STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155354	A. BUILDING -- B. WING	03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NEWBURGH HEALTH CARE	10466 POLLACK AVE NEWBURGH, IN 47630

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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: 03/07/18 Facility Number: 000245 Provider Number: 155354 AIM Number: 1002890800 At this Emergency Preparedness survey, Newburgh Health Care was found in substantial compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has 114 certified beds. At the time of the survey, the census was 94. Quality Review completed on 03/13/18 - DA The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000		
E 0036 SS=C Bldg. --	Based on record review and interview, the facility failed to develop and 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 in the facility. Findings include:	E 0036	Development of an emergency preparedness training and testing program included in the emergency plan manual. will be in place and include the overall plan review every year. Plan is located at nurses stations and key department heads.	03/30/2018

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

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	Based on review of the facility's Emergency Preparedness (EP) Plan on 03/07/18 between 9:30 a.m. to 12:00 p.m. with the Maintenance Supervisor and HR Coordinator present, there was no documentation available to show the facility had an emergency preparedness training and testing program. Based on interview at the time of record review, the HR Coordinator said there was no emergency preparedness training and testing program documentation available for review.		All staff trained in Inservice and new hires are trained in orientation. Amanda Shelby	
E 0037 SS=C Bldg. --	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 occupants in the facility. Findings include: Based on review of the Emergency Preparedness (EP) Plan on 03/07/18 between 9:30 a.m. and 12:00 p.m. with the Maintenance Supervisor and HR Coordinator present, there was no documentation to indicate facility staff were trained on the EP over the past 12 months. Based on an interview at the time of EP review, the HR Coordinator said the	E 0037	All staff will inserviced on the latest version of the Emergency Preparedness Plan Manual at the bi-weekly inservice meetings. All new hires will be orientated to the latest version of of the EPP. A signed acknowledgement to be filed in their personnel file. Volunteers and contractors will be inserviced to the latest version on the EPP. In addition to initial training, all staff, volunteers, and contractors will be inserviced on the emergency plan annually, after the annual review and updates to the plan. These inservices will be addition to required drills, table top exercises and full scale exercises. Lori Henrici Staff Development Coordinator	04/05/2018

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	facility has not trained the staff and documented the training on the EP and the facility does not have a testing program.			
E 0039 SS=C Bldg. --	Based on record review and interview, the facility failed to conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following: (i) participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the LTC facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event; (ii) conduct an additional exercise that may include, but is not limited to the following: (A) a second full-scale exercise that is community-based or individual, facility-based. (B) a tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan; (iii) analyze the LTC facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the LTC facility's emergency plan, as needed in accordance with 42 CFR 483.73(d)(2). This deficient practice could affect all occupants. Findings include: Based on review of the Emergency Preparedness	E 0039	A table top exercise will be completed on 4/6/2018. Contacted Emergency Management Agency there are no full scale exercise plans scheduled. Planing efforts will start immediately for an in house exercise. That will be completed by 5/30/2018. Data analysis of all drills, table top exercises, and full scale exercises will be maintained in the Administrators copy of the Emergency Preparedness Plan Manual. Amanda Shelby Suzanne Weigel	04/06/2018

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	(EP) Plan on 03/07/18 between 9:30 a.m. and 12:00 p.m. with the Maintenance Supervisor and HR Coordinator present, the facility was unable to provide documentation that two annual exercises were conducted during the past 12 months. Based on interview at the time of EP review, the HR Coordinator said the facility has not conducted two emergency preparedness exercises during the past 12 months.			
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: 03/07/18 Facility Number: 000245 Provider Number: 155354 AIM Number: 100290800 At this Life Safety Code survey, Newburgh Health Care was found not 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 with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 114 and had	K 0000		

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	a census of 94 at the time of this survey. All areas where the residents have customary access were sprinklered, and all areas providing facility services, including a detached garage used for a maintenance shop and maintenance and facility storage, were sprinklered, except a small detached wood framed shed used for furniture storage and a walk in cooler outside the kitchen service hall exit. Quality Review completed on 03/13/18 - DA			
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 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 2 fire alarm control panel was protected. NFPA 72, National Fire Alarm and Signaling Code 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.	K 0341	Repaired lock and put a key at west nurses station. Chuck Hergenrother Maintenance Supervisor **Monitoring**	03/15/2018

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	Findings include: Based on observation on 03/07/18 at 1:15 p.m. during a tour of the facility with the Maintenance Supervisor, the fire alarm control panel (FACP) door was not locked with the key hanging inside the panel. The FACP was located in the service hall where all staff and some visitors have access. Based on interview at the time of observation, the Maintenance Supervisor said the FACP door was unlocked because the lock on the door was broken a while back. 3.1-19(b)		The fire alarm control panel with locked cabinet will be checked daily. The key posted at the West nurses station will be checked daily to ensure availability. Both will be checked during business hours by the maintenance staff. The weekend west nurse will check availability on the weekend shifts.	
K 0363 SS=B 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 150 corridor doors were not equipped with deadbolt locks in addition to regular door handles to open the door. National Fire Protection Association (NFPA) 101, 2012 edition, at 7.2.1.5.10.2 requires the releasing mechanism shall open the door leaf with not more than one releasing operation. This deficient practice could affect up to 20 residents, as well as staff and visitors in the north unit. Findings include: Based on observation on 03/07/18 at 12:46 p.m. during a tour of the facility with the Maintenance Supervisor, the north unit Nursing Central Supply room door had both a deadbolt lock and separate door knob with lock. This was acknowledged by the Maintenance Supervisor at the time of observation. 3.1-19(b)	K 0363	Remove deadbolt and put a cover over hole in door. Chuck Hergenrother **Monitoring** The staff occupant of this room will monitor daily and report to the maintenance supervisor any defect for corrections.	03/19/2018

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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 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 2 of 11 sets of smoke barrier doors would restrict the movement of smoke for at least 20 minutes. LSC, Section 19.3.7.8 requires that doors in smoke barriers shall comply with LSC, Section 8.5.4. LSC, Section 8.5.4.1 requires doors in smoke barriers to close the opening leaving only the minimum clearance necessary for proper operation which is defined as 1/8 inch to restrict the movement of smoke. This deficient practice could affect up to 65 residents, as well as staff and visitors in the west and north units. Findings include: Based on observations on 03/07/18 between 12:00 p.m. and 1:45 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted: a. The west side door of the set of smoke barrier doors near room 10 did not close completely when tested several times leaving a six inch gap	K 0374	Adjusted door closure door is now closing. Tom Zinn Maintenance department **Monitoring** The door closures will be checked monthly by the maintenance department to ensure doors are kept closed properly without a gap.	03/18/2018

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	between the doors when closed to their fullest b. The set of smoke barrier doors in the north unit near rooms 23 and 24 had a one half inch gap between the doors when closed fully. Based on interview at the time of observations, the Maintenance Supervisor acknowledged the two sets of smoke barrier doors did not close completely and provide a smoke tight barrier. 3.1-19(b)			
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 Based on observation and interview, the facility failed to ensure 1 of 8 wet locations was provided with ground fault circuit interrupter (GFCI) protection against electric shock. NFPA 70, NEC 2011 Edition at 210.8 Ground-Fault Circuit-Interrupter Protection for Personnel, states, ground-fault circuit-interruption for personnel shall be provided as required in 210.8(A) through (C). The ground-fault circuit-interrupter shall be installed in a readily accessible location. Informational Note: See 215.9 for ground-fault circuit interrupter protection for personnel on feeders. (B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in 210.8(B)(1) through (8) shall have ground-fault circuit-interrupter protection for personnel.	K 0511	Installed a G.F.I. receptacle. Chuck Hergenrother **Monitoring** The maintenance department will monitor monthly for potential defects.	03/09/2018

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	(1) Bathrooms (2) Kitchens (3) Rooftops (4) Outdoors Exception No. 1 to (3) and (4): Receptacles that are not readily accessible and are supplied by a branch circuit dedicated to electric snow-melting, deicing, or pipeline and vessel heating equipment shall be permitted to be installed in accordance with 426.28 or 427.22, as applicable. Exception No. 2 to (4): In industrial establishments only, where the conditions of maintenance and supervision ensure that only qualified personnel are involved, an assured equipment grounding conductor program as specified in 590.6(B)(2) shall be permitted for only those receptacle outlets used to supply equipment that would create a greater hazard if power is interrupted or having a design that is not compatible with GFCI protection. (5) Sinks - where receptacles are installed within 1.8 m (6 ft.) of the outside edge of the sink. Exception No. 1 to (5): In industrial laboratories, receptacles used to supply equipment where removal of power would introduce a greater hazard shall be permitted to be installed without GFCI protection. Exception No. 2 to (5): For receptacles located in patient bed locations of general care or critical care areas of health care facilities other than those covered under 210.8(B)(1), GFCI protection shall not be required. (6) Indoor wet locations (7) Locker rooms with associated showering facilities (8) Garages, service bays, and similar areas where electrical diagnostic equipment, electrical hand tools. NFPA 70, 517-20 Wet Locations, requires all receptacles and fixed equipment within the area of			

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	the wet location to have ground-fault circuit interrupter (GFCI) protection. Note: Moisture can reduce the contact resistance of the body, and electrical insulation is more subject to failure. This deficient practice could affect mostly staff in the north unit. Findings include: Based on observation on 03/07/18 at 12:54 p.m. during a tour of the facility with the Maintenance Supervisor, there was one electric receptacle within one foot of the sink in the north unit employee breakroom. The electric receptacle was not provided with ground fault circuit interrupters (GFCI). This was confirmed when tested with a GFCI testing device. Based on interview at the time of observation, the Maintenance Supervisor agreed the receptacle in the north unit breakroom was not GFCI protected. 3.1-19(b)			
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3			

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	Based on record review and interview, the facility failed to provide a complete facility specific written fire safety plan for the protection of 94 of 94 residents to accurately address all life safety systems, plus a system addressing all items required by NFPA 101, 2012 edition, Section 19.7.2.2. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire This deficient practice could affect all occupants in the event of an emergency. Findings include: Based on a review of the facility's fire safety plan on 03/07/18 at 11:58 a.m. with the Maintenance Supervisor present, the fire safety plan did not address issues such as, staff response to battery powered smoke alarms in resident sleeping rooms. Based on interview at the time of record review, the Maintenance Supervisor acknowledged and agreed that the fire safety plan did not address staff response to battery powered smoke alarms in resident sleeping rooms. 3.1-19(b)	K 0711	Add room smoke detector in fire section in Emergency Plan. Each resident room has a battery operated smoke detector that are independent from building fire alarms. If a resident rooms smoke detector activates it will be investigated. The smoke detector has a reset button to test alarms. Smoke detectors are tested weekly by maintenance department. Batteries are replaced yearly. Smoke detectors changed at 10 years of service date on back of smoke detector. Chuck Hergenrother **Monitoring** The smoke alarm reset button will be tested weekly by the maintenance staff. All staff has been trained to respond to the activation of the smoke detectors during the emergency plan and fire drill training.	03/20/2018
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills			

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	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 1. Based on record review and interview, the facility failed to ensure 5 of 22 fire drill reports included complete documentation of the transmission of a fire alarm signal to the monitoring company/fire department during the past twelve months. LSC 19.7.1.4 requires fire drills in health care occupancies shall include the transmission of the fire alarm signal and simulation of emergency conditions. This deficient practice could affect all residents. Findings include: Based on review of the facility's fire drill reports on 03/07/18 at 11:05 a.m. with the Maintenance Supervisor present, all five documented third shift fire drill reports did not include information of the transmission of the alarm to the monitoring company. Based on interview at the time of record review, the Maintenance Supervisor agreed there was no documentation on the third shift fire drill reports that included information of the transmission of the alarm to the monitoring company. 3-1.19(b) 2. Based on record review and interview, the	K 0712	will pull fire alarms next business day after night shift has completed fire alarms on night shift. As to not have fire alarms go off in the middle of the night scaring residents. Chuck Hergenrother Suzy Singer **Monitoring** #2 Transmission of the fire alarm for the night shift will be included in the facility Fire Drill Report. The activation of the alarm will not exceed four (4) hours after the night shifts ends. Fire drill will be conducted at various times throughout each shift not to be closer than an hour apart.	03/23/2018

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	155354	A. BUILDING 01 B. WING	03/07/2018

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	facility failed to ensure fire drills were held at varied times for 3 of 3 employee shifts during 4 of 4 quarters. This deficient practice could affect all residents in the facility. Findings include: Based on review of the facility's fire drills on 03/07/18 at 11:05 a.m. with the Maintenance Supervisor present, the following was noted: a. Six of seven, first shift (day) fire drills were performed between 9:00 a.m. and 9:42 a.m. b. Four of four, second shift (evening) fire drills were performed between 2:03 p.m. and 3:10 p.m. c. Five of five, third shift (night) fire drills were performed between 4:38 a.m. and 5:15 a.m. During an interview at the time of record review, the Maintenance Supervisor acknowledged the times the first, second and third shift fire drills were performed and agreed the times were not varied enough. 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			

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	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 record review, observation, and interview; the facility failed to ensure power strips and multi plug adapters were not used as a substitute for fixed wiring in at least 4 of 64 resident rooms. 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 at least 6 residents in sleeping rooms. Findings include: Based on observations on 03/07/18 between 12:00 p.m. and 1:45 p.m. during a tour of the facility with the Maintenance Supervisor, the following was noted: a. Room 18 had a lamp and phone plugged into a power strip b. Room 26 had a computer plugged into a power strip c. Room 36 had a lamp and radio plugged into a power strip e. Room 63 had a lift chair plugged into a power strip	K 0920	Ordered outlets to install in rooms to eliminate power strips. Chuck Hergenrother Maintenance supervisor **Monitoring** The maintenance staff will monitor rooms monthly to ensure compliance with the elimination of power strips.	03/19/2018

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	Furthermore, the UL rating on the power strips mentioned did not meet the power strip requirements of UL 1363 for resident care rooms. This was acknowledged by the Maintenance Supervisor at the time of each observation. 3.1-19(b)			
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). 11.5.2.2 (NFPA 99) Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage locations where transfilling occurs was in accordance with NFPA 99, Health Care Facilities Code. NFPA 99, 2012 Edition, Section 11.5.2.3.1 states oxygen transfilling locations shall include the following: (1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire resistive construction. (2) The area is mechanically vented, is sprinklered, and has ceramic or concrete flooring. (3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted. (4) The individual transfilling the container(s) has	K 0927	Put up a temporary sign on oxygen 3-9-2018 Ordered by permanent sign. 3-12-2018 03/21/2018 Installed new sign on Oxygen door. Chuck hergenrother maintenance supervisor **Monitoring** The nursing staff and maintenance staff will monitor for the presence of the oxygen room signage daily.	03/21/2018

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	been properly trained in the transfilling procedures. Section 11.5.3.2.3 states in health care facilities where smoking is prohibited and signs are prominently (strategically) placed at all major entrances, secondary signs with no smoking language shall not be required. This deficient practice could affect up to 30 residents, staff and visitors in the east unit. Findings include: Based on observation on 03/07/18 at 1:20 p.m. during a tour of the facility with the Maintenance Supervisor, the entry door to the oxygen storage and transfilling room near the east unit nurse's station was not provided with signage indicating that transfilling is occurring. Seven liquid oxygen containers and five 'E' type cylinders were stored in the room. Based on interview at the time of the observations, the Maintenance Supervisor agreed the entry door to the room was not provided with the necessary signage. 3.1-19(b)		The facility respiratory vendor will monitor weekly.	