STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345441	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/05/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEXANDRIA PLACE	**1770 OAK HOLLOW ROAD** **GASTONIA, NC 28054**

(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: one Construction Type: 3(211) Constructed: 7/7/1993 Fully Sprinkled YES At time of survey the Licensed bed capacity 100 Total Certified Bed Count = 100 Census = 88	K 000		
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101 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	K 341		1/19/18

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

Electronically Signed | 01/17/2018

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K 341	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and/or documentation on 01/05/2018 at 9:30 AM through 2:00 PM the following deficiencies were noted: The standard is non-compliant, specific findings include: 1.The facility had two ceiling smoke detectors mounted closure than 3 feet to a ceiling HVAC return and/or supply grilles Smoke detector # 32 and #13. 2. The facility was missing documentation of every 2 year smoke detector sensitivity test. NFPA 101, 19, 9.6, NFPA 72, NFPA 70 This deficiency affected 2of 8 smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death due to smoke and or fire.	K 341	ALEXANDRIA PLACES RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW What corrective action(s) will be accomplished by the facility to correct the deficient practice and what led to the deficient practice: Alexandria Place will move Smoke detector #32 and #13 three feet away from a ceiling HVAC return and/or supply grilles. It has been determined that when the smoke detectors were installed, NFPA regulations were not properly maintained. The two year smoke detector sensitivity test was completed on 1/16/18. How will you identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this practice. All smoke detectors were checked for compliance to be at least three feet away from ceiling HVAC returns and/or supply grilles. This was completed on 1/11/18. The two ear smoke detector sensitivity test was completed and revealed no concerns. The facility determined that all other smoke	

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K 341	Continued From page 2	K 341	detectors were in compliance at this time. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur: The maintenance supervisor will audit all smoke detectors monthly for one year and then annually thereafter to ensure they are in proper compliance for K341. The maintenance supervisor will also audit future installations of smoke detectors to ensure they are in proper compliance for K341. The maintenance supervisor will complete annual audits of documentation for the two year smoke detector sensitivity test to ensure it is completed every two years. When a smoke detector needs to be replaced, the maintenance supervisor will ensure that it is in compliance. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place. The monthly an annual maintenance reports will be turned into the Quality Assurance committee on a quarterly basis for review and determination if additional action or amended action is necessary to ensure prompt follow up and/or repair completion. The Quality Assurance committee with be charged with the responsibility to ensure that correction is achieved and sustained.	
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than	K 363		1/19/18

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K 363	Continued From page 3 required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that 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: Based on observations, staff interview, and/or documentation on 01/05/2018 at 9:30 AM	K 363	ALEXANDRIA PLACES RESPONSE TO THIS REPORT OF SURVEY DOES NOT	

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K 363	Continued From page 4 through 2:00 PM the following deficiencies were noted: The standard is non-compliant, specific findings include: 1. One of the fire rated doors in the pair of cross corridor doors near rehab would not self latch. NFPA 101, 19.3.6.3, 7.2, 8.3 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 363	DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW What corrective action(s) will be accomplished by the facility to correct the deficient practice and what led to the deficient practice: Alexandria Place repaired the fire rated door in the pair of cross corridor doors near rehab. The deficient door will self latch to comply with NFPA 101, 19.3.6.3, 7.2, 8.3. The repair was completed on 1/9/18 by N2 Fire Protection. How will you identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this practice. All fire doors in the facility were tested to ensure they self latch on 1/11/18. It was determined that all other fire doors were in compliance with NFPA 101, 19.3.6.3, 7.2, 8.3. It was also determined that the deficient door did not self latch due to a lapse in fire rated door audits. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur: The maintenance supervisor will audit all fire rated doors to ensure they self latch to comply with NFPA 101, 19.3.6.3, 7.2, 8.3. On a monthly basis the maintenance supervisor will audit all fire rated doors to	

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K 363	Continued From page 5	K 363	ensure they are self latching. This will be done along with monthly fire drills. Any door needing corrective action will be corrected at the time of the audit. The maintenance supervisor will record his findings and bring them to the quarterly Quality Assurance meetings. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The quarterly maintenance reports will be turned into the Quality Assurance committee on a quarterly basis for review and determination if additional action or amended action is necessary to ensure prompt follow up and or repair. The Quality Assurance committee with be charged with the responsibility to ensure that correction is achieved and sustained.	
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 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	K 372		1/19/18

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K 372	Continued From page 6 by: Based on observations, staff interview, and/or documentation on 01/05/2018 at 9:30 AM through 2:00 PM the following deficiencies were noted: The standard is non-compliant, specific findings include: 1. The facility had unsealed penetrations in the smoke fire barrier wall in the attic above the cross corriodr doors near room 122. NFPA 101, 19.3.7.3, 8.6.7.1, 8.5 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 372	ALEXANDRIA PLACES RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW What corrective action(s) will be accomplished by the facility to correct the deficient practice and what led to the deficient practice: Alexandria Place repaired the unsealed penetrations in the smoke fire barrier wall in the attic above the cross corridor doors near room 122 on 1/12/18 with NFPA approved foam sealer. It was determined that after new camera wires were run that the penetrations were not re-sealed. How will you identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this practice. All smoke fire barrier walls were audited on 1/12/18 to ensure they are in compliance and do not have an unsealed penetrations. At that time all other smoke fire barrier walls were in compliance with K372 and did not have any unsealed penetrations. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur: The maintenance supervisor will audit all	

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K 372	Continued From page 7	K 372	smoke fire barrier walls monthly for one year and quarterly thereafter to ensure that all smoke fire barrier walls do not have any unsealed penetrations and are in compliance with K372. Any future work requiring penetration of the fire barrier walls in the attic will be monitored by the maintenance supervisor and all holes will be sealed with approved foam once work has been completed. Any smoke barrier wall needing corrective action will be corrected at the time of the audit. The maintenance supervisor will record his findings and present them to the quarterly Quality Assurance meeting. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The quarterly maintenance reports will be turned into the Quality Assurance meeting on a quarterly basis for review and determination if additional action or amended action is necessary to ensure prompt follow up/repair completion. The Quality Assurance committee will be charged with the responsibility to ensure that correction is achieved and sustained.	
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	K 521		1/19/18

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K 521	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and/or documentation on 01/05/2018 at 9:30 AM through 2:00 PM the following deficiencies were noted: The standard is non-compliant, specific findings include: 1. The facility was missing documentation of every 4 year fire/smoke damper test and maintenance. NFPA 101, 19.5.2.1, 9.2, NFPA 90 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 521	ALEXANDRIA PLACES RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW What corrective action(s) will be accomplished by the facility to correct the deficient practice and what led to the deficient practice: On 1/15/18 the 4 year fire/smoke damper test was completed by N2 Fire Protection. The fire/smoke damper test has been scheduled to be completed every 4 years with N2 Fire Protection. It was determined that turnover in the maintenance position caused a lapse in paperwork follow through. How will you identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this practice. The fire/smoke damper test was completed by N2 Fire Protection on 1/15/18 as required. The fire/smoke damper test has been scheduled to be completed every 4 years with N2 Fire Protection. The Maintenance Supervisor will keep logs of the 4 year	

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K 521	Continued From page 9	K 521	fire/smoke damper test. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur: The Maintenance Supervisor will complete monthly audits of all fire/smoke damper test documentation for one year and then will audit the documentation annually thereafter. A separate log will be maintained, as a back up for documentation, in the Administrators office. The maintenance director will maintain logs of documentation audits and will report them in the quarterly Quality Assurance meetings. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The completed monthly audits logs will be reviewed in the quarterly Quality Assurance meetings to ensure the fire/smoke damper test is completed as required. The Quality Assurance Committee will be charged with the responsibility to ensure that correction is achieved and sustained.	
K 712 SS=D	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	K 712		1/19/18

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K 712	Continued From page 10 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 01/05/2018 at 9:30 AM through 2:00 PM the following deficiencies were noted: The standard is non-compliant, specific findings include: 1. The facility was missing fire drills 1 per shift per quarter for 2017, they only had fire drills for Sept., Nov. and December of 2017. NFPA 101, 19.7.1 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 712	ALEXANDRIA PLACES RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW K712 What corrective action(s) will be accomplished by the facility to correct the deficient practice and what led to the deficient practice: On 1/10/18 The maintenance supervisor created a new log for fire drills completed once per shift per quarter to better reflect and keep track of required fire drills. The missing fire drill was completed on 1/12/18 and added to the log. The log will be maintained monthly by the maintenance supervisor. It was determined that turnover in the maintenance position caused a lapse in paperwork follow through. How will you identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this practice. The maintenance supervisor will audit the fire	

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K 712	Continued From page 11	K 712	drill log monthly to ensure drills are being completed as required. Any fire drill noted to be missed will be completed at the time of the audit. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur: The maintenance supervisor will complete monthly audits of the fire drill log. A separate long will be maintained in the Administrators office as back up for documentation. The fire drill audits will be reviewed by the quarterly Quality Assurance meeting. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The completed monthly fire drill audits will be reviewed in the quarterly Quality Assurance meetings. The Quality Assurance Committee will ensure that all fire drill are completed and documented as required. The Quality Assurance Committee will be charged with the responsibility to ensure that correction is achieved and sustained.	
K 912 SS=D	Electrical Systems - Receptacles CFR(s): NFPA 101 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	K 912		1/19/18

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K 912	Continued From page 12 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 observations, staff interview, and/or documentation on 01/05/2018 at 9:30 AM through 2:00 PM the following deficiencies were noted: The standard is non-compliant, specific findings include: 1. The med refrigerator was not plugged into an emergency powered recepticle in the med room adjacent the beauty shop. NFPA 101, NFPA 70 This deficiency affected 8 of 8 smoke compartments. Failure to comply with minimum standards as referenced increases the risk of injury and/or death due possiblity of medication not being stored at correct temperature.	K 912	ALEXANDRIA PLACES RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW K912 What corrective action(s) will be accomplished by the facility to correct the deficient practice and what led to the deficient practice: The emergency power receptacle in the med room will be replaced by Alexandria Place on 1/17/18. It was determined that when the refrigerator was placed in the med room that there was a failure to complete an assessment for compliance with K912. How will you identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this practice. All medication refrigerators in the facility will be audited to ensure they are plugged into emergency power receptacles. If an emergency power receptacle is warranted, it will be completed by 1/17/18. What measures will be put into place or	

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K 912	Continued From page 13	K 912	what systemic changes will you make to ensure that the deficient practice does not recur: The maintenance supervisor will audit all medication refrigerators are plugged into an emergency power receptacle monthly. He will record his findings and report them to the quarterly Quality Assurance meeting. If any receptacle is found to need repair or replacement, it will be repaired or replaced at the time of the finding. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The monthly audits will be turned into the Quality Assurance committee for review and determination if additional action or amended action is necessary and to ensure prompt follow up/repair completion. The Quality Assurance committee will be charged with the responsibility to ensure that correction is achieved and sustained.	
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	K 918		1/19/18

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K 918	Continued From page 14 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 01/05/2018 at 9:30 AM through 2:00 PM the following deficiencies were noted: The standard is non-compliant, specific findings include: 1. The facility was missing documentation of generator 4 hour run time every 3 years. 2. The facility was missing documentation of annual load bank test.	K 918	ALEXANDRIA PLACES RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW K918 What corrective action(s) will be accomplished by the facility to correct the deficient practice and what led to the	

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K 918	Continued From page 15 3. The facility was missing documentation of generator transfer switches being exercisesed each month and documentation of generator battery voltage or specific gravity being checked and documented each month. 4. The facility generator annunciator panel did not show loss of generator battery charger AC power when generator battery charger breaker was turned off. NFPA 101, 19, NFPA 99, NFPA 110 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 918	deficient practice: The 4 hour generator run was completed by Kraft Power on 1/9/18. The annual load bank test was also completed by Kraft power on 1/9/18. Transfer switches were assessed and the generator battery was checked along with the battery voltage and specific gravity on 1/9/18. The generator annunciator panel will be serviced and complaint by 1/19/18. How will you identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this practice. The 4 hour generator run, annual load bank test, transfer switches, generator battery, battery voltage and specific gravity and the generator annunciator panel will be audited to be sure they are in compliance for K918 and to ensure they are being checked monthly. The audit will be completed by 1/19/18. If any repairs or replacements are needed, they will be done at the time of the audit. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur: The maintenance supervisor will complete annual checks for the 4 hour generator run and as well and the annual load bank test. This will be added to the generator monthly documentation. The transfer switches, generator battery voltage and specific gravity and the generator	

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K 918	Continued From page 16	K 918	annunciator panel will be audited monthly to ensure they are in proper working condition and are in compliance with K918. These audits will be added to the monthly generator documentation and audit form to ensure they are in proper working condition and in compliance with K918. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The monthly documentation reports will be turned into the Quality Assurance committee monthly for review and determination if additional action or amended action is necessary to ensure prompt follow up/repair completion. The Quality Assurance committee will be charged with the responsibility to ensure that correction is achieved and sustained.	
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	K 923		1/19/18

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K 923	Continued From page 17 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 01/05/2018 at 9:30 AM through 2:00 PM the following deficiencies were noted: The standard is non-compliant, specific findings include: 1. The facility had O2 cylinders stored outdoors in an enclosed shed; the facility did not label and separate full and empty cylinder(s) locations in the shed. 2.The cylinders were stored within 5 feet of electrical recepticle and panel/ breaker box on the right side of the shed near the front door of the	K 923	ALEXANDRIA PLACES RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW K923 What corrective action(s) will be accomplished by the facility to correct the deficient practice and what led to the deficient practice:	

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K 923	Continued From page 18 shed. 3.One E cylinder and several smaller O2 cylinders were stored unsecured in the shed just standing upright and not in a proper individual safe storage racks. NFPA 101, 19, NFPA 99 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 923	The O2 cylinder shed was labeled with separate full and empty signs on 1/11/18. The O2 cylinders were moved 5 feet away from the electrical receptacle and panel/breaker box on the right side of the shed on 1/11/18. The small O2 cylinders and E cylinder were secured and stored in proper individual safe storage racks on 1/11/18 and 1/12/18. How will you identify other life safety issues having the potential to affect residents by the same deficient practice and what corrective action will be taken: All residents have the potential to be affected by this practice. All O2 cylinders and the O2 cylinder shed was audited to ensure it was in compliance with K923. The cylinders were properly labeled, 5 feet away from the electrical receptacle and panel/breaker box, and securely stored in individual safe storage racks. This audit was completed on 1/12/18. If any repairs or replacements were needed, it was completed at the time of the audit on 1/12/18. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur: The maintenance supervisor will audit all O2 Cylinder storage for correct signs, 5 feet away from the electrical receptacle and panel/breaker box, and safe storage racks monthly and record and report findings to the quarterly Quality Assurance meeting. If any repairs or replacements are warranted, they will be completed at	

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K 923	Continued From page 19	K 923	the time of the monthly audit. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place: The monthly reports will be turned into the Quality Assurance committee on a monthly basis for review and determination if additional action or amended action is necessary and to ensure prompt follow up/repair completion. The Quality Assurance committee will be charged with the responsibility to ensure that correction is achieved and sustained.	