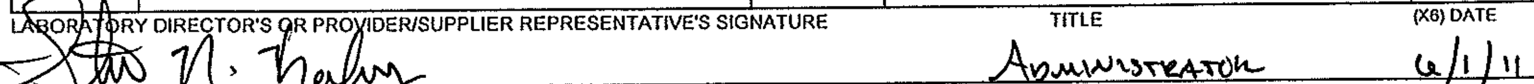
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING JUN 0 3 2011 B. WING	04/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

(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
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observations, record review, interviews facility failed to honor a diet request by a resident for 1 of 3 sampled residents. (Resident #177) Findings include: Resident #177 was admitted to the facility on 4/3/09 and re-admitted on 8/23/10. Diagnoses included Cerebral artery Occlusion, Cardiovascular accident with left hemiparesis and Hypertension. A review of the admission physician orders dated 4/3/09 revealed the resident was on a regular diet. A review of dietary notes dated 4/15/09 revealed the residents diet was down graded to mechanical soft because of dental issues. A review of the annual Minimum Data Set dated 3/7/11 revealed Resident #177 had long and short term memory problems. Cognitive skills for daily decision making were decisions poor, cues/supervision required. The functional ability for eating was set up only.	F 246	**This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.** **F246** **Corrective action to be accomplished for those residents found to have been affected by the deficient practice:** Resident #177 was upgraded to a regular diet on 4/20/11 and followed by speech therapy to ensure a regular diet was appropriate. **Corrective action to be accomplished for those residents having potential to be affected by the same deficient practice:** The facility recognizes that all residents have the potential to be affected by the alleged deficient practice. The facility screened all residents on downgraded diets to ensure diet residents are currently on are the most appropriate diet for that resident.	5/9/11



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6/1/11

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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F 246	Continued From page 1 An interview with a family member on 4/12/11 at 5:03pm revealed the resident was on a mechanical soft diet because he had a stroke and can only use one hand. Further discussion revealed that the facility had been asked several times to change his diet to regular and she was told that because he had the use of only one hand he had to remain on a soft diet. The person told her that if chicken was served he would not be able to get the meat off the bone. The family member could not remember who she talked with. The family member also stated when she takes the resident out of the facility he eats tacos, steaks and hamburgers without any problem and could not understand why the facility would not change his diet. An interview with the dietary staff member who changed the residents diet 4/13/11 at 3:00pm revealed that she down graded his diet because she was concerned about missing teeth. The dietary staff stated there was no speech therapy evaluation requested to confirm the need to change the residents diet due to eating problems. She did not remember a family member ever requesting the diet to be changed to a regular diet. The family could have talked with the speech therapist who is not her any more. "He had a rule of thumb that was if a resident could not cut his meat they stayed on chopped meat." The dietary staff indicated that the resident would answer questions by shaking his head yes or no as after his stroke he could not speak or use his left arm. The DON was present during the interview and confirmed the residents ability to answer simple questions with a shake of his head to indicated yes or no. The DON also stated she could not remember a	F 246	**F246 Cont.** **Measures to be put into place or systemic changes made to ensure that the deficient practice will not occur:** 1. The facility will conduct interviews on a sample of residents, which will include new residents, to ensure that the facility is honoring resident diet requests. 2. In the event a resident has a status change, the resident will be screened by Speech Therapy to ensure appropriateness of residents diet request. 3. For residents on downgraded diets, they will be screened by Speech Therapy during their quarterly review to ensure current diet is appropriate. The Rehab Manager will be responsible for ensuring the screens are completed by Speech Therapy. **Monitoring Process** 1. Interviews on 10% of the resident population will be performed by the DON and/or Clinical Nutritionist to ensure resident diet requests are honored. 2. The interviews will be conducted monthly for three months and then quarterly. 3. The Speech Therapy screens will be conducted quarterly on residents with downgraded diets 4. The results of the resident interviews and screens will be reviewed during the facility's QA meeting.	

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F 246	Continued From page 2 family member asking to change the residents diet to regular. On 4/13/11 at 4:16pm asked resident if he liked the meat chopped and he shook his head no. When asked if wanted his meat chopped he said no.	F 246	**F272** **Corrective action to be accomplished for those residents found to have been affected by the deficient practice:** Restraint Assessment was performed by the DON for resident #132. Restraint Assessment results indicated that current restraint is appropriate for resident #132.	5/9/11
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum	F 272	**Corrective action to be accomplished for those residents having potential to be affected by the same deficient practice:** All residents, currently with restraints, will be assessed by the DON and/or Unit Manager to ensure restraint is appropriate for resident. **Measures to be put in place or systemic changes made to ensure that the deficient practice will not occur:** 1. All new admissions are reviewed in the nursing meeting following admission. If it is found that the new resident needs restraining, a restraint evaluation form will be completed prior to initiating the restraint. 2. After the restraint is initiated, a rehab referral is submitted to ensure the restraint initiated is the least restrictive. 3. A Restraint Evaluation and Consent form will be attached to the Incident and Accident report to be completed if a restraint was put in place as a result of a resident status change.	

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F 272	Continued From page 3 Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to assess the use of a merri-walker for 1 of 3 sampled residents with a physical restraint. Resident #132. Findings included: Resident #132 was admitted to the facility on 3/16/07 with diagnoses which included: Alzheimer's disease; ischemic attacks; pulmonary fibrosis; hypertension; hyperlipidemia; thyroid disorder; glaucoma; and depression. Review of the annual MDS (Minimum Data Set) dated 1/11/11 indicated Resident #132 had short and long term memory problems with severely impaired decision-making skills. The MDS revealed the resident required extensive assistance of two people for bed mobility and transfers. The MDS also indicated the resident used a walker for mobility, but did not have use of any type of restraint. The review of the updated Care Plan dated 1/18/11 indicated due to Resident #132's impaired mobility related to muscle weakness, cognitive deficits, and vision problems, the	F 272	**F272 Cont.** **Monitoring Process:** 1. The DON will assess residents in restraints to ensure that the restraint remains appropriate. 2. The restraint assessments, by the DON, will be conducted monthly for three months and then quarterly. 3. Results of the assessments will be reviewed in facility's QA meetings.	

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F 272	Continued From page 4 resident required assistance into the merri-walker everyday. On 4/11/11 at 4:20pm, Resident #132 was observed in a merri-walker with a strap between her legs, ambulating in the hallway near the nursing station. On 4/13/11 at 10:15am, Resident #132 was observed sitting down in the merri-walker, near the nursing station. During an interview on 4/13/11 at 10:29am, NA#1 (Nursing Assistant) revealed Resident #132 had been using the merri-walker for ambulation for at least two years; and, the resident was not currently receiving physical therapy. NA#1 stated that the resident was unable to release or get out of the merri-walker, unassisted. During an interview on 4/13/11 at 11:04am, SN#2 (Staff Nurse) indicated Resident #132 was weight-bearing and was able to transfer with the assistance of one person. SN#2 also stated that the resident was not able to get out of the merri-walker, unassisted. There was no documentation available indicating Resident #132 had been assessed for the use of the merri-walker. During an interview on 4/13/11 at 3:33pm, the MDS Coordinator confirmed Resident #132 had not been assessed for the use of the merri-walker. The MDS Coordinator stated that the merri-walker was not a restraint for the resident, but allowed the resident to be more mobile.	F 272		

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F 272	Continued From page 5 During an interview on 4/13/11 at 4:00pm, the DON (Director of Nursing) stated that Resident #132 had been in the merri-walker since prior to her (DON) working at the facility. The DON confirmed the resident was unable to voluntarily get out of the merri-walker, unassisted. The DON revealed the resident had not been assessed for the use of the merri-walker because the facility did not consider the merri-walker a restraint since it enabled the resident to move around freely.	F 272	**F 282** **Corrective action to be accomplished for those residents found to have been affected by the deficient practice:** Resident #180's shunt site was assessed by the DON to ensure it was working properly. **Corrective action to be accomplished for those residents having potential to be affected by the same deficient practice:** All dialysis residents' shunt sites were assessed by the DON to ensure they were working properly. **Measures put into place or systemic changes made to ensure that the deficient practice will not occur:** 1. Facility implemented a Post-Dialysis Log 2. All nurses were in-serviced on the use of the Post-Dialysis Log and proper method of monitoring and assessing the shunt sites for dialysis residents. **Monitoring Process** 1. Audit of the Post-Dialysis Logs for all dialysis residents will be conducted once a week for 3 months and then quarterly by the DON and/or Unit Manager. 2. Results of the Weekly and Quarterly Post-Dialysis Log Audits will be reviewed in facilities QA meeting.	5/9/11
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interviews the facility failed to ensure the care plan was followed for one of one sampled residents receiving Dialysis (Resident #180). Findings include: Resident #180 was admitted to the facility on 3/16/2011 with diagnoses that included End Stage Renal Disease (ESRD) on Dialysis Monday, Tuesday, Thursday, and Saturday. The Admission Minimum Data Set (MDS) dated 3/26/2011 indicated that Resident #180 was cognitively intact and had a diagnosis of ESRD. In an interview on 4/11/2011 at 4:30 pm Resident #180 was found to be alert and oriented to person, place, time, and events and to be cognizant of her health care needs. On 4/12/2011	F 282		

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F 282	Continued From page 6 at 9:25 am, in a staff interview, Nurse #2 stated that Resident # 180 was oriented to person, place, time and events. The Care Plan dated 3/29/2011 for Dialysis specified that the (dialysis access) shunt site should be monitored for signs and/or symptoms of infection such as redness at the site, increased temperature, drainage, or fever. It also included monitoring the site for thrill and bruit (feeling a strong pulse over the site, and hearing a whooshing sound with a stethoscope at the site). Departmental Notes which included Nurses' Notes and Nurses' 24 hour Summary Notes from 3/17/2011 through 4/12/2011 reviewed revealed only one Nurses' Note dated 3/29/2011 documenting the shunt site being monitored for thrill and bruit. The note read in part "resident has an AV fistula (arterial/venous shunt) in left arm with positive bruit/thrill." On 4/13/2011 at 2:09 pm Nurse # 1 stated in an interview that the checking of the dialysis shunt site should be done before and after dialysis and would be documented in the Nurses' Notes or the Nurses' 24 hour Summary Note. Asked if there was a form or other documentation to record the shunt site checks, Nurse # 1 stated no there wasn't. In an interview on 4/13/2011 at 3:20 pm Resident #180 stated that no one in the facility checked the thrill and bruit for her dialysis shunt site. She also indicated that the nurse at the dialysis center checked it when she went for dialysis and she checked the thrill herself daily.	F 282		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP	F 364		

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F 364	Continued From page 7 Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on 3 of 3 sampled resident interviews, and 2 of 2 test tray observations, the facility failed to provide meals that were palatable and served at appropriate temperatures. (Residents #82, #191, #297). Findings included: Review of the Resident Council Meeting Minutes from October 2010 through March 2011 revealed no concerns with the temperatures and palatability of the foods served by the facility. There were also no documented food complaints noted in the facility's Grievance Logs reviewed from February 2011 through April 2011. During an interview on 4/11/11 at 4:12pm, Resident #191 revealed that most of the time the food is served cold, especially breakfast. During an interview on 4/11/11 at 4:46pm, Resident #82 stated that the food served to her in her room was either cold or lukewarm, primarily breakfast. During an interview on 4/12/11 at 11:14am, Resident #297 stated "the food tastes nasty and looks nasty". The resident revealed the eggs,	F 364	F364 **Corrective action to be accomplished for those residents found to have been affected by the deficient practice:** 1. New kitchen equipment ordered 2. Convection warmer ordered for wax pellets which will keep food temps at appropriate temperatures during transit from kitchen to resident. **Corrective action to be accomplished for those residents having potential to be affected by the same deficient practice:** The facility will provide meals that are palatable and at proper temperatures. **Measures put into place or systemic changes made to ensure that the deficient practice will not occur:** 1. Facility hired new Director of Dining Services. 2. New kitchen equipment ordered. 3. Convection warmer ordered for wax pellets which will keep food temps at appropriate temperatures during transit from kitchen to resident. 4. Staff was educated and will continue to be educated by new Director of Dining Services in regards to the proper methods of preparing food so that it is presentable and palatable.	5/12/11

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F 364	Continued From page 8 toast and coffee were served cold every morning. During an observation of the meal tray serving line in the kitchen on 4/14/11 at 7:09am, the temperatures of the hot food items (scrambled and pureed eggs, oatmeal, grits, and coffee) were above 135 degrees Fahrenheit. The temperature of the milk and nectar thickened orange juice were below 40 degrees Fahrenheit. The plates were maintained in a plate warmer next to the meal serving line until used. Stainless steel pellet inserts were also kept in the plate warmer, but because of their irregular fit, the inserts did not heat properly. The eggs and toast were placed on heated plates and covered with dome-shaped lid/bottom covers with the metal inserts; then placed on individual meal service trays. The meal service trays were placed in 6-open-sided and 6-closed stainless steel delivery carts. On 4/14/11 at 8:20am, a meal test tray observation was conducted, after the last meal tray was served to a resident on the 300 hall of Unit C. Temperatures were taken and food items of regular and pureed consistencies were tasted for palatability on a test meal tray with the assistance of the Dietary Manager. The temperatures of the scrambled and pureed eggs, oatmeal, and grits ranged from 119 degrees Fahrenheit to 134 degrees Fahrenheit. The coffee was 147 degrees Fahrenheit and the milk was 45 degrees Fahrenheit. During the taste testing, the scrambled eggs were lukewarm to taste; the pureed eggs were warm; the oatmeal and the grits (which were in covered bowls) were warm; and the coffee was hot to taste. The milk was cold and had a good flavor. On 4/14/11 at 8:23am, a second meal test tray	F 364	**F364 Cont.** **Monitoring Process** 1. A food temperature audit, measuring food temperatures from food leaving the kitchen to when it is delivered to the resident, will be conducted at least three times per week for four weeks and then quarterly by the Director of Dining Services. This audit is to verify the effectiveness of the wax pellet's ability to maintain food temperatures. 2. Interviews with 10% of the resident population will be performed by the DON and/or Clinical Nutritionist to ensure the palatability of resident meals. 3. The interviews will be conducted monthly for three months and then quarterly. 4. The results of the interviews and audits will be brought to the facility's quarterly QA meetings.	

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F 364	Continued From page 9 observation was conducted, after the last meal tray was served to a resident on the 100 hall of Unit A. Temperatures were taken and food items of regular consistencies were tasted for palatability on a test meal tray with the assistance of the Administrator. The scrambled eggs were 99 degrees Fahrenheit and tasted lukewarm. The grits tasted hot at 130 degrees Fahrenheit and the sliced bread was lukewarm, brown in color but not toasted. The milk was cold at 47 degrees Fahrenheit and the coffee was hot at 137 degrees Fahrenheit. During an interview on 4/14/11 at 3:00pm, the Administrator revealed it was brought to his attention approximately 30-60 days ago that there were problems with the facility's food service. He indicated some of the complaints regarding cold food were probably related to the ineffectiveness of the plate warmer used to heat the pellet inserts for the domed lid covers. The Administrator revealed that the facility was in the process of obtaining bids for new food service equipment and would soon be initiating a fine dining program.did not know issue with the tray distribution	F 364		

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OMB NO. 0938-0391

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	345443	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	05/18/2011

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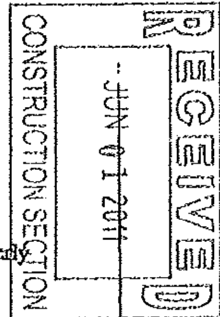
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following, 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation, on May 18, 2011 at approximately 1:00pm onward, there is a hole in the roof/ceiling assembly in room A405 - the hole is located at the sprinkler pipe penetration. 42 CFR 483.70(a)	K 012	K012 **Corrective action accomplished by the facility to correct the deficient practice:** The Director of Facility Services repaired the hole in the roof/ceiling assembly in room A405. **Corrective action to be accomplished for those residents having potential to be affected by the same deficient practice:** The Director of Facility Services inspected all sprinkler heads to ensure that there were not any holes in the roof/ceiling assemblies. **Measures put into place or systemic changes made to ensure that the deficient practice will not occur:** The Director of Facility Services will inspect all sprinkler heads to ensure that there are not any holes in the roof/ceiling assemblies. **Monitoring Process** 1. The inspection of the all sprinkler heads will be conducted monthly for 3 months, and then quarterly by the Director of Facility Services. 2. The results of the inspections will be discussed in facility's QA meeting.	5/20/11
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, on May 18, 2011 at approximately 2:00pm onward, there is a wedge under the mechanical room door near room 308. 42 CFR 483.70(a)	K 029		5/18/11



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 6/1/11

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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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

(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 076 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, on May 18, 2011 at approximately 2:00pm onward, there are unsupported oxygen cylinders stored in the mechanical room near room 308. 42 CFR 483.70(a)	K 076	K029 **Corrective action accomplished by the facility to correct the deficient practice:** The wedge under the mechanical room door near room 308 was removed. **Corrective action to be accomplished for those residents having potential to be affected by the same deficient practice:** The Director of Facility Services inspected all doors to ensure there were not any wedges holding them open. **Measures put into place or systemic changes made to ensure that the deficient practice will not occur:** The Director of Facility Services will inspect all doors to ensure there are not any wedges holding them open. **Monitoring Process** 1. The inspection of all doors will be conducted monthly for 3 months, and then quarterly by the Director of Facility Services. 2. The results of the inspections will be discussed in the facility's QA meeting.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345443	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	05/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK FOREST HEALTH AND REHABILITATION	5680 WINDY HILL DRIVE WINSTON SALEM, NC 27105

(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 076 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation, on May 18, 2011 at approximately 2:00pm onward, there are unsupported oxygen cylinders stored in the mechanical room near room 303. 42 CFR 483.70(a)	K 076	K076 **Corrective action accomplished by the facility to correct the deficient practice:** The unsupported oxygen cylinders in mechanical room near room 308 were placed in supported oxygen cylinder racks. **Corrective action to be accomplished for those residents having potential to be affected by the same deficient practice:** The Director of Facility services inspected all areas where oxygen cylinders are stored to ensure they were in supported oxygen cylinder racks. **Measures put into place or systemic changes made to ensure that the deficient practice will not occur:** The Director of Facility Services will inspect all areas where oxygen cylinders are stored to ensure that oxygen cylinders are being placed in supported oxygen cylinder racks. **Monitoring Process** 1. The inspection of all the areas where oxygen cylinders are stored will be conducted monthly for three months, and then quarterly by the Director of Facility Services. 2. The results of the inspections will be discussed in facility's QA meeting.	5/20/11