STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155455	A. BUILDING -- B. WING	11/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
WESLEYAN HEALTH CARE CENTER	729 WEST 35TH ST MARION, IN 46953

(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: 11/29/22 Facility Number: 000557 Provider Number: 155455 AIM Number: 100291240 At this Emergency Preparedness survey, Wesleyan Health Care Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 169 and had a census of 100 at the time of this survey. Quality Review completed on 12/08/22	E 0000	This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility respectfully requests a desk review for compliance.	
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: 11/29/22 Facility Number: 000557 Provider Number: 155455 AIM Number: 100291240 At this Life Safety Code survey, Wesleyan Health Care Center was found not in compliance with Requirements for Participation in	K 0000	This plan of correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The facility respectfully requests a	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
monica martin	EXECUTIVE DIRECTOR	12/22/2022

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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	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 was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms. The facility has a capacity of 169 and had a census of 100 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. It was determined that the separation wall between the Nursing Facility and the Assisted Living Hall had a one hour fire rating which required it to be surveyed also. Quality Review completed on 12/08/22		desk review for compliance.	
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 maintain latching hardware on 1 of 1 smoke barrier doors in the Business hall southeast. LSC 4.6.12.3 requires existing life safety	K 0100	K100 Due to the nature of the survey no residents were identified to be affected by the alleged deficient	12/21/2022

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	features obvious to the public if not required by the Code, shall be either maintained or removed. This deficient practice could affect staff in the Business-hall. Findings include: Based on observation with the Director of Plant Operations (DPO) on 11/29/22 at 3:35 p.m., the set of smoke barrier doors to the Business hall was provided with latching hardware but failed to latch when tested. Based on interview at the time of observation, the DPO agreed the smoke doors were equipped with latching devices, but the doors did not properly latching when tested. The finding was reviewed with the Administrator and DPO during the exit conference. 3.1-19(b)		practice. No residents were affected by the alleged deficient practice. Residents that live in the facility have the potential to be affected by the alleged deficient practice. The latching hardware on the smoke barrier door has been replacedl. Audits will be completed weekly by closing door and ensuring latching hardware works properly X 8 weeks then monthly thereafter until QA determines alleged deficient practice is corrected. QA will review compliance for a minimum of 6 months.	
K 0131 SS=E Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.			

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	Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 Based on observation and interview, the facility failed to ensure the penetration in 1 of 1 fire barrier walls that separated health care from assisted living was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.5.1 requires penetrations for cables, cable trays, conduits, pipes, tubes, combustion vents and exhaust vents, wires, and similar items to accommodate electrical, mechanical, plumbing, and communications systems that pass through a wall, floor, or floor/ceiling assembly constructed as a fire barrier shall be protected by a firestop system or device. The firestop system or device shall be tested in accordance with ASTM E 814, Standard Test Method for Fire Tests of Through Penetration Fire Stops, or ANSI/UL 1479, Standard for Fire Tests of Through-Penetration Fire Stops. This deficient practice could affect at least 20 residents. Findings include: Based on observation with the Director of Plant Operations (DPO) on 11/29/22 at 3:05 p.m., above the drop ceiling of the separation fire barrier in the Assisted Living Hall had an unsealed two-inch hole in the wall. Based on interview at the time of observation, the DPO agreed the separation fire barrier had an unsealed hole through the wall. The finding was reviewed with the Administrator and DPO during the exit conference.	K 0131	K131 Due to the nature of the survey no residents were identified to be affected by the alleged deficient practice. No residents were affected by the alleged deficient practice. Residents that live in the facility have the potential to be affected by the alleged deficient practice. The unsealed hole in the barrier wall has been repaired and this has been corrected. Audits of the firewalls will be completed monthly X 6 months. QA will review compliance for a minimum of 6 months.	12/21/2022

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	3.1-19(b)			
K 0222 SS=E Bldg. 01	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.			

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	18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4			
	Based on observation and interview, the facility failed to ensure the means of egress through 3 of 3 exit doors, one to the Breezeway and two entering Memory Lane were readily accessible for residents without a clinical diagnosis requiring specialized security measures. Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side unless otherwise permitted by LSC 19.2.2.2.4. Door-locking arrangements shall be permitted in accordance with 19.2.2.2.5.2. This deficient practice could	K 0222	K222 Due to the nature of the survey no residents were identified to be affected by the alleged deficient practice. No residents were affected by the alleged deficient practice. Residents that live in the facility have the potential to be affected by the alleged deficient practice. The doors that have magnetic locks with entry codes have had	12/22/2022

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	affect all staff and visitors entering Memory Lane and all staff, residents and visitors exiting through the Breezeway. Findings include: Based on observation with the Director of Plant Operations (DPO) on 11/29/22 at 3:30 p.m., the 3 exit doors, one to the Breezeway and two entering Memory Lane were marked as facility exits, were magnetically locked, and could be opened by entering a four-digit code on the access control pad, but the code was not posted at the exit doors. Based on interview at the time of observation, the DPO agreed the code to open the exit doors was not posted by the access control pad. The findings were reviewed with DPO and the Administrator during the exit conference. 3.1-19(b)		the codes posted on the entry pad on the doors defined in the survey. Audits will be performed on all doors that require entry codes will be audited weekly for a minimum of 6 months. QA will review for a minimum of 6 months.	
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 * 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			

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	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 1. Based on observation and interview, the facility failed to ensure staff had access to the shutoff switch for 1 of 1 cook tops in the therapy gym. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect five residents in the therapy gym. Findings include: Based on observation with the Director of Plant Operations (DPO) on 11/29/22 at 3:40 p.m., there was a cooktop in the therapy gym that was	K 0324	K324 Due to the nature of the survey no residents were identified to be affected by the alleged deficient practice. No residents were affected by the alleged deficient practice. Residents that live in the facility have the potential to be affected by the alleged deficient practice. The shut off valve for the stove identified has had the location and instructions for the shut off posted for the staff. Other shut off valves for stoves have been identified and instructions posted on how to shut off the access to the stove. Audits will be completed weekly X 8 weeks then monthly thereafter. QA committee will review for a minimum of 6 months to ensure compliance.	12/21/2022

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	separated from the corridor, but staff were unable to deactivate the cooktop from power. Based on interview at the time of observation, the DPO was asked if staff were able to deactivate the cooktop and lock the switch. The DPO stated the shut off switch is in the electrical room in a breaker box, but staff did not have access to the breaker box. The finding was reviewed with DPO and Administrator during the exit conference. 2. Based on observation and interview, the facility failed to ensure staff had access to the shutoff switch for 1 of 1 cook tops in the Assisted Living activity room. LSC 19.3.2.5.4 states within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions: (1) The space containing the cooking equipment is not a sleeping room. (2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5. (3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met. 19.3.2.5.3(9) states A switch meeting all of the following is provided: (a) A locked switch, or a switch located in a restricted location, is provided within the cooking facility that deactivates the cooktop or range. (b) The switch is used to deactivate the cooktop or range whenever the kitchen is not under staff supervision. This deficient practice could affect up to ten residents in the Assisted Living activity room. Findings include:			

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	Based on observation with the Director of Plant Operations (DPO) on 11/29/22 at 3:07 p.m., there was a cooktop in the Assisted Living activity room that was separated from the corridor, but staff were unable to deactivate the cooktop from power. Based on interview at the time of observation, the DPO was asked if staff were able to deactivate the cooktop and lock the switch. The DPO stated the shut off switch is in the electrical room in a breaker box, but staff did not have access to the breaker box. The finding was reviewed with DPO and Administrator during the exit conference. 3.1-19(b)			
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 1 fire alarm systems was continuously in proper operating condition. NFPA 72, National Fire Alarm and Signaling Code,	K 0341	K341 Due to the nature of the survey no residents were identified to be affected by the alleged deficient	12/21/2022

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	2010 Edition, Section 14.2.1.2.2 states system defects and malfunctions shall be corrected. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation of the fire alarm control panel with the Director of Plant Operations (DPO) on 11/29/22 at 1:30 p.m., the time on the display of the fire alarm control panel indicated the time to be 1422 and the date indicated 11/28/22. Based on interview at the time of observation, the Director of Plant Operations agreed the fire alarm control panel had the wrong time and date and will need to be changed. The finding was reviewed with the DPO and Administrator during the exit conference. 3.1-19(b)		practice. No residents were affected by the alleged deficient practice. Residents that live in the facility have the potential to be affected by the alleged deficient practice. The time and date noted on the fire alarm panel has been updated to the correct date and time. Audits will be performed weekly X 8 weeks then monthly thereafter. QA will monitor compliance for a minimum of 6 months.	
K 0363 SS=D 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.			

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	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 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 10 service corridor doors resist the passage of smoke and capable of resisting fire for 20 minutes. This deficient practice could affect 10 residents in one smoke compartment. Findings include: Based on observation with the Director of Plant Operations (DPO) on 11/29/22 at 3:00 pm, the corridor door to attic access across the hall from resident room 88 had one half inch hole that went through the door. Based on interview at the time of observation, the Maintenance Director stated	K 0363	K363 Due to the nature of the survey no residents were identified to be affected by the alleged deficient practice. No residents were affected by the alleged deficient practice. Residents that live in the facility have the potential to be affected by the alleged deficient practice. The door was identified, and door handle has been replaced. Audits of the corridor doors will be completed monthly for a minimum of 6 months. QA will monitor	12/21/2022

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(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
	the hole was due to switching the door handles. The finding was reviewed with the DPO and Administrator during the exit interview 3.1-19(b)		compliance for a minimum of 6 months.	
K 0920 SS=D 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 1. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were installed properly and used in a safe manor. NFPA 99, Section 10.2.4.2 states adapters and extension	K 0920	K920 Due to the nature of the survey no residents were identified to be affected by the alleged deficient	12/21/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155455	A. BUILDING 01 B. WING	11/29/2022

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	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 affect the resident in room 59. Findings include: Based on observation with the Director on Plant Operations (DPO) on 11/29/22 at 3:20 p.m., in resident room 59 a power strip used to power equipment, was not secured, and was dangling from the outlet on the wall. This condition could put stress on the power cord causing damage to the power cord. Based on interview at the time of observations, the DPO agreed the power strip was dangling, not secured, and stated the power strip will need to be mounted or set on the floor. This finding was reviewed with the DPO and Administrator during the exit conference. 2. Based on observation and interview, the facility failed to ensure 1 of 1 power strips for non-PCREE (patient-care-related electrical equipment) in resident rooms (outside of resident care vicinity) meet UL 1363. This deficient practice affects one resident. Findings include: Based on observation with the Director of Plant Operations (DPO) on 11/29/22 at 2:05 p.m., in resident room 32 there was a power strip in use		practice. No residents were affected by the alleged deficient practice. Residents that live in the facility have the potential to be affected by the alleged deficient practice. The identified power strip has been replaced and or removed with a medical grade power strip. Rm 32 has been replaced with a medical grade and only medical equipment plugged into it. In room 59 the resident was educated and power strip removed as no strip was actually in need. Audits will be performed weekly X 8 Weeks, then monthly thereafter. QA will monitor for compliance for a minimum of 6 months.	

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	outside of the resident care area that did not meet UL-1363. Based on interview at the time of observation, the DPO agreed a power strip was in use in a resident room and did not meet UL-1363. The findings were reviewed with the Administrator and the DPO during the exit conference. 3. Based on observation and interview, the facility failed to ensure 1 of 1 flexible cords were not used as a substitute for fixed wiring. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect up to 10 residents and one staff member in the Activity room. Findings include: Based on observation during a tour of the facility with the Director of Plant Operations (DPO) on 11/29/22 at 3:35 p.m., a DVD player was plugged into and supplied power by an extension cord in the Activity room. Based on interview at the time of observation, the DPO acknowledged an extension cord was in use in the Activity room during movie time. The finding was reviewed with the DPO and the Administrator during the exit conference. 3.1-19(b)			
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet			

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	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 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)	K 0923	K923 Due to the nature of the survey no	12/21/2022

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	Findings include: Based on observation and interview, the facility failed to ensure 3 of over 20 cylinders of nonflammable gases such as oxygen were properly secured from falling. 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 10 residents in one smoke compartment. Findings include: Based on observations during a tour of the facility with the Director of Plant Operations (DPO) on 11/29/22 at 3:10 p.m., three 'E' type oxygen cylinders were standing upright on the floor of the oxygen storage/trans-filling room and were not properly chained or supported in a proper cylinder stand or cart. Based on interview at the time of observation, the Maintenance Director acknowledged three 'E' type oxygen cylinders in the oxygen storage/trans-filling room were not properly chained or supported in a proper cylinder stand or cart. The finding was reviewed with the Administrator and the DPO during the exit conference. 3.1-19(b)		residents were identified to be affected by the alleged deficient practice. No residents were affected by the alleged deficient practice. Residents that live in the facility have the potential to be affected by the alleged deficient practice. The items identified in the survey have been secured to the wall. The oxygen rooms will be audited weekly X 8 weeks then monthly thereafter to ensure items are secured. QA will monitor for compliance for a minimum of 6 months.	