601-1 for medical equipment or UL 1363 for resident care rooms have been removed and replaced with either fixed electrical outlets or power strips that meet the LSC requirements. *The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that* the facility has hired a new Maintenance Supervisor. The facility has provided the new Maintenance Supervisor with a mandatory in-service on the requirements of NFPA 101 Power	

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			Cords and Extensions. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* that as part of the facility Preventative Maintenance Program the Maintenance Supervisor will conduct rounds at least monthly to identify and correct any areas of non-compliance of NFPA 101 Power Cords and Extensions. Any areas of non-compliance identified by any staff member will be promptly reported to the Maintenance Supervisor for correction	
K 0923 SS=F 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. >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			

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	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 3 of 6 cylinders of nonflammable gases such as oxygen were properly secured from falling in the oxygen storage/transfilling room. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 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 affect all residents, staff and visitors while in the dining room which was adjacent to the oxygen storage room.	K 0923	K 923 *The corrective action taken for those residents found to be affected by the deficient practice is that* no specific residents were identified however all residents, visitors and staff have the potential to be affected by the deficient practice. The three E type oxygen cylinders identified during the survey are now storage securely in proper cylinder carts. *The corrective action taken for the other residents having the potential to be affected by the*	03/16/2018

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	Findings include: Based on observation on 03/06/18 at 12:03 p.m. during a tour of the facility with the Maintenance Supervisor, there were three 'E' type oxygen cylinders standing upright on the floor in the oxygen storage/transfilling room that were not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of observation, the Maintenance Supervisor said he was not aware the oxygen cylinders were freestanding. 3.1-19(b)		*same deficient practice is that* a housewide audit was conducted throughout the facility to ensure that there were no other oxygen cylinders that were not properly secured. No other cylinders were identified. *The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that* a mandatory in-service has been provided for all nursing, housekeeping, laundry and maintenance staff on the facility practice of safe oxygen storage. The staff was directed that anyone that identifies an oxygen tank that is not stored securely is to immediately ensure that the tank is placed in a secure cylinder stand or cart. *The corrective action taken to monitor to assure performance to assure compliance through quality assurance is* that as part of the facility Preventative Maintenance Program the Maintenance Supervisor will check monthly all oxygen cylinders to ensure that they are being stored in a proper cylinder storage stand or cart.	