STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345102	A. BUILDING **03 - MAGGIE VALLEY REPLACE NH** B. WING ______	**11/29/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAGGIE VALLEY NURSING AND REHABILITATION	**75 FISHER LOOP** **MAGGIE VALLEY, NC 28751**

(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 This Life Safety Code(LSC) survey was conducted utilizing the 2012 edition of the National Fire Protection Association (NFPA) 101 - Life Safety Code (LSC) and 2012 edition of the NFPA 99 - Health Care Facilities Code (HCFC) and its referenced publications. The facility plan/construction approval occurred prior to July 5, 2016. The facility is utilizing special locking systems. In the exit conference all LSC deficiencies noted were discussed and acknowledged with Administration. Stories: *** Construction Type: V(111) Constructed: 8/17/2011 Fully Sprinkled At time of survey the Licensed bed capacity = 114 Total Certified Bed Count = 114 Census = 104	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and/or documentation on Wednesday 11/29/2017 at 8:30 AM onward the following deficiencies were noted: The standard is non-compliant, specific findings include:	K 211	The plan for correcting the specific deficiency. Staff have been educated on how to release the magnetically locked exit doors with a master override switch at the nurses station and/or switch at the	1/13/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 12/17/2017

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 211	Continued From page 1 1. Staff when questioned in the rehab area and staff on the North Hall did not know how to release the magnetically locked exit doors with the master override switch at the nurse station and/or switch at the door. As specified according to 2012 NFPA 101: 19.7.3.2 "Health care occupancies that find it necessary to lock means of egress doors shall, at all times, maintain adequate staff qualified to release locks and direct occupants from the immediate danger area to a place of safety in case of fire or other emergency." This deficiency affected wntire facility. Failure to comply with minimum standards as referenced increases the risk of death due to smoke and or fire.	K 211	door. There were no other areas of the facility that would be affected by this deficient practice. The Maintenance Director will educate new employees during orientation and existing employees yearly to ensure that the employee fully understands how to release the magnetically locked exit doors with a master override switch at the nurses station and/or switch at the door. The Maintenance Director will educate new employees during orientation and existing employees yearly to ensure that the employee fully understands how to release the magnetically locked exit doors with a master override switch at the nurses station and/or switch at the door. A fire drill was conducted and staff were educated again at that time to 1. Check the exit doors to ensure they will open during a fire and 2. Ask if staff were aware of the method to release the magnetically locked exit doors with a master override switch at the nurses station and/or switch at the door. Instructions on the master override switch has been added to the employee orientation package. The education records will be brought to the monthly QAPI meeting by the Maintenance Director for review and recommendations during next QAPI Meeting and as needed.	
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101	K 324		1/13/18

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	345102	A. BUILDING **03 - MAGGIE VALLEY REPLACE NH** B. WING ____________	**11/29/2017**

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K 324	Continued From page 2 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 observations, staff interview, and/or documentation on Wednesday 11/29/2017 at 8:30 AM onward the following deficiencies were noted: The standard is non-compliant, specific findings include: 1. Staff when questioned were not familiar on how to activate the manual pull for the kitchen ansul system. NFPA 96: 10.5.7	K 324	The plan for correcting the specific deficiency. Dietary staff have been educated on how to activate the manual pull for the kitchen ansul system. There are no other areas in the facility that would be affected by this deficient practice. Dietary staff have been educated on how	

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	345102	A. BUILDING 03 - MAGGIE VALLEY REPLACE NH B. WING ______	11/29/2017

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MAGGIE VALLEY NURSING AND REHABILITATION	75 FISHER LOOP MAGGIE VALLEY, NC 28751

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K 324	Continued From page 3 2012 NFPA 101: 19.3.2.5; This deficiency affected one smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death due to smoke and or fire.	K 324	to activate the manual pull for the kitchen ansul system. New hires in the dietary department will be educated during orientation on how to activate the manual pull for the kitchen ansul system. Staff will be educated yearly on how to activate the manual pull for the kitchen ansul system. The education records will be brought to the monthly QAPI meeting by the Maintenance Director for review and recommendations during next QAPI Meeting and as needed.	
K 352 SS=D	Sprinkler System - Supervisory Signals CFR(s): NFPA 101 Sprinkler System - Supervisory Signals Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and/or documentation on Wednesday 11/29/2017 at 8:30 AM onward the following deficiencies were noted: The standard is non-compliant, specific findings include: 1. The supervisory signal for the electronically supervised tamper alarm on the sprinkler control	K 352	The supervisory signal for the electronically supervised tamper alarm on the sprinkler control valve at the Fire Alarm Control Panel alarms after five minutes and cannot be silenced permanently. There are no other areas of the facility	1/13/18

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	345102	A. BUILDING **03 - MAGGIE VALLEY REPLACE NH** B. WING ______	**11/29/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 352	Continued From page 4 valve at the Fire Alarm Control Panel (FACP) could be silenced permanently when the valve was in the closed position in the sprinkler riser room. Supervisory signals shall not be silenced permanently except by reopening/restoration of the valve to the normal operating position. Reference 2012 NFPA 101 Section 9.7.2.1 Where supervised automatic sprinkler systems are required by another section of this code, supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72, National Fire Alarm and Signaling Code, AND a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. Supervisory signals shall sound and shall be displayed at a location within the protected building that is constantly attended by qualified personnel. NFPA 101 Section 9.7.2.1, 9.7.2.1 NFPA 25: 13.3.3.5 NFPA 72: 17.16.1.1 This deficiency affected the entire facility. Failure to comply with minimum standards as referenced increases the risk of death due to smoke and or fire.	K 352	affected by this deficient practice. We have contacted Southern Sound Fire Safety and they will inspect the Fire Alarm Control Panel 12/18/17 to ensure that electronically supervised tamper alarm on the sprinkler control valve at the Fire Alarm Control Panel cannot be silenced permanently. The report from Southern Sound's inspection of the Fire Alarm Control Panel will be given to the Maintenance Director and the Administrator as well as being placed on the TELS System.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 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	K 353		1/13/18

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	345102	A. BUILDING **03 - MAGGIE VALLEY REPLACE NH** B. WING ______	**11/29/2017**

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K 353	Continued From page 5 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: Based on observations, staff interview, and/or documentation on Wednesday 11/29/2017 at 8:30 AM onward the following deficiencies were noted: The standard is non-compliant, specific findings include: 1. Upon reiew of the sprinkler inspection documentation dated 3/29/2017 the water flow time at the inspector test pipe was in excess of 60 seconds. Recorded time documented was 1-min. 47-seconds. Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, or other features shall thereafter be continuously maintained. Maintenance shall be provided in accordance with applicable NFPA requirements or requirements developed as part of a performance-based design, or as directed by the authority having jurisdiction. 2012 NFPA 101: 19.7.6; 4.6.12.1	K 353	VSC Fire & Security inspected the sprinkler system on 11/30/2017 to ensure that the water flow time at the inspector test pipe was not in excess of 60 seconds. A full trip test was performed by VSC Fire & Security on 11/30/17 on System #2 with no other issues identified. The pressure was adjusted to a pressure of 46 seconds to comply with Life Safety Standards. VSC Fire & Security will continue to service and maintain the sprinkler system on a quarterly basis and will report any descrepancies in flow time to the Maintenance Director. The maintenance director will monitor VSC to ensure the inspector test pipe was not in excess of 60 seconds by reviewing the inspection tag placed on the equipment by VSC before VSC leaves the premises. The Maintenance Director will provide documentation of the VSC Fire & Security inspections to the Administrator who will	

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K 353	Continued From page 6 Building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7, This deficiency affected 8 of 8 smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death due to smoke and or fire.	K 353	also place these inspections on the TELS System that is used by the facility for preventative maintenance.	
K 521 SS=D	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and/or documentation on Wednesday 11/29/2017 at 8:30 AM onward the following deficiencies were noted: The standard is non-compliant, specific findings include: 1. Facility could not provide documentation that the fire/smoke dampers assemblies have been tested to see if they will close as specified according to 2010 NFPA 80: 19:4; and 2010 NFPA 105: 6.5.2 smoke detector. NFPA 101: 19.5.2.1; 9.2	K 521	The facility has contracted with LSS Life Safety Services who will inspect and replace the fusible links on dampers and test the dampers to ensure the fire/smoke dampers assemblies will close. No other areas of the facility have been affected by this deficient practice. LSS Life Safety will be in the facility the last week of January 2018 or sooner if they are able to pull staff from other regions. We are waiting a on a response for a true date of inspection.	1/13/18

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	345102	A. BUILDING **03 - MAGGIE VALLEY REPLACE NH** B. WING ______	**11/29/2017**

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K 521	Continued From page 7 This deficiency affected entire facility. Failure to comply with minimum standards as referenced increases the risk of death due to smoke and or fire.	K 521	They will inspect and replace the fusible links on the dampers and test the dampers to ensure the fire/smoke dampers assemblies will close. The reports from the damper inspection will be given to the Maintenance Director as well as the Administrator and placed on the facility TELS System. The Administrator will also request that TELS adds this tasks to the preventative Maintenance schedule for January 2022.	
K 712 SS=E	Fire Drills CFR(s): NFPA 101 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 observations, staff interview, and/or documentation on Wednesday 11/29/2017 at 8:30 AM onward the following deficiencies were noted: The standard is non-compliant, specific findings include: 1. The facility failed to conduct fire drills at least quarterly per shift. A review of the facility's fire drill records for the 12 month revealed the facility	K 712	The Maintenance Director will follow the following schedule to perform fire drills and submit fire drill reports to the Administrator. January-Day Shift February-Evening Shift March Night Shift April-Day Shift	1/13/18

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	345102	A. BUILDING **03 - MAGGIE VALLEY REPLACE NH** B. WING ___________	**11/29/2017**

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K 712	Continued From page 8 acknowledged was unable to provide documented fire drill reports for all of the shifts. 3rd shift for September 2017 and 1st shift for October 2017 were missing. NFPA 101, (2012) Chapter 19, Existing Healthcare Occupancies, 19.7* Operating Features 19.7.1.4* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. 19.7.1.5 Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building. 19.7.1.6 Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. 19.7.1.7 When drills are conducted between 9:00 p.m. and 6:00 a.m. (2100 hours and 0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. This deficiency affected two out of twelve fire drills. Failure to comply with minimum standards as referenced increases the risk of death due to smoke and or fire.	K 712	May-Evening Shift June-Night Shift July-Day Shift August-Evening Shift September-Night Shift October-Day Shift November-Evening Shift December-Night Shift There are no other areas of the facility affected by this deficient practice. The Maintenance Director has been educated and understands that he will follow the above schedule to perform fire drills. The fire drill schedule has been sent to TELS to be placed on the task schedule to alert the maintenance director when the fire drill is due and what shift. The Fire Drill reports will be uploaded to the TELS System monthly and will be taken to the monthly QAPI Meeting for review and recommendations for 3 months and as needed. The Administrator will upload the Fire Drills to the TELS Program.	
K 918 SS=F	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	K 918		1/13/18

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	345102	A. BUILDING **03 - MAGGIE VALLEY REPLACE NH** B. WING ______	**11/29/2017**

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K 918	Continued From page 9 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 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 observations, staff interview, and/or documentation on Wednesday 11/29/2017 at 8:30 AM onward the following deficiencies were noted: The standard is non-compliant, specific findings include: 1. The remote generator annunciator located at	K 918	Nixon Power the facility's contracted generator company corrected the issue of the generator annunciator located at the nurse station that did not provide a signal for the battery charger AC and the battery charger is now providing that signal to the nurses station. 11/30/2017.	

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K 918	Continued From page 10 the nurse station did not provide a signal for battery charger AC failure when checked. 2012 NFPA 99: 6.4.1.1.16.2 (Table item O), 2. The specific gravity for open cell batteries or a conductance test for closed cell bateries for the emergency generator had not been recorded in the documentation. Reference 2012 NFPA 101, 2010 NFPA 110 8.3.7 Storage batteries, including electrolyte levels or battery voltage, used in connection with systems shall be inspected weekly and maintained in full compliance with manufacturer's specifications. 8.3.7.1 Maintenance of lead-acid batteries shall include the monthly testing and recording of electrolyte specific gravity. Battery conductance testing shall be permitted in lieu of the testing of specific gravity when applicable or warranted. This deficiency affected entire facility. Failure to comply with minimum standards as referenced increases the risk of death due to smoke and or fire.	K 918	There are no other areas of the facility affected by this deficient practice. When the Maintenance Director does the monthly generator test, he will drop the battery charger fuse and then go and check the annunciator panel to ensure that the signal for the battery charger AC is provided and document the results on the TELS Generator test task. The Maintenance Director will document on the generator test task that he has dropped the battery charger fuse and checked the annunciator panel to ensure that the signal for the battery charger AC is provided. The results of this test will be taken to QAPI for review and recommendations for 3 months and as needed.	
K 923 SS=D	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	K 923		1/13/18

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	345102	A. BUILDING **03 - MAGGIE VALLEY REPLACE NH** B. WING ______	**11/29/2017**

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MAGGIE VALLEY NURSING AND REHABILITATION	**75 FISHER LOOP** **MAGGIE VALLEY, NC 28751**

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K 923	Continued From page 11 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) This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and/or documentation on Wednesday 11/29/2017 at 8:30 AM onward the following deficiencies were noted: The standard is non-compliant, specific findings include: 1. In the South Hall nurse station oxygen storage room and unsecured oxygen cyclinder was found in the room. FPA 99 11.6.2.3 (11) Freestanding cylinders shall be properly chained or supported in a proper cylinder stand or cart.	K 923	The staff have been educated that oxygen cylinders must be secured with a chain, or proper cylinder stand or cart. Oxygen cylinders were audited and no other cylinders were found to be stored improperly. Staff have been educated on the proper storage of oxygen cylinders. The Staff Development Coordinator educates new hires during orientation and twice yearly that oxygen cylinders will be secured in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345102	A. BUILDING **03 - MAGGIE VALLEY REPLACE NH** B. WING	**11/29/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 923	Continued From page 12 This deficiency affected one of three smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death due to smoke and or fire.	K 923	the provided cylinder stand. The Administrative Nurses are auditing the oxygen storage room 5 x a week to ensure the oxygen cylinders are properly stored and educating as needed. The audit results will be taken to QAPI monthly x 3 months for review and recommendations.	