STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315195	A. BUILDING **01** B. WING _____	**11/15/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT BERKELEY HEIGHTS	**35 COTTAGE STREET** **BERKELEY HEIGHTS, NJ 07922**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the New Jersey Department of Health, Health Facility Survey and Field Operations on 11/10/22, was found to be in noncompliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire, and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 EXISTING Health Care Occupancy The facility is a one-story building that was built in 80's, It is composed of Type I fire resistant construction. The facility is divided into 6- smoke zones. The generator does approximately 80% of the building. The current census is 118 at 77.	K 000		
K 211 SS=F	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 observations, interview and documentation review on 11/10/22, in the presence of the Maintenance Director (MD), it was determined that the facility failed to inspect fire doors annually in accordance with S&C 17-38-LSC. This deficient practice occurred for 7 of 7 fire doors observed, and was evidenced by the following:	K 211	Corrective action A third part vendor has been contacted to perform required testing. Identification of at risk residents All the residents at the facility were potentially at risk for this deficient	1/19/23

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

Electronically Signed | 11/24/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 211	Continued From page 1 From approximately 10:00 AM to 2:00 PM, the surveyor reviewed all documentation provided from the MD. The annual fire door inspection documentation was not provided for the facility's fire door assemblies. An interview was conducted with the MD, during the document review. He stated that currently they could not provide any documentation for the last 12-months as identified in the S&C 17-38-LSC documentation. The Administrator was informed of the finding's at the Life Safety Code exit conference held on 11/10/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 80 NFPA 101 2012 edition Life Safety Code 7.2.1.15 Inspection of Door Openings. 7.2.1.15.1* to 7.2.1.15.8 S&C 17-38-LSC NFPA 101- 2012 edition Life Safety Code 19.7.3 Maintenance of Means of Egress 19.7.3.1	K 211	practice. Systematic change The Administrator In-serviced the Maintenance Director regarding inspecting the fire doors annually. Maintenance Director was made aware that all fire doors need to be inspected annually. The Maintenance Director will see to it that all fire doors are inspected annually. Quality Assurance QAPI team will audit the Maintenance Directors annual fire inspection log quarterly to ensure all fire doors are inspected annually.	
K 281 SS=E	Illumination of Means of Egress CFR(s): NFPA 101 Illumination of Means of Egress Illumination of means of egress, including exit discharge, is arranged in accordance with 7.8 and shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/10/22,	K 281	Corrective action	12/16/22

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K 281	Continued From page 2 in the presence of facility management, it was determined that the facility failed to provide emergency illumination that would operate automatically along the means of egress in accordance with NFPA 101, 2012 Edition, Section 19.2.8 and 7.8. The deficient practice affected 2 of 6 exit access areas observed and was evidenced by the following: 1). At 10:37 AM, the surveyor in the presence of the Maintenance Director (MD), observed the exit/egress main foyer had four light switches by the receptionist desk, that shutoff 13 ceiling fixtures in the means of egress and had no lighting when the switches was in the off position. 2). At 12:42 PM, the surveyor in the presence of the MD, observed in the resident dining room, that 2 sets of wall light switches when shutoff, the means of egress and had no lighting. The MD, confirmed the findings at the time of observations. The Administrator was informed of these findings at the Life Safety Code survey exit conference on 11/10/22. NFPA 101-2012 edition Life Safety Code: 7.8 Illumination of Means of Egress: 7.8.1.3* (2) NJAC 8:39-31.2(e)	K 281	Immediately installed keyed toggle switch at receptionist area and In the resident dining room on 11.16.22 At risk residents All residents at the facility were potentially at risk for this deficient practice Systematic change The Administrator in serviced the Maintenance Director regarding illumination of means of Egress that shall be either continuously in operation or capable of automatic operation without manual intervention. The Maintenance Director will check the illumination of all Egress weekly. QA Maintenance Director will check all Egress weekly to ensure proper illumination of means of Egress. QAPI team will audit the log monthly.	
K 324 SS=E	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	K 324		12/16/22

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K 324	Continued From page 3 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 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, interview and review, on 11/10/22, in the presence of facility management, it was determined that the facility failed to ensure that 1 of 1 kitchen ansul system inspection tags were inspected monthly in accordance with NFPA 96 and NFPA 10. The deficient practice was evidenced by the following: At 12:50 PM, the surveyor and Maintenance Director (MD) observed in the facility kitchen, that the monthly inspection tag was blank and no required monthly inspection of the ansul system was logged.	K 324	Corrective action The Ansul system was inspected immediately and found to be in good working condition. At risk residents All the residents in the facility were potentially at risk for this deficient practice. Systemic change The Administrator in serviced the Maintenance Director that Ansul system	

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K 324	Continued From page 4 At this time, the surveyor interviewed the MD, who confirmed that the ansul monthly inspection tag was not completed and left blank. The Administrator was informed of the deficiency at the Life Safety Code exit conference on 11/10/22. NJAC 8:39-31.2(e) NFPA 96 and NFPA 10.	K 324	needs to be inspected monthly. Maintenance Director added Ansul system to his monthly log. QA Administrator will audit Ansul system inspection log monthly which shows that the system is operating correctly. The QAPI team meets monthly and administrator will review the results of audit at the monthly QAPI meeting.	
K 341 SS=F	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/10/22, in the presence of the Maintenance Director (MD), it was determined that the facility failed to	K 341	Corrective action Horn strobe installed on 1.20.2023.	1/24/23

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K 341	Continued From page 5 provide fire alarm notification by audible and visible signals for 1 of 1 enclosed courtyards in accordance with NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9 The deficient practice was evidenced by the following: At 12:38 PM, the surveyor and MD, observed in the enclosed [redacted] courtyard, that no evidence of a fire alarm notification (horn/strobe) was located. An interview was conducted during the observation and the surveyor asked the MD, if there was a horn/strobe, tied into the fire alarm system within the above enclosed courtyard. The MD both confirmed that currently there are no horn/strobe devices tied into the fire alarm system in the enclosed courtyard observed. The Administrator was notified of the findings at the Life Safety Code exit conference on 11/10/2022. NJAC 8:39-31.2(a) NFPA 101, 2012 LSC Edition , Section 19.3.4.3.1, 9.6.3, 9.6.3.2, 9.6.3.6 and NFPA 72, 2010 LSC Edition, Section 18.5, 18.5.2.4, 24.4.2.20.9	K 341	At risk residents All the residents in the facility were potentially at risk for this deficient practice. Systemic change The administrator in serviced the maintenance director that the facility needs to provide fire alarms with notification by audible and visible signals for enclosed courtyards. QA Maintenance Director will audit the courtyard monthly to ensure it has a fire alarm with notification by audible and visible signals. QAPI team will review the findings quarterly.	
K 347 SS=F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2	K 347		11/24/22

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K 347	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review on 11/10/22, in the presence of the Maintenance Director, it was determined that the facility failed to ensure that there was a testing, maintenance, and battery replacement program to ensure proper operation of the battery operated smoke detectors as per NFPA 72. This deficient practice was evidenced for 30 of 40 observed battery operated smoke detectors and evidenced by the following: A tour of the facility at 11:15 AM, revealed that the facility resident rooms were provided with battery operated smoke detectors except for the [redacted] resident rooms. A review of the facility's preventative maintenance logs did not indicate that there was a preventative maintenance program for the testing of the detectors or for battery replacement. In an interview, at 11:55 AM, the facility's Maintenance Director, stated that there was no preventative maintenance documentation for testing the battery operated smoke detectors in resident rooms and could not provide any documentation on the year of installation. He stated that he tested the alarms by pushing the test button periodically and replaced the batteries when the alarms indicated low battery, but he did not record any information on a log. This deficient practice would not ensure the proper operation of these devices and would not ensure that staff was signaled of a smoke	K 347	Corrective action Maintenance Director added the detector type, brand, installation date, and battery type to monthly smoke detector inspection log. At risk resident All the residents in the facility were potentially at risk for this deficient practice. Systemic change Administrator in serviced Maintenance Director that all battery-operated smoke detectors in the facility need testing, maintenance, and battery replacement program to ensure proper operation of the battery-operated smoke detectors. QA QAPI team will audit quarterly the smoke detector log to ensure that all battery-operated smoke detectors have testing, maintenance, and battery replacement program to ensure proper operation of the battery operated smoke detectors.	

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K 347	Continued From page 7 condition prior to the smoke entering the exit corridor where permanently wired smoke detectors were located. The administrator was informed of the findings at the Life Safety Code exit conference on 11/10/22. NJAC 8:39-31.2(e) NFPA 101 Life Safety Code 2012 edition 19.3.6.1, 19.3.4.5.2	K 347		
K 363 SS=E	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	K 363		12/16/22

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K 363	Continued From page 8 materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/10/22 in the presence of the Maintenance Director (MD), it was determined that the facility failed to ensure that corridor doors were able to resist the passage of smoke in accordance with the requirements of NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5. This deficient practice of not ensuring room doors closed completely to properly confine fire and smoke products and to properly defend occupants in place. This deficient practice was further identified in 5 of 40 residents' room doors observed and was evidenced by the following: During the building tour from 9:15 AM to 3:00 PM, the surveyor and MD toured the facility and observed: Resident Room [redacted] would not latch, due to a hardware malfunction. Resident Room # B-31 top section of the wooden	K 363	Corrective action Immediately fixed all doors and made sure that they were smoke proof. At risk residents All the residents in the facility were potentially at risk for this deficient practice. Systemic change Administrator in serviced the Maintenance Director that all doors need to resist the passage of smoke, therefore all doors need to latch and warp. QA Maintenance Director will audit 4 doors a week to ensure they resist the passage of smoke. Maintenance Director will review findings every quarter at QAPI	

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K 363	Continued From page 9 door was warped, preventing the door from being smoke resistant. Resident Room [redacted] top section of the wooden door was warped, preventing the door from being smoke resistant. Resident Room [redacted] top section of the wooden door was warped, preventing the door from being smoke resistant. Resident room [redacted] would not latch, due to a hardware malfunction. At the time of observations, the surveyor interviewed the MD, who confirmed the above findings. The Administrator was informed of the findings at the Life Safety Code Exit Conference on 11/10/22. NJAC 8:39-31.1(c), 31.2(e) NFPA 101, 2012 LSC Edition, Section 19.3.6, 19.3.6.3, 19.3.6.3.1 and 19.3.6.5.	K 363		
K 911 SS=E	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:	K 911		12/16/22

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K 911	Continued From page 10 Based on observation and interview, the facility did not maintain the required clearance around electrical panels, guarding of live parts of electrical equipment and controls with unlocked panels in resident accessible areas in accordance with NFPA 101, 2012 Edition, Section 19.5.1,19.5.1.1, 9.1, 9.1.2, NFPA 99 2012 Edition, Section 6.3.2.1, 15.5.1.2 and NFPA 70 2011 Edition, Section 110.26, 110.27 and 110.16. This deficient practice of electrical panels not guarded against accidental contact by approved enclosures and unlocked panels in resident accessible areas. At 11:38 AM, the surveyor and Maintenance Director (MD), observed two (2) electrical wall panels marked: EM-2, UP-2, that were not locked. The panels were located in the exit/egress corridor. The observations were confirmed by the MD during the tour of the facility. The Administrator was informed of the above observations at the Life Safety Code exit conference on 11/10/22. NJAC 8:39-31.2(e) NFPA 70, 99	K 911	Corrective action Electric panels were locked immediately At risk residents All the residents in the facility were potentially at risk for this deficient practice. Systemic change Administrator in serviced Maintenance Director that the facility needs to guard live parts of electrical equipment and controls by locking the panels in resident areas. QA Maintenance director will audit live parts of electrical equipment and controls to make sure their panels are locked weekly. QAPI team will review quarterly	
K 918 SS=E	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	K 918		12/16/22

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K 918	Continued From page 11 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 installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on observations, interview, and review of facility documents on 11/10/22, in the presence of the Maintenance Director (MD), it was determined that the facility failed to a.) certify the time needed by their generator to transfer power to the building was within the required 10-second time frame, in accordance with NFPA 99 for emergency electrical generator systems and b.) ensure that a	K 918	Corrective action Transfer of power from generator to the building was checked immediately and was found in compliance it took less than 10 seconds. Remote stop for generator installed immediately	

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	315195	A. BUILDING **01** B. WING _____	**11/15/2022**

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AUTUMN LAKE HEALTHCARE AT BERKELEY HEIGHTS	**35 COTTAGE STREET** **BERKELEY HEIGHTS, NJ 07922**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 12 remote manual stop station for the generator was provided in accordance with the requirements of NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. This deficient practice was evidenced for 1-generator log provided by the MD by the following: a). At 9:30 AM, a review of the generator records for the previous twelve months did not reveal documented certification that the generator would start and transfer power to the building within ten seconds. Currently, the monthly load test document provided by the MD indicated no transfer time was being logged. An interview was conducted with the MD during the document review and he stated that no transfer time was being documented currently on the log provided. b). At 12:40 PM, the surveyor, and MD, observed that the facility's generator did have a remote shutoff. An interview was conducted during the observation with the MD, he confirmed that the generator did not have a remote manual stop station to prevent inadvertent or unintentional operation located (remote) of the (yellow) enclosure housing the prime mover. The Administrator was informed of the findings at the Life Safety Code Exit Conference on 11/10/22. NJAC 8:39-31.2(e), 31.2(g) NFPA 99	K 918	At risk residents All the residents in the facility were potentially at risk for this deficient practice. Systemic change Administrator in serviced Maintenance Director that the generator needs to be capable of transferring power to the facility within 10 seconds. Administrator also in serviced Maintenance Director generator needs a remote shutoff to prevent inadvertent or unintentional operation located of the enclosure housing the prime mover. QA Maintenance Director will audit the transfer of power from the generator to the facility monthly. Maintenance Director will also audit that the generator has a remote shutoff weekly. QAPI team will review this with the Maintenance Director quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315195	A. BUILDING **01** B. WING _____	**11/15/2022**

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AUTUMN LAKE HEALTHCARE AT BERKELEY HEIGHTS	**35 COTTAGE STREET** **BERKELEY HEIGHTS, NJ 07922**

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K 918	Continued From page 13 NFPA 110, 2010 Edition, Section 5.6.5.6 and 5.6.5.6.1. NFPA 101 Life Safety Code 2012 edition 9.1.3.1 Standard for Emergency and Standby Power Systems	K 918		
K 927 SS=F	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview on 11/10/22, in the presence of facility management, it was determined that the facility failed to maintain the trans filling liquid oxygen room to prevent accidental ignition in accordance with NFPA 99, 2012 Edition, Section 11.3.3.2 and 11.3.2.7 by ensuring that the room is properly designed and protected. This deficient practice was evidenced for 1 of 1 light fixtures and was evidenced by the following: At approximately 10:40 AM, the surveyor and Maintenance Director (MD) observed in the liquid oxygen trans filling room, that contained 40 portable oxygen cylinders and 2 liquid oxygen	K 927	Corrective action Explosion proof light ordered immediately At risk residents All residents at the facility were potentially at risk for this deficient practice Systemic change Administrator in serviced Maintenance Director that the oxygen room needs to be properly protected with explosion proof light.	12/16/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315195	A. BUILDING **01** B. WING _____	**11/15/2022**

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K 927	Continued From page 14 tanks,a non-explosion proof light fixture was installed. An interview was conducted during the observation with the MD, who stated and confirmed that the trans filling room had a source of ignition (1) non-explosion proof ceiling light fixture. The Administrator was informed of the finding at the Life Safety Code exit conference on 11/10/22. NJAC 8:39-31.2(e)	K 927	QA Maintenance Director will audit that the oxygen room has a explosion proof light monthly and the QAPI team will review with the maintenance Director quarterly	