STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495142	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/14/2019**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN HEALTH AND REHAB	**380 MILLWOOD AVENUE WINCHESTER, VA 22601**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS Surveyor: 35701 The facility is a two story skilled nursing facility. The facility is Type II (111) construction and is fully sprinklered. An unannounced Life Safety Code recertification survey was conducted on 05/14/2019 in accordance with 42 Code of Federal Regulations, Part 483.150 and 410 to 480: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing Regulations. The facility was found to be not compliance with the Requirements for Participation for Medicare and Medicaid. The Findings that follow demonstrate noncompliance with title 42 Code of Regulations. Part 483.150 and 410 to 480 (Life safety from Fire).	K 000	**Preparation of the following plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. This plan of correction is prepared because it is required by the provisions of federal and state law and is created for the purpose of quality improvement. The plan of correction constitutes the facility's allegation of compliance with federal and state laws.**	
K 222 SS=E	Egress Doors CFR(s): NFPA 101 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	K 222	K 222 1. The exit door located across from 204, the exit door located in Wing 1 exit enclosure, the exit door located in Wing 1 end stairwell, and the exit door located in Wing 3 have all been reprogrammed to release with a 30 second delay. Door knobs on the exit doors to exit enclosures located at Wing 1, Wing 2 and the end stairwell have been changed out to levered handles. 2. Other delayed egress doors have been checked to ensure that are functioning correctly. 3. During maintenance rounds once weekly, delayed egress doors will be checked for proper functioning and documented. If any malfunction is found it will be reported immediately so that corrective action can be taken. 4. Maintenance Director/designee will monitor rounds logs weekly to ensure checks are being done and that doors are functioning appropriately. Any issues will be reported to Administrator/designee for follow-up. 5. Completion Date: June 7, 2019	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ramona J. Rmgstaff — TITLE: Administrator — (X6) DATE: 5/28/2019

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

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K 222	Continued From page 1 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. 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 This REQUIREMENT is not met as evidenced by:	K 222		

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K 222	Continued From page 2 Surveyor: 35701 Based on observation, the facility failed to maintain egress doors. This has the potential to affect all residents and staff. The Findings include: It was observed on 05/14/2019 at 12:25 PM, the exit door located across from 204 was identified as a delayed egress door with a 30 second delay. When activated, the door was releasing in 15 seconds. It was observed on 05/14/2019 at 12:49 PM, the exit door located in Wing 1 exit enclosure was identified as a delayed egress with a 30 second delay. When activated, the door was releasing in 12 seconds. It was observed on 05/14/2019 at 1:15 PM, the exit door located in Wing 1 end stairwell was identified as a delayed egress with a 30 second delay. When activated, the door was releasing in 15 seconds. It was observed on 05/14/2019 at 1:17 PM, the exit door located in Wing 3 was identified as a delayed egress with a 30 second delay. When activated, the door was releasing in 33 seconds. It was observed on 05/14/2019 from 12:10 PM to 1:15 PM the exit doors to exit enclosures located at Wing 1, Wing 2 and the end stairwell was identified as delayed egress doors with a release time at 30 seconds. Observation revealed the doors was equipped with a knob that requires tight grasping and turning of the wrist to open.	K 222		
K 225 SS=D	Stairways and Smokeproof Enclosures CFR(s): NFPA 101	K 225		

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K 225	Continued From page 3 Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2 This REQUIREMENT is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to maintain smoke proof enclosures. This has the potential to affect one smoke compartment. The Findings include: It was observed on 05/14/2019 at 1:06 PM, the fire rated door to the exit/smoke proof enclosure near room 108 was not completely closing.	K 225	K 225 1. The fire rated door to the exit/smoke proof enclosure near room 108 has been adjusted to ensure that it completely closes. 2. Other doors have been checked to verify that the smoke proof enclosures are maintained. 3. During maintenance rounds one time monthly doors to smoke proof enclosures will be checked to ensure they are closing properly. If any issue is found it will immediately corrected. 4. Maintenance Director/designee will monitor rounds logs monthly to ensure checks are being done and that doors are functioning appropriately. Any issues will be reported to Administrator/designee for follow-up. 5. Completion Date: June 7, 2019	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 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	K 363	K 363 1. The door to resident room 118 has been adjusted so that it now closes completely. 2. Other doors have been evaluated to ensure they meet requirements. 3. Doors will be checked on a monthly basis to ensure that corridor doors meet fire safety standards. Door checks will be performed by the Maintenance Dept. 4. Maintenance Director/designee will be responsible for ongoing compliance. Any continuing issues will be brought to the attention of the Administrator for further action. 5. Completion Date: June 7, 2019	

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K 363	Continued From page 4 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. This REQUIREMENT is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to maintain corridor doors. This has the potential to affect one smoke compartment. The Findings include: It was observed on 05/14/2019 at 1:14 PM, the door to resident room 118 was not completely closing.	K 363		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour	K 372	K 372 1. The unsealed opening around the inactive electrical conduit and in the smoke barrier above ceiling and above the single panel smoke door of Wing 4 have been fire caulked and are now sealed.	

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K 372	Continued From page 5 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. This REQUIREMENT is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to maintain the smoke barrier. This has the potential to affect two smoke compartments. The Findings include: It was observed on 05/14/2019 at 1:35 PM, penetrations in the smoke barrier located in the Service Hall above the fire door was not sealed around the inactive electrical conduit. It was observed on 05/14/2019 at 2:08 PM, penetrations in the smoke barrier above ceiling and above the single panel smoke door of Wing 4 was not sealed at the conduit opening and MC cable on the resident side.	K 372	2. Other smoke barriers have been evaluated for integrity. 3. Maintenance staff will monitor smoke barrier walls monthly for the next 6 months to ensure their integrity is maintained. If no problems are identified then they will be monitored every six months thereafter. 4. Administrator /designee will monitor for ongoing compliance. Corrective action will be developed as needed. 5. Completion Date: June 7, 2019	
K 711 SS=D	Evacuation and Relocation Plan CFR(s): NFPA 101 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	K 711	K 711 1. The facility is protected by a fire security system that automatically notifies the fire monitoring company anytime the fire alarm goes off. The fire monitoring company sends the alarm directly to the local fire department. A staff directive has been added to the facility emergency and evacuation plan that assigns responsibility for calling 911 in the event of an emergency. 2. Residents and staff have the potential to be affected by this.	

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K 711	Continued From page 6 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 This REQUIREMENT is not met as evidenced by: Surveyor: 35701 Based on record review, the facility failed to maintain the emergency and evacuation plan. This has the potential to affect all residents and staff. The Findings include: A record review on 05/14/2019 at 11:25 AM revealed notification to the fire department by dialing 911 was not identified in the emergency and evacuation plan.	K 711	3. Nursing and Maintenance staff have been in-serviced on the new procedure of calling 911 should a fire emergency occur. 4. Maintenance Director/designee will monitor to ensure policy is being followed. Should discrepancies be noted he will inform Administrator so corrective action can be taken. 5. Completion Date: June 7, 2019	
K 761 SS=E	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by:	K 761	K 761 1. Inspection of door openings will be completed and documented. Paint has been removed from the door frame and door located in Wing 2 exit enclosure. 2. Inspection of door openings will identify any other areas of concern and will be corrected immediately. 3. Maintenance staff will be responsible for doing door opening inspections and documenting such on an annual basis. 4. Administrator/designee will monitor that door opening inspections are occurring as required and will sign off as reviewing at the time they are done. 5. Completion Date: June 7, 2019	

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K 761	Continued From page 7 Surveyor: 35701 Based on interview and observation, the facility failed to conduct and document inspections of door openings. This has the potential to affect all residents and staff. The Findings include: An interview with the maintenance supervisor on 05/14/2019 at 11:55 AM revealed the inspections of door openings was not being conducted and documented. It was observed on 05/14/2019 at 12:10 PM, the tags on the door frame and door located in Wing 2 to the exit enclosure was painted. 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* Where required by Chapters 11 through 43, the following door assemblies shall be inspected and tested not less than annually in accordance with 7.2.1.15.2 through 7.2.1.15.8: (1) Door leaves equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7 (2) Door assemblies in exit enclosures (3) Electrically controlled egress doors (4) Door assemblies with special locking arrangements subject to 7.2.1.6 7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105,	K 761		

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K 761	Continued From page 8 Standard for Smoke Door Assemblies and Other Opening Protectives. 7.2.1.15.3 The inspection and testing interval for fire-rated and nonrated door assemblies shall be permitted to exceed 12 months under a written performance-based program in accordance with 5.2.2 of NFPA 80, Standard for Fire Doors and Other Opening Protectives. 7.2.1.15.4 A written record of the inspections and testing shall be signed and kept for inspection by the authority having jurisdiction. 7.2.1.15.5 Functional testing of door assemblies shall be performed by individuals who can demonstrate knowledge and understanding of the operating components of the type of door being subjected to testing. 7.2.1.15.6 Door assemblies shall be visually inspected from both sides of the opening to assess the overall condition of the assembly. 7.2.1.15.7 As a minimum, the following items shall be verified: (1) Floor space on both sides of the openings is clear of obstructions, and door leaves open fully and close freely. (2) Forces required to set door leaves in motion and move to the fully open position do not exceed the requirements in 7.2.1.4.5. (3) Latching and locking devices comply with	K 761		

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K 761	Continued From page 9 7.2.1.5. (4) Releasing hardware devices are installed in accordance with 7.2.1.5.10.1. (5) Door leaves of paired openings are installed in accordance with 7.2.1.5.11. (6) Door closers are adjusted properly to control the closing speed of door leaves in accordance with accessibility requirements. (7) Projection of door leaves into the path of egress does not exceed the encroachment permitted by 7.2.1.4.3. (8) Powered door openings operate in accordance with 7.2.1.9. (9) Signage required by 7.2.1.4.1(3), 7.2.1.5.5, 7.2.1.6, and 7.2.1.9 is intact and legible. (10) Door openings with special locking arrangements function in accordance with 7.2.1.6 (11) Security devices that impede egress are not installed on openings, as required by 7.2.1.5.12. 7.2.1.15.8 Door openings not in proper operating condition shall be repaired or replaced without delay.	K 761		
K 901 SS=D	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99)	K 901	K 901 1. The HVAC system has been categorized as part of our risk assessment. 2. All systems are now being categorized in accordance with NFPA 99 2012 edition. 3. Maintenance staff will be responsible for scheduling and ensuring the risk management assessments are completed quarterly that include all needed systems reviewed.	

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K 901	Continued From page 10 This REQUIREMENT is not met as evidenced by: Surveyor: 35701 Based on record review, the facility failed to categorize all systems in accordance with NFPA 99 2012 edition. This has the potential to affect all residents and staff. The Findings include: A record review on 05/14/2019 at 11:25 AM revealed the HVAC system was not categorize in accordance with NFPA 99 2012 edition.	K 901	4. Administrator/designee will review each assessment upon completion for any identified concerns and to ensure all systems are being reviewed. Any concerns will be brought to the attention of the weekly Risk Management committee so that action plans can be developed to address risks. 5. Completion Date: June 7, 2019	
K 918 SS=D	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder	K 918	K 918 1. Emergency lighting with battery backup power will be installed in the boiler room where the transfer switch for the generator is located. 2. Residents and staff have the potential to be affected by this practice. 3. Maintenance staff will monitor that emergency lighting is available in the boiler room where the transfer switch is located during weekly maintenance rounds. Any issue found will be addressed immediately. 4. Administrator/designee will monitor rounds logs to ensure compliance is maintained. 5. Completion Date: June 7, 2019	

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K 918	Continued From page 11 circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to maintain the generator set. This has the potential to affect all residents and staff. The Findings include: It was observed on 05/14/2019 at 1:56 PM, the automatic transfer switch's for the generators identified as 45 kW and 100 kW was located in the boiler room. Observation revealed emergency lighting with battery backup power was not installed in the room. 7.3 Lighting. 7.3.1 The Level 1 or Level 2 EPS equipment location(s) shall be provided with battery-powered emergency lighting. This requirement shall not apply to units located outdoors in enclosures that do not include walk-in access. 7.3.2 The emergency lighting charging system and the normal service room lighting shall be supplied from the	K 918		

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	495142	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/14/2019**

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K 918	Continued From page 12 load side of the transfer switch. 7.3.3* The intensity of illumination in the separate building or room housing the EPS equipment for Level 1 shall be 32.3 lux (3.0 ft-candles), unless otherwise specified by a requirement recognized by the authority having jurisdiction.	K 918		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 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 This REQUIREMENT is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to	K 920	K 920 1. The commercial refrigerator located in the kitchen is now connected to an outlet. 2. Maintenance department has made rounds in ancillary areas to ensure that no other extension cords are in use. 3. Maintenance Dept. will add monitoring for extension cords to the monthly rounds log. Any extension cords found will be removed immediately. 4. Any ongoing issues of noncompliance will be reported to the Administrator/designee so that corrective action can be developed. 5. Completion Date: June 7, 2019	

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K 920	Continued From page 13 maintain electrical equipment in accordance with manufacturer guidelines. This has the potential to affect all staff in the kitchen. The Findings include: It was observed on 05/14/2019 at 1:43 PM, the commercial refrigerator located in the kitchen was connected to an extension cord as a permanent power supply.	K 920		
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 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 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."	K 923	K 923 1. The oxygen cylinder in room 204 was removed at the time of the survey. The 3 E cylinders of oxygen have been removed from the Rehab room closet. Room 327 had signage placed on the day of the survey so it was identified as an oxygen in use room. Full and empty oxygen cylinders are now separated in the oxygen storage room. 2. Oxygen will be stored so as to meet NFPA 99 2012 standards. 3. Nursing and Rehab staff will be in-serviced on the proper storage of oxygen cylinders and identification of rooms where oxygen is in use. Re-education or disciplinary action will occur as needed. 4. Both Maintenance staff and Central Supply clerk will monitor for issues relating to the above during their rounds five times weekly. Any ongoing concerns will be reported to the Administrator/designee so that corrective action can be taken. Completion Date: June 7, 2019	

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K 923	Continued From page 14 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) This REQUIREMENT is not met as evidenced by: Surveyor: 35701 Based on observation, the facility failed to maintain oxygen cylinder and container storage in accordance with NFPA 99 2012 edition. This has the potential to affect all residents and staff. The Findings include: It was observed on 05/14/2019 at 12:22 PM, an E cylinder of oxygen in resident room 204 located next to the dresser was not secure. It was observed on 05/14/2019 at 12:30 PM, 3 E cylinders of oxygen was stored in the Rehab Room closet. Observation revealed the room was not identified as an oxygen storage room. Further observation revealed light switches and outlets was not protected from physical impact. It was observed on 05/14/2019 at 1:26 PM, an oxygen concentrator located in room 327 was in use. The room was not identified as an oxygen in use room. It was observed on 05/14/2019 at 1:49 PM, approximately 32 E cylinders of oxygen was stored in the oxygen storage room. Observation revealed empty oxygen cylinders was stored in the same racks with full oxygen cylinders.	K 923		

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K 923	Continued From page 15 5.1.3.3.2 Design and Construction. Locations for central supply systems and the storage of positive-pressure gases shall meet the following requirements: (1) They shall be constructed with access to move cylinders, equipment, and so forth, in and out of the location on hand trucks complying with 11.4.3.1.1. (2) They shall be secured with lockable doors or gates or otherwise secured. (3) If outdoors, they shall be provided with an enclosure (wall or fencing) constructed of noncombustible materials with a minimum of two entry/exits. (4) If indoors, they shall be constructed and use interior finishes of noncombustible or limited-combustible materials such that all walls, floors, ceilings, and doors are of a minimum 1-hour fire resistance rating. (5)*They shall be compliant with NFPA 70, National Electrical Code, for ordinary locations. (6) They shall be heated by indirect means (e.g., steam, hot water) if heat is required. (7) They shall be provided with racks, chains, or other fastenings to secure all cylinders from falling, whether connected, unconnected, full, or empty. (8)*They shall be supplied with electrical power compliant with the requirements for essential electrical	K 923		

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K 923	Continued From page 16 systems as described in Chapter 6. (9) They shall have racks, shelves, and supports, where provided, constructed of noncombustible materials or limited-combustible materials (10) They shall protect electrical devices from physical damage.	K 923		