

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155478	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2013
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NAME OF PROVIDER OR SUPPLIER TIMBERS OF JASPER THE	STREET ADDRESS, CITY, STATE, ZIP CODE 2909 HOWARD DR JASPER, IN 47546
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K010000	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 06/25/13</p> <p>Facility Number: 000314 Provider Number: 155478 AIM Number: 100274210</p> <p>Surveyor: Lex Brashear, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, The Timbers of Jasper was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.</p> <p>This one story facility was determined to be of Type V (000) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detectors in the corridors and spaces open to the corridors, plus battery operated smoke detectors in all resident sleeping</p>	K010000	<p>The creation and submission of this Plan Of Correction does not constitute an admission by this provider of a conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan Of Correction be considered the letter of credible allegation and request a desk review on or after July 25, 2013.</p>	

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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	<p>rooms. The facility has a capacity of 94 and had a census of 82 at the time of this survey.</p> <p>All areas where residents have customary access were sprinklered. All areas providing facility services were sprinklered, except two detached sheds used for facility storage.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/03/13.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p>				

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K010018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities. 1. Based on observation and interview, the facility failed to ensure 2 of 2 sets of double doors to the corridors were equipped with positive latches and latched into their door frames. This deficient practice could affect up to 9 residents, as well as staff and visitors while moving between the 100 hall and main dining room, plus up to 22 residents, as well as staff and visitors in the 300 hall.</p> <p>Findings include:</p> <p>Based on observations on 06/25/13 between 11:30 a.m. and 2:00 p.m. during a tour of the facility with the Environmental Supervisor, the Marketing/Admissions Office had a set of</p>	K010018	<p>K 018</p> <p>COMPLETION DATE 7/25/2013</p> <p>Plan Of Correction Text:</p> <p>It is the intent of this community to ensure that all doors have proper door closing devices per Life Safety Code Standard.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>All residents have the potential to be affected.</p> <p>A latch was installed July 8, 2013 on the double doors located on the Marketing office as well as the closet</p>	07/25/2013			

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	<p>double doors to the corridor that did not latch positively into the door frame, furthermore, the closet for briefs and batteries storage in the 300 hall had a set of double doors to the corridor that did not latch positively into the door frame. Both sets of double doors had to be manually latched with a slide bolt latch located on the side of the doors. This was acknowledged by the Environmental Supervisor at the time of each observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure 1 of 1 Dutch doors was smoke resistant. NFPA 101 at 19.3.6.3.6 states Dutch doors shall be permitted as long as the meeting edges of the upper and lower leaves shall be equipped with an astragal, a rabbet, or a bevel. This deficient practice could affect up to 22 residents, as well as staff and visitors in Auguste's Cottage (500 hall).</p> <p>Findings include:</p> <p>Based on observation on 06/25/13 at 1:22 p.m. during a tour of the facility with the Environmental Supervisor, the office in Auguste's Cottage was equipped with a Dutch door to the corridor which had a one inch gap between the upper and lower</p>		<p>door on the brief and storage closet, located on 300 hall. These latches are positive latching into the door frame.</p> <p>This corrective action will ensure that the closing device of these doors meets Life Safety Code Standards.</p> <p>A Hard wired smoke detector and an Astragal were installed in the Auguste's Cottage 500 hall in the room where the Dutch doors are located.</p> <p>This corrective action will ensure that this room will meet the Life Safety Code Standards.</p>				

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	<p>leaves of the door and did not have an astragal, a rabbet, or a bevel. This was acknowledged by the Environmental Supervisor at the time of observation.</p> <p>3.1-19(b)</p>			

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K010029 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>Based on observation and interview, the facility failed to ensure 3 of 18 hazardous area room doors, such as rooms over 50 square feet containing combustible material, were equipped with self closing devices on the doors. This deficient practice could affect mostly staff and visitors in the 200 hall because residents do not use this area.</p> <p>Findings include:</p> <p>Based on observation on 06/25/13 between 11:30 a.m. and 2:00 p.m. during a tour of the facility with Environmental Supervisor, the corridor doors to the Maintenance Shop, Housekeeping room, and the Medical Records room were not provided with self closing devices. All three of these rooms were over one hundred square feet in size and contained combustible material such as cardboard</p>	K010029	<p>K 029</p> <p>COMPLETION DATE 7/25/2013</p> <p>Plan of Correction Text:</p> <p>It is the intent of this community that all doors are equipped with a self closing device per Life Safety Code Standards.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>All residents have the potential to be affected.</p> <p>A self closing device was installed on the Maintenance Shop, the Housekeeping room, and the Medical Records room.</p> <p>This corrective action will ensure</p>	07/25/2013	

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	boxes, paper, plastic, and cleaning chemicals. This was acknowledged by the Environmental Supervisor at the time of each observation. 3.1-19(b)		that the closing of these doors will meet the Life Safety Code Standards.		

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K010052 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on record review and interview, the facility failed to ensure documentation for the testing of 41 of 41 smoke detectors was correct. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72, 7-3.2 requires fire alarm system devices such as smoke detectors be tested annually. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on review of the facility's semiannual fire alarm system inspection reports from IEI on 06/25/13 at 10:55 a.m. with the Environmental Supervisor present, the most recent fire alarm system inspection report dated 12/19/12 indicated on the cover page the facility had thirty two Ion type smoke detectors and eleven Photo type smoke detectors, however, the itemized list of smoke detectors on the same report, as well as the previous semiannual report dated 06/26/12 and the most recent sensitivity testing report dated 01/05/12 all indicated the facility was</p>	K010052	<p>K 052</p> <p>It is the intent of this community to keep accurate documentation according Life Safety Code Standards.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>All residents have the potential to be affected.</p> <p>The Fire Alarm inspector, IEI was contacted for a revisit to verify and provide an accurate smoke detector audit. This audit was completed 6/26/2013 by IEI and is accurate. This corrective action will ensure that all inspection reports are accurate and meet the Life Safety Code Standards.</p>	07/25/2013			

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	<p>equipped with thirty five Ion type smoke detectors and six Photo type smoke detectors. During an interview at the time of record review, the Environmental Supervisor acknowledged the discrepancy in the number of smoke detectors listed on the cover page in comparison to the itemized lists of previous reports.</p> <p>3-1.19(b)</p>				

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K010056 SS=B	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to insure 1 of 8 smoke compartments had sprinkler heads installed in accordance with NFPA 13, Section 5-1.1 and 5-6.3.4 which requires sprinklers be located no closer than six feet measured on center. This deficient practice could affect up to 9 residents, as well as staff and visitors while near the Nurses' Station on 100 and 200 hall.</p> <p>Findings include:</p> <p>Based on an observation on 06/25/13 at 12:15 p.m. during a tour of the facility with the Environmental Supervisor, there were two sprinkler heads within four and a half feet of each other over the Nurses' Station for the 100 and 200 halls. This was acknowledged by the Environmental</p>	K010056	<p>K 056</p> <p>COMLETION DATE 7/25/2013</p> <p>Plan of correction Text:</p> <p>It is the intent of the community to have a Sprinkler System to provide complete coverage for all portions of the building.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice;</p> <p>All residents have the potential to be affected.</p> <p>The sprinkler heads located above the 100 hall nurse station will be relocated to the appropriate location to ensure Life Safety Code</p>	07/25/2013			

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	Supervisor at the time of observation. 3.1-19(b)		Standards. This corrective action will ensure that proper sprinkler head coverage is in place to meet the Life Safety Code Standards.		

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K010062 SS=C	<p>NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>1. Based on observation and interview, the facility failed to ensure 4 of over 500 sprinkler heads in the facility were free of paint. NFPA 101 Section 9.7.5 refers to NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25 2-2.1.1 requires sprinklers to be free of paint. Any sprinkler shall be replaced that is painted. This deficient practice could affect mostly staff and visitors while in the 200 hall because residents do not use this area.</p> <p>Findings include:</p> <p>Based on observations on 06/25/13 between 11:30 a.m. and 2:00 p.m. during a tour of the facility with the Environmental Supervisor, the sprinkler head in the storage closet by the MDS office was partially covered with paint, furthermore, three of five sprinkler heads (including the bathroom sprinkler head) in the Medical Records room were partially covered with paint. This was acknowledged by the Environmental Supervisor at the time of each</p>	K010062	<p>K 062</p> <p>COMPLETION DATE 7/25/2013</p> <p>Plan of Correction Text:</p> <p>It is the intent of this community to ensure that an automatic sprinkler system is continuously maintained in reliable operating condition and are inspected and tested periodically.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>All residents have the potential to be affected.</p> <p>New sprinkler heads were ordered July 8, 2013 for 4 of over 500 sprinkler heads located on the 200 hall, storage closet, the bathroom sprinkler head and Medical Records room do to paint splatters on sprinkler heads.</p> <p>New sprinkler heads were ordered July 8, 2013 for 15 of over 500 sprinkler heads located near the main entrance, 100 and 200 hall</p>	07/25/2013			

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	<p>observation.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to ensure only one type of sprinkler head, i.e., quick response or standard sprinklers were installed in a compartmented space in 2 of 8 smoke compartments. NFPA 13, 1999 Edition, Installation of Sprinkler Systems, 5-3.1.5.2 states when existing light hazard systems are converted to use quick response or residential sprinklers, all sprinklers in a smoke compartment shall be changed. This deficient practice could affect up to 9 residents, as well as staff and visitors while near the Front Entrance area which included the 100 and 200 hall Nurses' Station and Reception area, also, 2 residents in room 406.</p> <p>Findings include:</p> <p>Based on observations on 06/25/13 between 11:30 a.m. and 2:00 p.m. during a tour of the facility with the Environmental Supervisor, three of the fourteen sprinkler heads in the Front Entrance area were quick response sprinkler heads and the other eleven were standard response sprinkler heads, furthermore, resident room 406 had one quick response sprinkler head and one</p>		<p>nurses station, and room 406. These new sprinkle heads will be installed by qualified professionals to ensure proper installation to meet the requirements of Life Safety Code Standards.</p> <p>Additional sprinkler heads were ordered July 8, 2013, 2 Sidewall, 2 Standard Response, 2 Quick Response were ordered according to Life Safety Code Standards to ensure we have accurate supply when needed.</p> <p>This corrective action will ensure that all requirements are met for Life Safety Code Standards pertaining to Sprinkler systems.</p>				

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	<p>standard response sprinkler head together. This was acknowledged by the Environmental Supervisor at the time of each observation.</p> <p>3.1-19(b)</p> <p>3. Based on observation and interview, the facility failed to ensure 1 of 1 automatic sprinkler head storage cabinets was provided with at least two of each type of sprinkler head used in the facility. NFPA 25, 2-4.1.4 requires a minimum of two sprinklers of each type and temperature rating installed shall be stored in a cabinet on the premises for replacement purposes. This deficient practice could affect all residents, as well as staff and visitors in the facility.</p> <p>Findings include:</p> <p>Based on observations on 06/25/13 between 11:30 a.m. and 2:00 p.m. during a tour of the facility with the Environmental Supervisor, the spare sprinkler head cabinet in the facility had more than six spare sprinkler heads, however, there were no side wall, standard response pendent, and quick response pendent type sprinkler heads included. The only spare sprinkler heads available were quick response overhead type. Sidewall sprinkler heads were</p>				

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	<p>observed outside a few exits under overhangs, plus standard pendent type and quick response pendent type sprinkler heads were observed throughout the facility. This was acknowledged by the Environmental Supervisor at the time of observations, furthermore, the Environmental Supervisor indicated there were no other spare sprinkler heads in the facility.</p> <p>3-1.19(b)</p>			

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(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			
K010066 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>Based on observation and interview, the facility failed to ensure cigarette butts were properly disposed of at 1 of 1 areas where smoking was allowed. This deficient practice could affect 3 residents who smoke, plus up to 5 more residents, as well as staff and visitors that would use this area to evacuate the Physical Therapy area in the event of a fire or other emergency.</p> <p>Findings include:</p> <p>Based on observation on 06/25/13 at</p>	K010066	<p>K 066</p> <p>COMPLETION DATE 7/25/2013</p> <p>Plan of Correction Text:</p> <p>It is the intent of this community to provide proper means of disposal of cigarette butts per Life Safety Code Standards.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p>	07/25/2013			

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	<p>12:45 p.m. during a tour of the facility with the Environmental Supervisor, the smoking area outside the Physical Therapy hall exit was provided with two smoke towers for the disposal of cigarette butts, however, one of the smoke towers had the top portion off exposing a large bucket full of cigarette butts.</p> <p>Furthermore, forty to fifty cigarette butts were scattered on the ground all around this area. This was acknowledged by the Environmental Supervisor at the time of observation.</p> <p>3-1.19(b)</p>		<p>All residents have the potential to be affected.</p> <p>New Ashtrays of noncombustible material with self-closing cover devices were purchased. These Ashtrays are available in all areas where smoking is permitted.</p> <p>This corrective action will ensure that we meet Life Safety Code Standards.</p>		

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K010130 SS=F	<p>NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation, record review, and interview; the facility failed to ensure 4 of 4 fuel fired water heaters had an inspection certificate that was current to ensure the water heaters were in safe operating condition. NFPA 101 in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect all residents, as well as staff and visitors because the water heaters were located throughout the facility.</p> <p>Findings include:</p> <p>Based on observations on 06/25/13 between 11:30 a.m. and 2:00 p.m. during a tour of the facility with Environmental Supervisor, the inspection certificates located next to the four fuel fired water heaters had expiration dates of 12/10/12. During an interview at the time of observations, the Environmental Supervisor acknowledged the expiration dates on water heaters and said he was not aware of the water heaters being inspected since the expiration dates.</p> <p>3.1-19(b)</p>	K010130	<p>K 130</p> <p>COMPLETION DATE 7/25/2013</p> <p>Plan of Correction Text:</p> <p>It is the intent of this community to ensure that the water heaters have inspection certificates and in safe operating condition.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>All residents have the potential be affected.</p> <p>The 4 of 4 fuel fired Boilers/water heaters were inspected by a qualified inspector 7/2/2013 and inspection certificates posted.</p> <p>This corrective action will ensure that the 4 of 4 fuel fired boilers/water heaters remain in safe operating order according to Life Safety Code Standards.</p>	07/25/2013			

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K010143 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is:</p> <p>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;</p> <p>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and</p> <p>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2</p> <p>Based on observation and interview, the facility failed to ensure the door to 1 of 1 oxygen storage/transferring rooms was provided with a self closing device, furthermore, the facility failed to ensure electrical fixtures in 1 of 1 oxygen storage/transferring rooms were positioned at least five feet above the floor. NFPA 99, 1999 Edition Standard for Health Care Facilities, Section 8-3.1.11.2(f) requires electrical fixtures in oxygen storage locations shall meet 4-3.1.1.2(a)11(d) which requires ordinary electrical wall fixtures in supply rooms shall be installed in fixed locations not less than 5 feet above the floor to avoid physical damage. This deficient practice could affect up to 5 residents, as well as staff and visitors while in the Physical</p>	K010143	<p>K 143</p> <p>COMPLETION DATE 7/25/2013</p> <p>Plan of Correction Text:</p> <p>It is the intent of this community that the oxygen storage/transferring room have a self closing device, the Electrical fixture be located at least 5 feet above the floor.</p> <p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>All residents have the potential to be affected.</p>	07/25/2013			

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	<p>Therapy area which was in the same smoke compartment as the oxygen storage/transferring room.</p> <p>Findings include:</p> <p>Based on observation on 06/25/13 at 12:40 p.m. during a tour of the facility with the Environmental Supervisor, the door to the oxygen storage/transferring room was not provided with a self closing device, furthermore, there were two electrical fixtures on the wall (one light switch and one outlet) installed less than five feet above the floor. Based on interview at the time of observation, the Environmental Supervisor acknowledged there was no self closing device on the oxygen storage/transferring room door and there were two electrical fixtures located less than five feet above the floor.</p> <p>3.1-19(b)</p>		<p>A self closing device was installed on the door of 1 of 1 oxygen storage/transferring rooms.</p> <p>This corrective action will ensure that the closing of this door will meet Life Safety Code Standards.</p> <p>The electrical fixtures in the 1 of 1 oxygen storage/transferring room were repositioned to five feet above the floor.</p> <p>This corrective action will ensure that the electrical fixture will meet the Life Safety Code Standards.</p>		