Life Safety Code Question & Answer
March 2021

1) **The Life Safety Code requires a facility with a generator to manually exercise all breakers and itemize all of the electrical panels used for the generator.**
    a. **How often does this need to occur?**
    b. **Does the facility have to have to follow the same procedure for all panels, even if they are not connected to the generator?**

The LSC requires annual inspection and annual testing on all electrical panels attached to the generator unless the manufacturer's guide states otherwise.

This only applies to the panels the generator utilizes (which will include the panels used for the Life Safety branches).

NFPA 99, 2012 edition:
6.4.4.1.2.1* Circuit Breakers. Main and feeder circuit breakers shall be inspected annually, and a program for periodically exercising the components shall be established according to manufacturer's recommendations.
A.6.4.4.1.2.1 Main and feeder circuit breakers should be periodically tested under simulated overload trip conditions to ensure reliability.

2) **The facility must test receptacles (outlets) annually.**
    a. **What are the four test needed on non-hospital grade outlets?**
    b. **Are facilities required to document each electrical outlet annually?**
    c. **What documentation should the facility retain for each electrical receptacle?**
    d. **What happens if an outlet fails the inspection?**
    e. **What inspections does the facility need for hospital-grade outlets?**

NFPA 99, 2012 edition:
6.3.3.2 Receptacle Testing in Patient Care Rooms.
6.3.3.2.1 The physical integrity of each receptacle shall be confirmed by visual inspection.
6.3.3.2.2 The continuity of the grounding circuit in each electrical receptacle shall be verified.
6.3.3.2.3 Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed.
6.3.3.2.4 The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz.).

The facility needs to document every outlet in the patient areas. The inspection report needs to show every outlet tested and includes areas such as resident rooms. The facility staff need to complete all four tests annually. These inspections may be a pass/fail for the four tests; however, the pass/fail must be for each specific test (e.g. grounding, polarity), and the pass/fail cannot just be for the outlet.

If the facility does not label every outlet, then there needs to be a system so everyone reading the documentation will know which outlet was tested. An example could be starting at the entrance, going around the room clockwise/counter clockwise, and naming the first outlet A, the second B and so on, until all outlets are recorded on the inspection sheet. The facility needs to document their system and use the same system throughout the facility. If one or more of the outlets in a room/area are hospital grade, the facility staff may document it on the form to show why annual testing did not occur (if applicable).

When an outlet fails any of the four tests, the facility needs to replace the outlet with a hospital grade outlet and staff need to document they replaced the outlet on the inspection sheet.

For any hospital grade outlet, the facility must create a system to complete a risk assessment and decide how often they want to complete the maintenance/testing, which can be longer than annually. The risk assessment system must be in place as soon as the facility has a hospital grade outlet. When due for an inspection and testing, these outlets must also be individually itemized on the documentation.

An example of a label on an outlet.

NFPA 99, 2012 edition:
10.3 Testing Requirements — Fixed and Portable.
10.3.1* Physical Integrity. The physical integrity of the power cord assembly composed of the power cord, attachment plug, and cord-strain relief shall be confirmed by visual inspection.
10.3.2* Resistance.
10.3.2.1 For appliances that are used in the patient care vicinity the resistance between the appliance chassis, or any exposed conductive surface of the appliance, and the ground pin of the attachment plug shall be less than 0.50 ohm under the following conditions:
(1) The cord shall be flexed at its connection to the attachment plug or connector.
(2) The cord shall be flexed at its connection to the strain relief on the chassis.
10.3.2.2 The requirement of 10.3.2.1 shall not apply to accessible metal parts that achieve separation from main parts by double insulation or metallic screening or that are unlikely to become energized (e.g., escutcheons or nameplates, small screws).
10.3.3* Leakage Current Tests.
10.3.3.1 General.
10.3.3.1.1 The requirements in 10.3.3.2 through 10.3.3.4 shall apply to all tests.
10.3.3.1.2 Tests shall be performed with the power switch ON and OFF.
10.3.3.2 Resistance Test. The resistance tests of 10.3.3.3 shall be conducted before undertaking any leakage current measurements.
10.3.3.3* Techniques of Measurement. The test shall not be made on the load side of an isolated power system or separable isolation transformer.
10.3.3.4* Leakage Current Limits. The leakage current limits in 10.3.4 and 10.3.5 shall be followed.
10.3.4 Leakage Current — Fixed Equipment.
10.3.4.1 Permanently wired appliances in the patient care vicinity shall be tested prior to installation while the equipment is temporarily insulated from ground.
10.3.4.2 The leakage current flowing through the ground conductor of the power supply connection to ground of permanently wired appliances installed in general or critical care areas shall not exceed 10.0 mA (ac or dc) with all grounds lifted.
10.5.2.1 Testing Intervals.

10.5.2.1.1 The facility shall establish policies and protocols for the type of test and intervals of testing for patient care–related electrical equipment.
10.5.2.1.2 All patient care–related electrical equipment used in patient care rooms shall be tested in accordance with 10.3.5.4 or 10.3.6 before being put into service for the first time and after any repair or modification that might have compromised electrical safety.
10.3.5.4 Touch Leakage Test Procedure. Measurements shall be made using the circuit, as illustrated in Figure 10.3.5.4, with the appliance ground broken in two modes of appliance operation as follows:

(1) Power plug connected normally with the appliance on
(2) Power plug connected normally with the appliance off (if equipped with an on/off switch)

3) Does Life Safety Code allow candles in a certified facility?

- **a. Can candles ever be lit?**
- **b. Can a facility use a candle during a Birthday celebration?**
- **c. Can a facility use a candle during religious activities?**

Facilities may not use candles with wicks for décor. If a facility chooses to use candles as décor, the candle shall not have a wick, and the wick must be pulled out. It is not acceptable to have the wick cut flush to the candle.

Facility staff may use lit candles for a birthday celebration, but facility staff must continually supervise the candles while lit.

If a facility uses candles for religious purposes, these lit candles must be supervised 24/7 or be in a different occupancy with a 2-hour wall that separates it from the rest of the facility. The facility has the option to utilize an electric candle when it is not possible or practical to supervise the lit candles.

4) How can corridor doors resist the passage of smoke?

- **a. Can a facility have roller latches on doors?**
- **b. What should we look at on double doors to ensure there is a good smoke seal?**
- **c. Where can there be transfer grilles in doors?**

From the **Federal Register** / Vol. 81, No. 86 / Wednesday, May 4, 2016 / Rules and Regulations
Sections 18.3.6.3.9.1 and 19.3.6.3.5—
Roller Latches
A roller latch is a type of door latching mechanism to keep a door closed. The 2012 edition of the LSC requires corridor doors to be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction. The LSC permits roller latches capable of keeping the door fully closed if a force of 5 pounds is applied at the latch edge or roller latches in fully sprinklered buildings.

However, we proposed not to adopt these standards from the 2012 LSC. Through fire investigations, roller latches have proven to be an unreliable door latching mechanism requiring extensive maintenance to operate properly. Many roller latches in fire situations failed to provide adequate protection to residents in their rooms during an emergency. Roller latches will be prohibited in existing and new Health Care Occupancies for corridor doors and doors to rooms containing flammable or combustible materials. These doors will be required to have positive latching devices instead.

CMS continues to prohibit the use of roller latches in healthcare settings per federal statues, despite the 2012 edition allowing some exceptions in new facilities. Even if a facility follows all the exceptions, the use of roller latches will continue to be out of compliance in a CMS Certified facility.

Double doors need astragal and if the double doors are not positive latching into the frame, then the inactive leaf should have an automatic flush bolt. This includes all corridor doors, even doors such as linen and janitor closets. Corridor doors must resist the passage of smoke.

The only exception is the use of transfer grilles (louvers). Transfer grilles in corridor doors are acceptable, but only for toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. These rooms cannot contain combustible materials such as soiled linens. HVAC room doors cannot have transfer grilles.

NFPA 101, 2012 edition:

18/19.3.6.3* Corridor Doors.

18/19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be doors constructed to resist the passage of smoke and shall be constructed of materials such as the following:

(1) 13⁄4 in. (44 mm) thick, solid-bonded core wood

(2) Material that resists fire for a minimum of 20 minutes

18/19.3.6.3.2 The requirements of 19.3.6.3.1 shall not apply where otherwise permitted by either of the following:

(1) Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials shall not be required to comply with 19.3.6.3.1.

(2) In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.7, the door construction materials requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.

18/19.3.6.4 Transfer Grilles.

18/19.3.6.4.1 Transfer grilles, regardless of whether they are protected by fusible link–operated dampers, shall not be used in corridor walls or doors, unless otherwise permitted by 18.3.6.4.2.

18/19.3.6.4.2 Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials shall be permitted to have ventilating louvers or to be undercut.

18/19.3.6.3.5 Doors shall be self-latching and provided with positive latching hardware.

18/19.3.6.3.6 Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials shall not be required to meet the latching requirements of 18.3.6.3.5.

18/19.3.6.5 Openings.

18/19.3.6.5.1* Miscellaneous openings, such as mail slots, pharmacy pass-through windows, laboratory pass-through windows, and cashier pass-through windows, shall be permitted to be installed in vision panels or doors without special protection, provided that both of the following criteria are met:

(1) The aggregate area of openings per room does not exceed 20 in.2 (0.015 m2).

(2) The openings are installed at or below half the distance from the floor to the room ceiling.

18/19.3.6.5.2 The alternative requirements of 19.3.6.5.1 shall not apply where otherwise modified by the following:

(1) Openings in smoke compartments containing patient bedrooms shall not be permitted to be installed in vision panels or doors without special protection.

(2) For rooms protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.7, the aggregate area of openings per room shall not exceed 80 in.2 (0.05 m2).

5) <u>What if a sprinkler head gets paint on it or has corrosion?</u>

No one can successfully remove paint or corrosion from a sprinkler head and the facility must replace those sprinkler heads. There is currently not any UL listed paint remover.

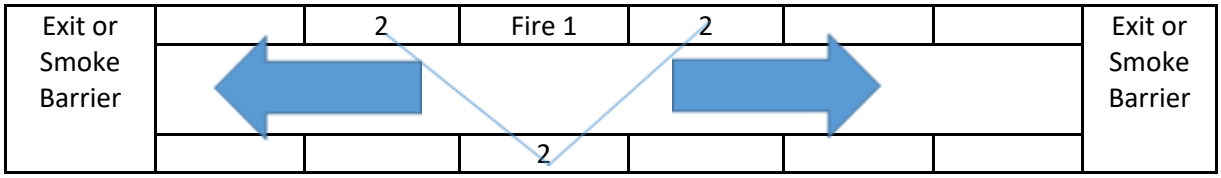
NFPA 25, 2011 edition:
5.2.1.1 Sprinklers shall be inspected from the floor level annually.
5.2.1.1.1 Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall).
5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced:

(1) Leakage
(2) Corrosion
(3) Physical damage
(4) Loss of fluid in the glass bulb heat responsive element
(5) Loading
(6) Painting unless painted by the sprinkler manufacturer

5.2.1.1.3 Any sprinkler that has been installed in the incorrect orientation shall be replaced.
5.2.1.1.4 Any sprinkler shall be replaced that has signs of leakage; is painted, other than by the sprinkler manufacturer, corroded, damaged, or loaded; or is in the improper orientation.
5.2.1.1.5 Glass bulb sprinklers shall be replaced if the bulbs have emptied.

6) What is expected in a facility's smoke compartment zone evacuation plan?

The facility needs to have a smoke compartment evacuation plan if they don't plan to evacuate everyone immediately to the outside (meeting point) when the fire alarm sounds. The plan should begin with staff determining the need to evacuate. If evacuation is necessary, staff should begin evacuating residents in the immediate surrounding area of the fire, then the triangle of rooms around the room of fire origin (next to and across the hall from the room of origin), then the remaining rooms in the smoke compartment working away from the room of origin, trying not to cross the line of fire with the residents. Consider the fire exposure and Jack and Jill bathrooms. Some residents may be evacuated outside while others may be evacuated beyond a set of smoke doors.



The goal is to get all residents evacuated around the area of fire regardless of ambulatory status. After evacuation of the smoke compartment or origin and into another smoke compartment or an area of refuge; then it is determined whether an evacuation is needed further away (such as outside or a different smoke compartment). It may be prudent to evacuate based on ambulation status after evacuation of the zone of origin (ambulatory, wheelchair, bedridden). If the facility has a separate fire and evacuation plan, ensure the plans are consistent with the zone evacuation concept.

It would be wise to keep the plans simple and to have a written smoke compartment plan for every smoke zone in the building. Facilities may use things such as color-coded map/layouts. The facility needs to ensure when doing a zone evacuation, the residents are going to another smoke section, not just through a double door in the corridor (not all double doors are smoke/fire doors).

NFPA 101, 2012 edition:
4.7.3 Orderly Evacuation. When conducting drills, emphasis shall be placed on orderly evacuation rather than on speed.

7) Does the fire alarm system electronically supervise the Post Indicator Valve, as required by NFPA?

- **a. Where would a facility find documentation that shows if the fire alarm system is electronically supervising the Post Indicator Valve?**

Yes, the fire alarm system must include electronic supervision of all tamper and flows, including the Post Indicator Valve. This is one of the devices tested and inspected during the annual fire alarm and sprinkler system inspections and will be on those reports.

Please see the reference in NFPA 72, 2010 edition: Table 14.4.2.2

8) How often does the facility need to ensure the generator transfers power within 10 seconds?

- **a. What information is required for the documentation?**
- **b. Does it have to be under load?**

The facility staff must document a transfer within ten seconds at least annually. This documentation must include all legs with the amperage under load. The load test must last at least 30 minutes, which is in addition to (warm up is not allowed) cool down times. This is not a load bank test, which is available only for diesel generators who cannot meet at least 30% of load.

NFPA 110, 2010 edition:
4.3 Type. The type defines the maximum time, in seconds, that the EPSS will permit the load terminals of the transfer switch to be without acceptable electrical power. Table 4.1(b) provides the types defined by this standard.

9) Does the sprinkler company put the "red" tag on the sprinkler system to show impairments?

- **a. Where and how are the impairment tags placed when the system is not working properly?**

Not all vendors utilize a red tag. However, there needs to be a system to show the system is impaired.

Impairment tags from chapter 15 are not from vendors but from the maintenance staff. This is more like a lock out/tag out system.

NFPA 25, 2011 edition:
Tag Impairment System
15.3.1 A tag shall be used to indicate that a system, or part thereof, has been removed from service.
15.3.2 The tag shall be posted at each fire department connection and the system control valve, and other locations required by the authority having jurisdiction, indicating which system, or part thereof, has been removed from service.

10) What is required on a fire alarm/sprinkler system annual report?

- **a. What components are required to be on a fire alarm report?**
- **b. Who tests elevator recall, if the range hood is connected to the fire alarm system, dampers, and magnetic locks?**
- **c. Can a facility staff switch the breaker to the fire alarm panel?**

100% testing of all devices tied to a fire alarm is required.

One of the reasons for having the qualifications for the fire alarm technicians is to ensure they have proper ITM knowledge of systems tied to the fire alarm.
Another method allowed is to have the other systems witnessed by the FA vendor. See below:

A.14.2.6.1 As an example, testing of the elevator fire service and shutdown functions will usually require a coordinated multi-discipline effort with presence of qualified service personnel for the fire alarm system, the elevator system, and other building systems. The presence of inspection authorities might also be needed in some jurisdictions. The development of a test plan should be considered to ensure that the testing of these features is accomplished in a coordinated and timely manner. This plan should also ensure that all appropriate parties and personnel are present when needed, and that the testing requirements for both the fire alarm system and the elevator system are fulfilled. See Section 21.3 and Section 21.4 for specific elevator emergency control functions.

The fire alarm vendor shall test or witness all devices tied to the fire alarm, including elevator recall, range hood, dampers, and door locks annually during their inspections.

Circuit breaker needs to be locked 'on'.

Credential Requirements Fire Alarms

NFPA 72, 2010 edition:
10.4.3 Inspection, Testing, and Maintenance Personnel.
10.4.3.1* Service personnel shall be qualified and experienced in the inspection, testing, and maintenance of systems addressed within the scope of this Code. Qualified personnel shall include, but not be limited to, one or more of the following:

(1)*Personnel who are factory trained and certified for the specific type and brand of system being serviced
(2)*Personnel who are certified by a nationally recognized certification organization acceptable to the authority having jurisdiction
(3)*Personnel who are registered, licensed, or certified by a state or local authority to perform service on systems addressed within the scope of this Code
(4) Personnel who are employed and qualified by an organization listed by a nationally recognized testing laboratory for the servicing of systems within the scope of this Code

10.4.3.2 Evidence of qualifications shall be provided to the authority having jurisdiction upon request.

NFPA 72, 2010 edition:
Table 14.4.2.2

*One of the most recognized credential is NICET, and their lookup website is:
https://nicet.useclarus.com/view/verify/.

Level I Content Outline

Technician Trainee

The candidates for NICET certification at Level I in Fire Alarm Systems should have the knowledge, experience and basic skills needed to work in the industry. Under direct supervision, they perform limited job tasks. They are learning, (much like an apprentice) about fire alarm system components, installation methods, basic tools, worksite safety, and testing and inspecting. Level I technicians have at least 6 months of experience in fire alarm systems.

Level II Content Outline

Associate Engineering Technician

The candidates for NICET certification at Level II in Fire Alarm Systems should have the knowledge, experience and basic skills needed to work in the industry. Under limited supervision, they perform routine job tasks. They can review drawings, specifications, codes, and standards. They may conduct basic installation activities, perform basic troubleshooting, or prepare technical or sales documents. Level II technicians have at least 2 years of experience in fire alarm systems.

Level III Content Outline

Engineering Technician

The candidates for NICET certification at Level III in Fire Alarm Systems should have the knowledge, experience and basic skills needed to work in the industry. Working independently without supervision, they can interpret codes, standards, and specifications to produce fire alarm system shop drawings. They perform fire alarm system layout activities, supervise Level I and II technicians, provide submittal packages, and interact with AHJs. Level III technicians have at least 5 years of experience in fire alarm systems.

11) Can residents have a microwave in their room?

K324 – Cooking is not allowed in resident rooms. NFPA 19.3.2.5.3 and 19.3.2.5.4
K925 – Cooking appliances cannot be within 15 feet of an area of administration in a resident room.

NFPA 101, 2012 edition:
18/19.3.2.5.2* Where residential cooking equipment is used for food warming or limited cooking, the equipment shall not be required to be protected in accordance with 9.2.3, and the presence of the equipment shall not require the area to be protected as a hazardous area.
18/19.3.2.5.4* Within a smoke compartment, residential or commercial cooking equipment that is used to prepare meals for 30 or fewer persons shall be permitted, provided that the cooking facility complies with all of the following conditions:

(1) The space containing the cooking equipment is not a sleeping room.
(2) The space containing the cooking equipment shall be separated from the corridor by partitions complying with 19.3.6.2 through 19.3.6.5.
(3) The requirements of 19.3.2.5.3(1) through (10) and (13) are met.

12) What kind of documentation should a facility provide to the surveyor when on a fire watch?

Most facilities have one fire watch policy. If a facility has one policy, then the policy must have all the items in Chapter 15 within NFPA 25, 2011 edition. If the facility has two separate policies, the sprinkler system fire watch policy is required to include all the items in Chapter 15.

NFPA 25, 2011 edition:

Minimum Requirements

15.1.1.1 This chapter shall provide the minimum requirements for a water-based fire protection system impairment program.

15.1.1.2 Measures shall be taken during the impairment to ensure that increased risks are minimized and the duration of the impairment is limited.

Impairment Coordinator

15.2.1 The property owner or designated representative shall assign an impairment coordinator to comply with the requirements of this chapter.

15.2.2 In the absence of a specific designee, the property owner or designated representative shall be considered the impairment coordinator.

Tag Impairment System

15.3.1 A tag shall be used to indicate that a system, or part thereof, has been removed from service.

15.3.2 The tag shall be posted at each fire department connection and the system control valve, and other locations required by the authority having jurisdiction, indicating which system, or part thereof, has been removed from service.

Impaired Equipment

15.4.1 The impaired equipment shall be considered to be the water-based fire protection system, or part thereof, that is removed from service.

15.4.2 The impaired equipment shall include, but shall not be limited to, the following: Sprinkler systems, Standpipe systems, Fire hose systems, Underground fire service mains, Fire pumps, Water storage tanks, Water spray fixed systems, Foam-water systems, Fire service control valves

Preplanned Impairment Programs

15.5.1 All preplanned impairments shall be authorized by the impairment coordinator.

15.5.2 Before authorization is given, the impairment coordinator shall be responsible for verifying that the following procedures have been implemented:

(1) The extent and expected duration of the impairment have been determined.
(2) The areas or buildings involved have been inspected and the increased risks determined.
(3) Recommendations have been submitted to management or the property owner or designated representative.
(4) Where a required fire protection system is out of service for more than 10 hours in a 24-hour period, the impairment coordinator shall arrange for one of the following:
    (a) Evacuation of the building or portion of the building affected by the system out of service
    (b) An approved fire watch
    (c) Establishment of a temporary water supply
    (d) Establishment and implementation of an approved program to eliminate potential ignition sources and limit the amount of fuel available to the fire
(5) The fire department has been notified.
(6) The insurance carrier, the alarm company, property owner or designated representative, and other authorities having jurisdiction have been notified.
(7) The supervisors in the areas to be affected have been notified.
(8) A tag impairment system has been implemented. *(See Section 15.3.)*
(9) All necessary tools and materials have been assembled on the impairment site.

Emergency Impairments

15.6.1 Emergency impairments shall include, but are not limited to, system leakage, interruption of water supply, frozen or ruptured piping, and equipment failure.

15.6.2 When emergency impairments occur, emergency action shall be taken to minimize potential injury and damage.

15.6.3 The coordinator shall implement the steps outlined in Section 15.5.

15.7 Restoring Systems to Service

When all impaired equipment is restored to normal working order, the impairment coordinator shall verify that the following procedures have been implemented:

(1) Any necessary inspections and tests have been conducted to verify that affected systems are operational. The appropriate chapter of this standard shall be consulted for guidance on the type of inspection and test required.
(2) Supervisors have been advised that protection is restored.
(3) The fire department has been advised that protection is restored.
(4) The property owner or designated representative, insurance carrier, alarm company, and other authorities having jurisdiction have been advised that protection is restored.
(5) The impairment tag has been removed.

13) Acceptable Plans of Correction

A plan of correction (POC) must be submitted within 10 calendar days from the date the facility receives its Form CMS-2567. According to the State Operations Manual (SOM) §7317, an acceptable POC must:

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

Ensure every example, especially for those tags that encompass multiple deficient practices, has been addressed. K918 for example, covers generator installation, testing, maintenance, records, fuel, connections, and electrical mains and circuit breakers. If the SOD contains an example of the facility not completing the monthly 30 minute load bank test, an example of the diesel fuel not tested annually, and an example of the main and circuit breakers not inspected/tested annually, then each example needs to be identified on the POC and needs to state in detail what will be done to ensure each example is corrected.

Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

How will all residents at risk for the deficient practice be identified? How will the deficient practice be corrected for all residents, not just the cited examples? For example, if five sprinkler heads are identified as having paint on them and cited as examples under K353, **all** sprinkler heads in the facility that have paint on them will need to be replaced, not just the five cited examples.

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

Has the deficient practice that caused the deficiency been identified? What changes will occur to prevent the deficient practice from reoccurring? For example, if K363 was cited on the SOD for examples of corridor doors not latching and having penetrations and gaps, **all** corridor doors shall be maintained to resist the passage of smoke. Who is responsible for inspecting the corridor doors and how often? Is there a system for direct care staff to report maintenance issues to the maintenance department? What in-services need to occur and who needs to be involved in the training.

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained and;

How will the monitoring be accomplished? Who is responsible for monitoring and what are their qualifications? What is the frequency of monitoring? For example, K923 was cited for not securing oxygen cylinders within the oxygen storage room. Although this is considered a LSC issue due to the risk of fire, nursing staff are the primary handlers of the oxygen cylinders and typically access the oxygen storage room more than maintenance staff. In this case, the maintenance staff may have not been monitoring the oxygen storage room and relying on nursing to ensure the oxygen cylinders are secured.

The POC should then identify who will monitor the oxygen storage room moving forward (Maintenance, Charge Nurse, DON, etc…?). What form will the individual use to document their monitoring and how often will monitoring occur (Daily, Weekly, etc…?). Do policies need to be revised related to who will monitor, how often, what forms will be used, and who will oversee to ensure the monitoring is being completed? Does the POC state whether the deficient practice is being addressed with the QA Committee on a regular basis?

Include dates when corrective action will be completed.

Is there a date for completion of the corrective action? Is the timeframe reasonable given the work that is being done? **Remember, the deficient practice is not completely corrected until all work is finished.** A deficiency cannot be corrected if an item has been ordered but not yet installed. An invoice or confirmation of a future installation or inspection will not put the facility back into compliance. Is a time limited waiver needed to accomplish this? If so, the facility should reach out to the department to discuss a waiver. For example, a facility was cited for not having access to their smoke barriers and their POC states they are adding an access door through the ceiling, the completion date on the POC should reflect when the access door will be physically installed and not just scheduled. Each specific deficiency should include a corrective action date and the facility should adhere to those dates as stated on the POC. Staff education should also be considered when determining the corrective action completion dates.