STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634560	A. BUILDING _____ B. WING _____	4/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKLD BLOOMFIELD HILLS	2975 N ADAMS ROAD BLOOMFIELD HILLS, MI 48304

(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
E0000 SS=	Initial Comments On April 23, 2021, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs. At the survey SKLD Bloomfield Hills was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness.	E0000		
E0015 SS= F	403.748(b)(1), 418.113(b)(6)(iii), 441.184(b)(1), 482.15(b)(1), 483.475(b)(1), 483.73(b)(1), 485.625(b)(1) Subsistence Needs for Staff and Patients [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated every 2 years (annually for LTC). At a minimum, the policies and procedures must address the following: (1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following: (i) Food, water, medical and pharmaceutical supplies (ii) Alternate sources of energy to maintain the following: (A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (B) Emergency lighting. (C) Fire detection, extinguishing, and alarm systems. (D) Sewage and waste disposal. *[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and	E0015	The facility has ordered and replaced the missing water to meet the number of gallons required for compliance. No residents were affected by this occurrence. The policy has been reviewed and deemed appropriate. A monthly audit of emergency water will be done to ensure that facility maintains the required amount of water to meet the need of the residents and staff in the facility for three months and quarterly thereafter. Dietary Manager has been in-serviced to not use the water and the emergency water has been taped off to designate it as the emergency water and that it is not to be used. The facility has a capacity of 159 and employs about 40 people a day; the equation used to determine the amount of water needed is 199x3 days = 597 gallons of water which is one gallon per person for three days. Emergency water will be monitored monthly for three months to ensure compliance and quarterly thereafter. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator/designee will be responsible for continuing compliance.	5/24/2021

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

Electronically Signed | 05/14/2021

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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	procedures must address the following: (iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following: (A) Food, water, medical, and pharmaceutical supplies. (B) Alternate sources of energy to maintain the following: (1) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop, at a minimum, policies and procedures that address; the provision of subsistence needs for staff and patients whether they evacuate or shelter in place, including, but not limited to: Food, water, medical and pharmaceutical supplies, alternate sources of energy to maintain temperatures to protect patient health and safety and for the safe and sanitary storage of provisions, emergency lighting, fire detection, extinguishing and alarm systems, and sewage and waste disposal. This deficient practice could affect all of the occupants in the event of an emergency. Findings Include: On April 23, 2021, at approximately 1:50 PM record review revealed the facility Emergency Preparedness plan for water subsistence needs for staff and residents calls for 597 gallons to be available onsite for the required three-day supply. Observation of the water supply revealed a quantity of 378 gallons onsite. This deficient practice could result in a water shortage during a		5/24/21 Compliance	

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	shelter-in-place event. These findings were confirmed by the Maintenance Director at the time of discovery through interview.			
K0000 SS=	INITIAL COMMENTS On April 23, 2021, a Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Community and Health Systems. At the survey, SKLD Bloomfield Hills was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire and the applicable provisions of the 2012 Edition of the National Fire Protection Agency (NFPA) 101, Life Safety Code and the 2012 Edition of NFPA 99, Health Care Facilities Code. The facility is a 3 story building of Type II (222) construction, built in 1971. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors. The facility has 159 certified beds. At the time of the survey the census was 150. The requirement at 42 CFR, subpart 483.90 (a) is NOT MET as evidenced by:	K0000		
K0321 SS= E	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved	K0321	A door closer with latching hardware will be installed on the door to room 102 to ensure compliance while the room is used for storage. The Maintenance Director will monitor storage areas monthly as part of his QAPI audits to ensure compliance is sustained.	5/24/2021

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	automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide Hazardous areas protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke revisiting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. This deficient practice could affect 18 occupants in the event of a fire. Findings Include:		The Administrator will confirm installation upon completion. The facility will stay compliant through monthly rounding to ensure that storage is only in those areas designated for storage. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Maintenance Director/designee will be responsible for continuing compliance. 5/24/21 Compliance	

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	On April 23, 2021, at approximately 1:10 PM observation revealed the facility failed to have a self-closing door with latching hardware for Room 102 that contained combustibles and is being used for storage. These findings were confirmed by the Maintenance Director at the time of discovery through interview.			
K0324 SS= E	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 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 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure cooking facilities are protected in accordance with NFPA 96, unless meeting the requirements of 19.3.2.5.2, 19.3.2.5.3 or 19.3.2.4.4, as required by 19.3.2.5.1 through 19.3.2.5.5, 9.2.3 and TIA 12-2. This deficient	K0324	The facility has instituted documented monthly inspections of the kitchen hood. The operation of the hood was deemed to be functioning correctly. No residents were affected by this occurrence due to the hoods proper functioning. The Maintenance Director has been in-serviced on monthly hood inspections. The Maintenance Director has instituted monthly inspections, the results of the inspection will be submitted to QAPI for review to ensure sustained compliance. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Maintenance Director /designee will be responsible for continuing compliance 5/24/21 Compliance	5/24/2021

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	practice could affect 6 occupants in the event of a fire. Findings Include: On April 23, 2021, at approximately 10:35 AM record review revealed the facility failed to record the required monthly kitchen hood inspections for the past 12 months. The Maintenance Director had no knowledge of this requirement. These findings were confirmed by the Maintenance Director at the time of discovery through interview.			
K0331 SS= E	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that interior wall and ceiling finishes have a flame spread rating of Class A or B, unless permitted to be reduced by 10.2.8.1, as required by 19.3.3.1 and 19.3.3.2. This deficient practice could affect 30 occupants in the event of a fire. Findings Include: On April 23, 2021 at approximately 10:43 AM	K0331	The wall paneling in the Maintenance Director□s office has been removed. Flame spread rating sheet for the divider curtains in Central Supply Room has been obtained by the Maintenance Director on 5/10/21. No residents were affected by this occurrence, they will be protected by the removal of the wall paneling which could not be accessed by residents. The Administrator will confirm removal of the wall paneling upon completion Monthly rounds will be done by the Maintenance Director/Designee to identify any potential similar occurrences.. Documentation of the flame spread rating and removal of the paneling and audits will be submitted to QAPI for review to ensure compliance. The Maintenance Director/designee will be responsible for continuing compliance. 5/24/21 Compliance	5/24/2021

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	record review revealed the facility failed to provide documentation of the flame spread rating for the wood wall paneling in the Maintenance Director's office. This deficient practice could result in the spread of fire by having unacceptable material as an interior finish. On April 23, 2021 at approximately 11:40 AM record review revealed the facility failed to provide documentation of the flame spread rating for the two divider curtains in the Central Supply Room. This deficient practice could result in a spread of fire by not having approved fire rated curtains. These findings were confirmed by the Maintenance Director at the time of discovery through interview.			
K0353 SS= E	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K0353	The ceiling tile around the sprinkler head near the elevator room has been replaced to close the penetration by the maintenance department. Residents residing in the facility have the potential to be affected by this occurrence, no residents were affected by this occurrence. Building rounds have been done to identify and fix any additional penetrations found by the maintenance department. Monthly rounding will be done to identify and fix any penetrations found; repairs will be made to ensure this occurrence does not recur by the Maintenance Director/Designee. The results of audits will be presented to the QAA committee for review and consideration of further corrective actions. The Maintenance Director/designee will be responsible for continuing compliance.	5/24/2021

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	Based on observation and interview, the facility failed to ensure the automatic sprinkler and standpipe systems are inspected, tested and maintained in accordance with NFPA 25, and records are readily available as required by 9.7.5, 9.7.7, 9.7.8 and NFPA 25. This deficient practice could affect 15 occupants in the event of a fire. Findings Include: On April 23, 2021, at approximately 10:45 AM observation revealed a ½ inch annular penetration around the sprinkler head in the Housekeeping hallway by the Elevator Room. This deficient practice could result in the inability of the sprinkler head to activate in the event of a fire. These findings were confirmed by the Maintenance Director at the time of discovery through interview.		5/24/21 Compliance	

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K0511 SS= D	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 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure equipment using gas or gas-related piping complies with NFPA 54, and electrical wiring and equipment complies with NFPA 70, as required by 19.5.1.1, 9.1.1 and 9.1.2. This deficient practice could affect 2 occupants in the event of an emergency. Findings Include: On April 23, 2021, at approximately 11:50 AM observation revealed storage of a gas grill and a kitchen slicer less than 3 feet from the electrical panels in the Mechanical Room. NEC 70 Table 110.26(A)(1) requires 3 foot of clearance in front of working spaces. These findings were confirmed by the Maintenance Director at the time of discovery through interview.	K0511	Access to the electrical panels has been cleared on 5/19/21 by the Maintenance Director. No residents were affected by this occurrence. The floor in front of the electrical panels will be taped to designate the area in front to not be blocked. In-serving has been done with the Maintenance department regarding safe access in utility areas to prevent a similar occurrence. Monthly rounding will be done to ensure access to the electrical panels by the maintenance department. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Maintenance Director/designee will be responsible for continuing compliance. 5/24/21 Compliance	5/24/2021

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K0712 SS= F	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions, are held at unexpected times under varying circumstances, conducted at least quarterly on each shift and responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership as required by 19.7.1.4 through 19.7.1.7. This deficient practice could affect all of the occupants in the event of a fire. Findings Include: On April 23, 2021, at approximately 9:40 AM record review revealed the facility failed to record the required quarterly fire drills for the 2nd shift 2nd and 4th quarters and the third shift 2nd quarter. These findings were confirmed by the Maintenance Director at the time of discovery through interview.	K0712	A schedule will be created to ensure that fire drills are conducted according to regulations and to prevent a further occurrence. No residents were affected by this occurrence. The policy has been reviewed and deemed appropriate. The schedule will be followed to ensure sustained compliance. The Administrator will confirm creation of the schedule upon completion and will review the schedule against the actual drills to ensure compliance. Drills will be reviewed monthly by the Administrator to ensure sustained compliance. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Maintenance Director/designee will be responsible for continuing compliance. 5/24/21 Compliance	5/24/2021

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K0912 SS= D	NFPA 101 Electrical Systems - Receptacles Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure power receptacles comply with the requirements of 6.3.2.2.6.2(F) and 6.3.2.4.2 of NFPA 99. This deficient practice could affect 1 occupant in the event of an electrical shock.. Findings Include: On April 23, 2021, at approximately 1:38 PM observation revealed the facility failed to have the 2nd floor West Lounge aquarium plugged into a GFCI outlet. This deficient practice creates an electrocution risk in a wet location. These findings were confirmed by the Maintenance Director at the time of discovery through interview.	K0912	A GFCI outlet has been installed to protect all residents residing in the facility by the maintenance department 5/14/21. No residents were affected by this occurrence. The policy was reviewed and deemed appropriate to prevent a recurrence. The Administrator will confirm the installation of the GFCI. The Maintenance Director will do building rounds monthly for three months or until compliance has been sustained. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Maintenance Director/designee will be responsible for continuing compliance. 5/24/21 Compliance	5/24/2021
K0918 SS= F	NFPA 101 Electrical Systems - Essential Electric Syste 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	K0918	A fuel quality analysis has been ordered for the emergency diesel generator to protect residents residing in the facility and will be done annually per requirements. No residents were affected by this occurrence.	5/24/2021

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	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 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: Based on record review and interview, the facility failed to ensure generators or other alternative power sources and associated equipment is capable of supplying service within 10 seconds, is maintained, inspected, tested and exercised in accordance with NFPA 110, and records are readily available as required by 6.4.4, 6.5.4 and 6.6.4 of NFPA 99, NFPA 110, NFPA 111 and		The policy was reviewed and deemed appropriate for sustained compliance. The Maintenance Director has been in-serviced on annual fuel quality analysis testing. Fuel analysis tests will be submitted to QAPI for review to ensure compliance. The Maintenance Director/designee will be responsible for continuing compliance. 5/24/21 Compliance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634560	A. BUILDING _____ B. WING _____	4/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	700.10 of NFPA 70. This deficient practice could affect all of the occupants in the event of a fire. Findings Include: On April 23, 2021 at approximately 10:36 AM during review of records, when asked for the emergency generator diesel fuel quality analysis the Maintenance Director replied, "I did not know that was a requirement." A fuel quality test shall be performed at least annually using tests approved by ASTM standards required by NFPA 110, 2010 Edition, section 8.3.8. These findings were confirmed by the Maintenance Director at the time of discovery through interview.			
K0920 SS= E	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	K0920	The power strips have been removed from the mini fridges in the Human Resources room and the Activity Room by the Maintenance Director on 4/23/21. Residents residing in the facility are at risk for a similar occurrence, no residents were affected by this occurrence. The policy has been reviewed and deemed appropriate for sustained compliance. Building rounds have been done to identify mini fridges with power strips and remove them if found to prevent a further occurrence. Monthly rounding will be done to identify mini fridges with power strips and remove them if found by the Maintenance Director/Designee. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Maintenance Director/designee will be responsible for continuing compliance.	5/24/2021

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	(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: Based on observation and interview, the facility failed to ensure power strips are listed for the area in which they are used as required by 10.2.3.6 of NFPA 99, 400-8 of NFPA 70 and TIA 12-5, and extension cords are placed in use only temporarily as required by 10.2.4 of NFPA 99 and 590.3(D) of NFPA 70. This deficient practice could affect 10 occupants in the event of a fire. Findings Include: On April 23, 2021, at approximately 1:10 PM observation revealed a mini fridge plugged into a power strip in the Human Resources room. On April 23, 2021, at approximately 1:31 PM observation revealed a mini fridge plugged into a power strip in the Activities' Room. These findings were confirmed by the Maintenance Director at the time of discovery through interview.		5/24/21 Compliance	
K0925 SS= E	NFPA 101 Gas Equipment - Respiratory Therapy Sources Gas Equipment - Respiratory Therapy Sources of Ignition Smoking materials are removed from patients receiving respiratory therapy. When a nasal cannula is delivering oxygen outside of a patient's room, no sources of ignition are within in the site of intentional expulsion (1-foot). When other oxygen deliver equipment is used or oxygen is delivered inside a patient's room, no sources of ignition are within the area are of administration (15-	K0925	A No Oxygen sign will be posted at the beauty salon on 5/14/21 by the Maintenance Director to protect current residents, no residents were affected by this occurrence. The policy has been reviewed and deemed appropriate for sustained compliance. A permanent sign has been ordered and will be hung to replace the temporary sign to prevent a further occurrence. The Administrator will confirm the sign posting upon completion.	5/24/2021

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	feet). Solid fuel-burning appliances is not in the area of administration. Nonmedical appliances with hot surfaces or sparking mechanisms are not within oxygen-delivery equipment or site of intentional expulsion. 11.5.1.1, TIA 12-6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure when oxygen is being used, all sources of ignition are eliminated as required by 11.5.1.1 and TIA 12-6 of NFPA 99. This deficient practice could affect 5 occupants in the event of a fire. Findings Include: On April 23, 2021, at approximately 11:45 AM observation revealed the facility failed to post the Beauty Salon with a No Oxygen use in Salon sign. Oxygen use near the heating elements in the hair dryers could potentially lead to a fire emergency that involves a resident. These findings were confirmed by the Maintenance Director at the time of discovery through interview.		Monthly spot checks to ensure the sign is appropriately hung will be done by the Maintenance Director to ensure sustained compliance. Audit will be done monthly for three months or until compliance is sustained. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Maintenance Director/designee will be responsible for continuing compliance. 5/24/21 Compliance	