STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205060	A. BUILDING 01 B. WING _____	01/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CEDAR RIDGE CENTER	23 CEDAR RIDGE DRIVE SKOWHEGAN, ME 04976

(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
E 000	Initial Comments Federal Recertification Survey 01/29/2025 Cedar Ridge Center, a long term care facility, is not in substantial compliance with 42 Code of Federal Regulations Part 483.73- Emergency Preparedness Requirement for Long Term Care Facilities.	E 000		
E 015 SS=F	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) §403.748(b)(1), §418.113(b)(6)(iii), §441.184(b)(1), §460.84(b)(1), §482.15(b)(1), §483.73(b)(1), §483.475(b)(1), §485.542(b)(1), §485.625(b)(1) [(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 facilities]. 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	E 015		

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

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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E 015	Continued From page 1 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 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 interview and record review, the long-term care facility failed to maintain provision of subsistence needs for staff and patients whether they evacuate or shelter in place for Emergency Preparedness Plan in accordance with 42 CFR 483.73 Finding: On 01/29/2025, between 10:00 AM and 3:00 PM, a surveyor, with the Maintenance Director and the Administrator present, observed the following:	E 015		

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E 015	Continued From page 2 1. The was no documentation provided in the emergency preparedness plan for fuel with updated Memorandums of Understanding to verify how they would get replenished in the event they had to evacuate or shelter in place. When I asked for documentation, no MOUs could be produced. The surveyor confirmed this finding with the Maintenance Director and the Administrator at the time of the observation.	E 015		
E 037 SS=F	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency	E 037		

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E 037	Continued From page 3 procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency	E 037		

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E 037	Continued From page 4 preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at	E 037		

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E 037	Continued From page 5 least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff,	E 037		

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E 037	Continued From page 6 individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the long term care facility failed to maintain an annual training program for the Emergency Preparedness Plan in accordance with 42 CFR 483.73 Finding: On 01/29/2025, between 10:00 AM and 3:00 PM, a surveyor, with the administrator present, observed the following: 1. Review of two employee training files revealed	E 037		

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E 037	Continued From page 7 that neither one completed annual emergency preparedness training for the calendar year 2024. The surveyor confirmed this finding with the administrator at the time of the observation.	E 037		
K 000	INITIAL COMMENTS Federal Recertification Survey Date of Survey 01/29/2025 Cedar Ridge Center, a long-term care facility, was surveyed pursuant to the National Fire Protection Association, 101 Life Safety Code, 2012 Edition as referenced in Part 483.90(a-d) - Physical Environment is not in substantial compliance.	K 000		
K 211 SS=D	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 observation and interview the facility failed to ensure that aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with NFPA 101, Life Safety Code, 2012 edition, Chapter 7.1.10.1, and that the means of egress is continuously maintained free of all obstructions to full use in case of emergency unless modified by NFPA 101, Life Safety Code, 2012 edition, sections 19.2.2 through 19.2.11, 19.2.1, and 7.1.10.1.	K 211		

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K 211	Continued From page 8 Finding: Observation and Interview during a facility tour with the Sr. Maintenance Director, and the Maintenance Director present on 01/29/2025 from 10:00 AM to 3:00 PM identified: 1) There is a hole in the exit discharge paved pathway from the B wing Therapy exit to the public way. The hole was approximately 10 inches in diameter and three inches deep. This failure occurred in one of five resident care wings. This deficient practice could affect the evacuation of the residents of the wing, and the staff members and visitors in this location. This finding were verified by the Sr. Maintenance Director, and the Maintenance Director at the time of observations on 01/29/2025 from 10:00 AM to 3:00 PM.	K 211		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 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	K 324		

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K 324	Continued From page 9 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 observation, the long-term care facility failed to properly install and maintain equipment protected by the kitchen hood extinguishing system NFPA Standard: NFPA 101, Life Safety Code (2012) Sections 19.3.2.5.2, 9.2.3, NFPA Standard: NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations (2011) Section 12.1.2.3.1. Finding: Observation and Interview during a facility tour with the Sr. Maintenance Director, and the Maintenance Director present on 01/29/2025 from 10:00 AM to 3:00 PM identified: 1. The wheeled, 6 burner gas-fired stove/oven located on the cooking line in the kitchen was not provided with an approved method that would ensure that the appliance would be returned to an approved design location after they had been moved for maintenance and cleaning. The surveyor confirmed this finding with the Sr. Maintenance Director, and Maintenance Director	K 324		

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K 324	Continued From page 10 at the time of the observation on 01/29/2025, between 10:00 AM and 3:00 PM.	K 324		
K 355 SS=D	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, the long-term care facility failed to properly select and install portable fire extinguishers and applicable accessories in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 edition, Section 5.5.5.3, and 6.6.1 as referenced by NFPA 101, Life Safety Code 2012 edition, Sections 19.3.5.12, and 9.7.4.1. Findings: Observations during a facility tour with the Sr. Maintenance Director and Management Director present on 01/29/2025, between 10:00 AM and 3:00 PM identified: 1. A placard shall be conspicuously placed near the class K extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher. There is no placard installed near the class K extinguisher in the kitchen. 2. Class K fire extinguishers shall be provided for hazards where there is a potential for fires involving combustible cooking media. There was	K 355		

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K 355	Continued From page 11 no class K extinguisher installed within 30 feet of the cooking stove in the activities kitchen. The surveyor confirmed these findings with the Sr. Management Director and Maintenance Director at the time of the observation on 01/29/2025, between 10:00 AM and 3:00 PM.	K 355		
K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors 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	K 363		

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K 363	Continued From page 12 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 observation, the long-term care facility failed to maintain the corridor doors to resist the passage of smoke to and from the corridor as referenced by NFPA 101, Life Safety Code 2012 edition, Section 19.3.6.3 Finding: Observations during a facility tour with the Sr. Maintenance Director and the Maintenance Director present on 01/29/2025, between 10:00 AM and 3:00 PM identified: 1. The D wing scheduling manager's office door has a hole that penetrates the thickness of the door, the hole which is approximately 5/8 of an inch and located below the doorknob. The surveyor confirmed this finding with the Sr. Maintenance Director and the Maintenance Director at the time of the observation on 01/29/2025, between 10:00 AM and 3:00 PM.	K 363		
K 371 SS=F	Subdivision of Building Spaces - Smoke Compar CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Compartments	K 371		

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K 371	Continued From page 13 2012 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping floor with a 30 or more patient bed capacity. Size of compartments cannot exceed 22,500 square feet or a 200-foot travel distance from any point in the compartment to a door in the smoke barrier. 19.3.7.1, 19.3.7.2 Detail in REMARKS zone dimensions including length of zones and dead-end corridors. This REQUIREMENT is not met as evidenced by: Based on observation and life safety plans documentation review prior to the tour, the long-term care facility failed to maintain the construction of the building to form at least two smoke compartments in accordance with NFPA 101, Life Safety Code 2012 edition, Section 19.3.7.1., and 8.5.2 Finding: Observations and documentation review during a facility tour with the Sr. Maintenance Director and the Maintenance Director present on 01/29/2025, between 10:00 AM and 3:00 PM identified: 1. No one-hour smoke barrier walls could be located in accordance with the life safety plans presented during the survey. The building plans indicated smoke barrier walls were to be constructed, but upon inspection no one-hour smoke barriers were found as indicated on the drawings. During the inspection is was discovered that the one-hour smoke barrier walls stopped just above the monolithic ceiling and did not extend through the interstitial space to the underside of the roof. This deficient practice could effect all 5 resident sleeping wings,	K 371		

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	205060	A. BUILDING 01 B. WING _____	01/29/2025

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K 371	Continued From page 14 including all 75 residents, staff and visitors in the facility. The surveyor confirmed this finding with the Sr. Maintenance Director and the Maintenance Director at the time of the observation on 01/29/2025, between 10:00 AM and 3:00 PM.	K 371		
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation, the long-term care facility failed to maintain the faceplates on the electrical receptacles to ensure they completely cover the opening per NFPA 70, National Electrical Code, 2011 edition, section 406 as referenced by NFPA 99, Healthcare Facilities Code, 2012 edition, Chapter 6. Finding: Observations during a facility tour with the Sr. Maintenance Director and the Maintenance Director present on 01/29/2025, between 10:00 AM and 3:00 PM identified: 1. The 4-gang electrical outlet at the C/D nurses station under the desk has a broken cover with the box opening exposed.	K 911		

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	205060	A. BUILDING **01** B. WING _____	**01/29/2025**

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K 911	Continued From page 15 The surveyor confirmed this finding with the Sr. Maintenance Director and the Maintenance Director at the time of the observation on 01/29/2025, between 10:00 AM and 3:00 PM.	K 911		
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 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	K 918		

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K 918	Continued From page 16 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 observation, interview and record review, the long-term care facility failed to install a remote emergency shut-off device per NFPA 110, Standard for Emergency and Standby Power Systems, 2010 Edition, Section 5.6.5.6 and NFPA 99, Health Care Facilities Code, 2012 Edition, Section 6.4.4. Finding: Observations during a facility tour with the Sr. Maintenance Director and the Maintenance Director present on 01/29/2025, between 10:00 AM and 3:00 PM identified: 1. All generating stations shall have a labeled remote manual stop device on the premises outside of the generator housing. The surveyor confirmed this finding with the Sr. Maintenance Director and the Maintenance Director at the time of the observation on 01/29/2025, between 10:00 AM and 3:00 PM	K 918		
K 919 SS=D	Electrical Equipment - Other CFR(s): NFPA 101 Electrical Equipment - Other List in the REMARKS section any NFPA 99 Chapter 10, Electrical Equipment, requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	K 919		

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K 919	Continued From page 17 Chapter 10 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the long term care facility failed to recharge electrical equipment in accordance with NFPA 99, Healthcare Facilities Code, 2012 edition, sections 10.5.2.7, and 10.5.3.1, as referenced by NFPA 101, Life Safety Code, 2012 Edition. Finding: Observations during a facility tour with the Sr. Maintenance Director and the Maintenance Director present on 01/29/2025, between 10:00 AM and 3:00 PM identified: 1. In Balsam House Residential Care Wing, multiple battery operated wheelchairs were found charging in the common area. Batteries shall not be charged in any area open to resident living, sleeping areas including exit access corridors or exits unless specifically allowed by the battery manufacturer. The surveyor confirmed this finding with the Sr. Maintenance Director and the Maintenance Director at the time of the observation on 01/29/2025, between 10:00 AM and 3:00 PM.	K 919		
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	K 923		

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K 923	Continued From page 18 Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." 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 observation and interview, the long-term care facility failed to ensure that the Oxygen cylinder storage complies with NFPA 99, Health Care Facilities Code, 2012 Edition, Sections 11.3.2.1, and 11.6.5. Findings:	K 923		

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K 923	Continued From page 19 Observations during a facility tour with the Sr. Maintenance Director and the Maintenance Director present on 01/29/2025, between 10:00 AM and 3:00 PM identified: 1. The wooden shed located outside near the loading dock, was being used to store 2 M cylinders and 88 E cylinders or (2200 cubic feet.) at the time of survey. Outdoor oxygen storage locations shall be in an enclosure of noncombustible or limited combustible construction. The surveyor confirmed these findings with the Maintenance Director at the time of the inspection on 01/29/2025, between 10:00 AM and 3:00 PM.	K 923		