| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 205128 | A. BUILDING 01<br>B. WING _____ | 07/07/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| MAPLECREST REHAB & LIVING CENTER | 174 MAIN ST<br>MADISON, ME 04950 |

| (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<br><br>Federal Recertification Survey<br>Survey Date: 07/07/2025<br><br>Maplecrest Rehab & Living Center, a long-term care facility, was surveyed on 07/07/2025 between the hours of 9:00 AM and 3:00 PM and is not in substantial compliance with 42 Code of Federal Regulations Part 483.73 Requirement for Long Term Care Facilities for Emergency Preparedness. | E 000 | | |
| E 036 SS=D | EP Training and Testing<br>CFR(s): 483.73(d)<br><br>§403.748(d), §416.54(d), §418.113(d), §441.184(d), §460.84(d), §482.15(d), §483.73(d), §483.475(d), §484.102(d), §485.68(d), §485.542(d), §485.625(d), §485.727(d), §485.920(d), §486.360(d), §491.12(d), §494.62(d).<br><br>*[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §441.184, PACE at §460.84, Hospitals at §482.15, HHAs at §484.102, CORFs at §485.68, REHs at §485.542, CAHs at §486.625, "Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.360, and RHC/FHQs at §491.12:] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. | E 036 | | |

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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| | 205128 | A. BUILDING **01**<br>B. WING _____ | **07/07/2025** |

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| E 036 | Continued From page 1<br><br>*[For LTC facilities at §483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.<br><br>*[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(i).<br><br>*[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and | E 036 | | |

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| E 036 | Continued From page 2<br>updated at every 2 years.<br>This REQUIREMENT is not met as evidenced by:<br>Federal Recertification Survey<br>Date: 07/07/2025<br><br>Based on record review, the long-term care facility failed to maintain a training and testing program for Emergency Preparedness Plan in accordance with 42 CFR 483.73<br><br>Findings:<br><br>On 07/07/2025, between 9:00 AM and 3:00 PM, a surveyor, with the Maintenance Director and Director of Nursing present, observed the following:<br><br>1. The training documentation provided by the Director of Nursing shows training records for 5 employees. Of the 5 records given, 2 records show no documentation of Emergency Preparedness Training for the year provided.<br><br>The surveyor confirmed this finding with the Maintenance Director and Director of Nursing at the time of the observation and exit interview. | E 036 | | |
| K 000 | INITIAL COMMENTS<br><br>Federal Recertification Survey<br><br>Date of Survey: 07/07/2025<br><br>Maplecrest Rehabilitation and Living 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 | K 000 | | |

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| K 000 | Continued From page 3<br>substantial compliance. | K 000 | | |
| K 211 SS=F | Means of Egress - General<br>CFR(s): NFPA 101<br><br>Means of Egress - General<br>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.<br>18.2.1, 19.2.1, 7.1.10.1<br>This REQUIREMENT is not met as evidenced by:<br>Federal Recertification Survey<br>Date: 07/07/2025<br><br>Based on observation, and interview, the long-term care facility failed to maintain the Exit Corridors free of obstructions per NFPA 101, Life Safety Code, 2012 Edition, Sections 18.2.1, 19.2.1, 7.1.5.1 and 7.1.10.1<br><br>Findings:<br><br>During a survey on 07/07/2025 between the hours of 9:00 AM and 3:00 PM, a surveyor, with the Maintenance Director observed the following:<br><br>Interview with the maintenance director during the observation, headroom requirements were discussed, 6' 8" in height above the floor and the maximum projection is 6 inches from the wall would be required and the director acknowledged the requirement.<br>1. A chair is located in the exit access corridor in the EMBDEN Wing and is not secured to the floor. The chair was removed at the time of the | K 211 | | |

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| K 211 | Continued From page 4<br>survey.<br>2. There are bins and trash cans stored in the corridor outside of a patient room located in the EMBDEN Wing.<br>3. A medication cart was observed unattended for more than 30 minutes in the corridor by the nurse station.<br>4. The patio area gate located off the day room has a locking mechanism that is located on the street side of the gate and no device on the patio side to allow egress from the patio.<br>5. The air conditioner unit on the wall in the Embden wing was 6' 2" above the floor to the base of the unit. The projection from the wall was 8.5 inches.<br>6. The air conditioner unit on the wall in the Lakewood wing was 6' 2" above the floor to the base of the unit. The projection from the wall was 10 inches.<br>7. The air conditioner unit on the wall in the Admin wing was 6' 2" above the floor to the base of the unit. The projection from the wall was 8 inches.<br>8. The air conditioner unit on the wall in the Cleaarview wing was 6' 5" above the floor to the base of the unit. The projection from the wall was 8 inches.<br><br>The surveyor confirmed these findings with the Maintenance Director during the survey and with the Maintenance Director & Director of Nursing at the time of exit interview. | K 211 | | |
| K 291<br>SS=E | Emergency Lighting<br>CFR(s): NFPA 101<br><br>Emergency Lighting<br>Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 | K 291 | | |

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| K 291 | Continued From page 5<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the facility failed to provide operational emergency lighting testing in accordance with NFPA 101, Life Safety Code, 2012 edition, sections 19.2.9.1, and 7.9.3.1.1.<br><br>Finding:<br><br>Documentation review and interview during a facility tour with the Maintenance Director present on 07/07/2025 from 09:00 AM to 3:00 PM identified:<br><br>1) The only emergency light testing that was documented in the last year was in June of 2025. An interview with the Maintenance Manager revealed that the former maintenance manager has recently separated and it was likely that the testing did not occur.<br><br>This finding was acknowledged by the Maintenance Director at the time of documentation review and with the Maintenance Director & Director of Nursing at the exit interview on 07/07/2025 from 09:00 AM to 3:00 PM. | K 291 | | |
| K 293 SS=D | Exit Signage<br>CFR(s): NFPA 101<br><br>Exit Signage<br>2012 EXISTING<br>Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system.<br>19.2.10.1<br>(Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit | K 293 | | |

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| K 293 | Continued From page 6<br>travel is obvious.)<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the facility failed to provide illuminated exit sign testing in accordance with NFPA 101, Life Safety Code, 2012 edition, sections 19.2.10.1, 7.9.3.1.3, and 7.10.9.1.<br><br>Finding:<br><br>Documentation review and interview during a facility tour with the Maintenance Director present on 07/07/2025 from 09:00 AM to 3:00 PM identified:<br><br>1) The only illuminated exit sign testing that was documented in the last year was in June of 2025. The interview with the Maintenance Manager revealed that the former maintenance manager had recently separated and it was likely that the testing did not occur.<br><br>This finding was acknowledged by the Maintenance Director at the time of documentation review and with the Maintenance Director & Director of Nursing at the exit interview on 07/07/2025 from 09:00 AM to 3:00 PM. | K 293 | | |
| K 353 SS=D | Sprinkler System - Maintenance and Testing<br>CFR(s): NFPA 101<br><br>Sprinkler System - Maintenance and Testing<br>Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are | K 353 | | |

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| K 353 | Continued From page 7<br>maintained in a secure location and readily available.<br>a) Date sprinkler system last checked<br>_____<br>b) Who provided system test<br>_____<br>c) Water system supply source<br>_____<br>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.<br>9.7.5, 9.7.7, 9.7.8, and NFPA 25<br>This REQUIREMENT is not met as evidenced by:<br>Federal Recertification Survey<br>Date: 07/07/2025<br><br>Based on observations and record review, the long-term care facility failed to ensure that Sprinkler System was inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 edition, Chapter 5, 5.3.1.1.2 and Chapter 13.4.4.1.4 (3) and NFPA 13 Chapter 8, 8.5.5.3.<br><br>Findings:<br><br>During a survey conducted on 07/07/2025 between the hours of 9:00 AM and 3:00 PM, a surveyor with the Director of Maintenance observed the following:<br><br>1. Documentation provided going back to October 4, 2024, to June 26, 2025, shows a sprinkler head located in the basement has expired. No documentation was provided saying this was corrected at the time of the survey. | K 353 | | |

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| K 353 | Continued From page 8<br><br>2. Documentation provided going back to January 4, 2025, to June 26, 2025, show a dry pipe valve located in the basement is leaking. No documentation was provided saying this was corrected at the time of the survey.<br><br>3. A sprinkler head located in the boiler room has a light within 2 inches proximity that could alter the water dispersal pattern if activated.<br><br>The surveyor confirmed these findings with the Maintenance Director at the time of record review and with the Maintenance Director and Director of Nursing at the time of exit interview. | K 353 | | |
| K 355 SS=E | Portable Fire Extinguishers<br>CFR(s): NFPA 101<br><br>Portable Fire Extinguishers<br>Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.<br>18.3.5.12, 19.3.5.12, NFPA 10<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, the long-term care facility failed to ensure that portable fire extinguishers are inspected monthly by staff in accordance with NFPA 10, Standard for Portable Fire Extinguishers, 2010 edition, Sections 7.2.1.2, and 7.2.4.4, as referenced by NFPA 101, Life Safety Code 2012 edition, Sections 19.3.5.12, and 9.7.4.1.<br><br>Finding:<br><br>During a survey conducted on 07/07/2025 | K 355 | | |

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| K 355 | Continued From page 9<br>between the hours of 9:00 AM and 3:00 PM, a surveyor with the Maintenance Director observed the following:<br><br>1. The following portable fire extinguishers were missing a monthly inspection for the month of June, 2025:<br>a. Lakewood sitting area<br>b. Lakewood resident wing<br>c. Lakewood therapy area<br>d. Kitchen ABC<br>e. Kitchen K<br><br>The surveyor confirmed this finding with the Maintenance Director at the time of the survey and with the Maintenance Director & Director of Nursing at the exit interview on 07/07/2025 from 09:00 AM to 3:00 PM. | K 355 | | |
| K 363<br>SS=D | Corridor - Doors<br>CFR(s): NFPA 101<br><br>Corridor - Doors<br>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 | K 363 | | |

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| K 363 | Continued From page 10<br>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.<br><br>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485<br>Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.<br>This REQUIREMENT is not met as evidenced by:<br>Federal Recertification Survey<br>Date: 07/07/2025<br><br>Based on observation, the long-term care facility failed to maintain the corridor door from closing and positively latching per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.3.6.3, and 19.3.6.3.5<br><br>Finding:<br><br>On 07/07/2025 between the hours of 9:00 AM and 3:00 PM, a surveyor, with the Maintenance Director present, observed the following:<br><br>1. Resident Room 429 does not latch due to the patient curtain obstructing the doorway. | K 363 | | |

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| K 363 | Continued From page 11<br><br>This finding was confirmed by the Maintenance Director at the time of the observation. | K 363 | | |
| K 712 SS=F | Fire Drills<br>CFR(s): NFPA 101<br><br>Fire Drills<br>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.<br>19.7.1.4 through 19.7.1.7<br>This REQUIREMENT is not met as evidenced by:<br>Based on documentation review and interview, the long-term care facility failed to ensure that fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift per NFPA 101, Life Safety Code, 2012 Edition, Sections 19.7.1.4 through 19.7.1.7.<br><br>Finding:<br><br>Documentation review and interview during a facility tour with the Maintenance Director present on 07/07/2025 from 09:00 AM to 3:00 PM identified:<br><br>1. The facility failed to conduct the proper number of fire drills during the previous 12 months. The interview with the Maintenance Manager revealed | K 712 | | |

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| K 712 | Continued From page 12<br>that the former maintenance manager had recently separated from the facility and it was likely that the testing did not occur. No drills occurred from October of 2024 to February of 2025. The following fire drills for the facility were not completed or missing:<br><br>A. Third quarter of 2024, first, second and third shift<br>B. First quarter of 2025, first shift<br>C. First quarter of 2025, second shift<br><br>This finding was acknowledged by the Maintenance Director at the time of documentation review and with the Maintenance Director & Director of Nursing at the exit interview on 07/07/2025 from 09:00 AM to 3:00 PM. | K 712 | | |
| K 761 SS=D | Maintenance, Inspection & Testing - Doors<br>CFR(s): NFPA 101<br><br>Maintenance, Inspection & Testing - Doors<br>Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives.<br>Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program.<br>Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.<br>Written records of inspection and testing are maintained and are available for review.<br>19.7.6, 8.3.3.1 (LSC)<br>5.2, 5.2.3 (2010 NFPA 80)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, the facility failed to | K 761 | | |

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| K 761 | Continued From page 13<br>maintain fire rated doors in accordance with NFPA 80, Standard for Fire Door and Other Opening Protectives, 2010 edition Section 5.1, and 5.2 as referenced by NFPA 101, Life Safety Code, 2012 Edition, Sections 19.7.6, and 8.3.3.1.<br><br>Findings:<br><br>Observations during a facility tour with the Maintenance Director present on 07/07/2025 from 09:00 AM to 3:00 PM identified:<br><br>1) The labeled fire rated door to the laundry room has an eyebolt attached which is a modification to the fire door.<br>2) The exit sign, and the bulletin board that is attached to the same fire rated door in the laundry room cannot be attached to the door.<br><br>These findings were acknowledged by the Maintenance Director at the time of observation on 07/07/2025 from 09:00 AM to 3:00 PM. | K 761 | | |
| K 918 SS=E | Electrical Systems - Essential Electric Syste<br>CFR(s): NFPA 101<br><br>Electrical Systems - Essential Electric System Maintenance and Testing<br>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.<br>Generator sets are inspected weekly, exercised | K 918 | | |

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| K 918 | Continued From page 14<br>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.<br>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, and interview, and generator inspection documentation review during the facility tour, the long-term care facility failed to maintain the Essential Electric System Generator per NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, sections 8.3.7., 8.3.8, and 8.4.1, and NFPA 99, Healthcare Facilities Code, 2012 edition, section 6.4.4.1.1.3.<br><br>Findings:<br><br>Documentation review and interview during a facility tour with the Maintenance Director present on 07/07/2025 from 09:00 AM to 3:00 PM | K 918 | | |

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| K 918 | Continued From page 15<br>identified:<br><br>1. All generating stations shall have a labeled remote manual stop device on the premises where the prime mover is located outside the building, outside of the generator housing. The only emergency stop device was inside the locked generator housing.<br><br>2. No weekly Generator inspections were documented for the year 2024 and 2025 until June of 2025. The interview with the Maintenance Manager reveals that it is very likely that the previous maintenance manager failed to perform these inspections.<br><br>3. There was no annual fuel test documentation at the time of the survey. A call to Dead River from the staff revealed that one was not done.<br><br>These findings were acknowledged by the Maintenance Director at the time of documentation review and with the Maintenance Director & Director of Nursing at the exit interview on 07/07/2025 from 09:00 AM to 3:00 PM. | K 918 | | |
| K 920 SS=D | Electrical Equipment - Power Cords and Extens<br>CFR(s): NFPA 101<br><br>Electrical Equipment - Power Cords and Extension Cords<br>Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident | K 920 | | |

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| K 920 | Continued From page 16<br>rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.<br>10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview, the long-term care facility failed to ensure that power strips and extension cords are not used as a substitute for fixed wiring in accordance with NFPA 99, Healthcare Facilities Code, 2012 edition, Chapter 10, and NFPA 70 , National Electric Code, 2011 edition, chapter 4 {400.8(1)}<br><br>Findings:<br><br>Observation and interview during a facility tour with the Maintenance Director present on 07/07/2025 from 09:00 AM to 3:00 PM identified:<br><br>1. In the dayroom there are two floor mounted air conditioners plugged into extension cords. Interview with the Maintenance Manager revealed that the factory installed cord could not reach the buildings' fixed wiring receptacles.<br><br>2. In the staff breakroom there is a Keurig coffee machine, hot/cold water dispenser, toaster, and microwave plugged into a multi-plug adapter in | K 920 | | |

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| K 920 | Continued From page 17<br>the same outlet.<br><br>These findings were acknowledged by the Maintenance Director at the time of documentation review and with the Maintenance Director & Director of Nursing at the exit interview on 07/07/2025 from 09:00 AM to 3:00 PM. | K 920 | | |
| K 923 SS=D | Gas Equipment - Cylinder and Container Storag<br>CFR(s): NFPA 101<br><br>Gas Equipment - Cylinder and Container Storage<br>Greater than or equal to 3,000 cubic feet<br>Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3.<br>>300 but <3,000 cubic feet<br>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.<br>Less than or equal to 300 cubic feet<br>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.<br>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."<br>Storage is planned so cylinders are used in order | K 923 | | |

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| K 923 | Continued From page 18<br>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:<br>Federal Recertification Survey<br>Date: 07/07/2025<br><br>Based on observation, the long-term care facility failed to ensure that oxygen cylinders in storage are stored in accordance with NFPA 99, Healthcare Facilities Code, 2012 edition, Section 11.6.5.3.<br><br>Finding:<br><br>During a survey conducted on 07/07/2025 between the hours of 9:00 AM and 3:00 PM, a surveyor with the Maintenance Director observed the following:<br><br>1. The oxygen tanks stored in the oxygen room are in a rack system and have no markings showing which are full and which are empty. Signage indicating empty and full cylinders shall be placed to avoid confusion and delay if a full cylinder is needed in a rapid manner.<br><br>The surveyor confirmed this finding with the Maintenance Director at the time of survey and with the Maintenance Director & Director of Nursing at the exit interview on 07/07/2025 from 09:00 AM to 3:00 PM. | K 923 | | |