

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155094	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED  08/21/2012
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NAME OF PROVIDER OR SUPPLIER  ST MARY HEALTHCARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2201 CASON ST LAFAYETTE, IN 47904
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K0000	<p>A Life Safety Code Recertification, State Licensure, and a Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/21/12</p> <p>Facility Number: 000037 Provider Number: 155094 AIM Number: 100291350</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, St. Mary Healthcare Center 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 (111)</p>	K0000	Submission of this Plan of Correction does not constitute an admission by St. Mary Healthcare Center of any wrong doing or failure to comply with federal and state regulations. St. Mary Healthcare Center submits this Plan of Correction as its letter of credible allegation.	

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>construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors, spaces open to the corridors and resident rooms. The facility has the capacity for 70 and had a census of 58 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to smoke detector and sprinkler coverage with the exceptions noted at K-56 and K-62.</p> <p>All areas accessible to residents were not sprinklered. All areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/28/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by:</p>			

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K0018 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. Based on observation and interview, the facility failed to ensure doors protecting corridor openings in 1 of 12 smoke compartments could latch into the door frame. This deficient practice affects staff, visitors and 16 residents in the Legacy Hall smoke compartment.</p> <p>Findings include:  Based on observation with the maintenance director on 08/21/12 between 1:00 and 1:30 p.m., doors protecting resident rooms 209 and 212 on the Legacy hall failed to latch when each was tested twice. The maintenance</p>	K0018	<p>CORRECTIVE ACTIONThe Director of Plant Operations took the strike plate off and adjusted the stripe plate for proper closure for rooms 209 and 212. OTHER RESIDENTS The Director of Plant Operations will check all resident rooms for proper closure and will adjust stripe plates if needed. MEASURES/SYSTEMIC CHANGESThe Director of Plant Operations or designee will check each resident room one time per week for proper closure. The results will be documented on an audit form. MONITORING CORRECTIVE ACTIONThe Director of Plant Operations will report results of the audit form to the QA Committee monthly x 6 months.</p>	09/20/2012			

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	<p>director acknowledged at the time of observations, the doors were not latching.</p> <p>3.1-19(b)</p>			

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K0025 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>Based on observation and interview, the facility failed to ensure openings through ceiling and wall smoke barriers in 2 of 9 smoke compartments were maintained to provide the 1/2 hour smoke resistance of the smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient could affect visitors, staff and 49 residents in the Legacy and center smoke compartments.</p>	K0025	<p>CORRECTIVE ACTIONThe fire wall on the south side of room #201 will be corrected with proper fire wall materials that meet fire rating standards. In addition the facility has received a copy of the MSDS sheets for the fire rated packing material which was used on the north side of the firewall. IDENTIFY OTHER RESIDENTSAll fire walls will be inspected by the outside contractor and Director of Plant Operations to ensure fire rated materials are used. MEASURES/SYSTEMIC CHANGESDuring inspection of all fire walls, the Director of Plant Operations will ensure fire wall materials are used and are corrected immediately. CORRECTIVE ACTIONThe Director of Plant Operations will report findings of the inspection of fire walls to the QA Committee. The Director of Plant Operations will also inspect fire walls when</p>	09/20/2012	

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	<p>Findings include:</p> <p>Based on observation with the maintenance director on 08/21/12 between 12:05 p.m. and 3:00 p.m., the two to four inch gaps in the smoke barrier wall above the lay in ceiling and south center smoke barrier doors had been filled with a foam material and painted. On the north side of the fire wall above the lay in ceiling near room 201, a gap of two to four inches had been filled with a foam material and painted. On the south side of the same fire wall near 201, the gap was filled with fiberglass insulation. The maintenance director said at the time of observations, contractors had used fire rated materials to seal these but he had no documentation to evidence their fire ratings.</p> <p>3.1-19(b)</p>		contractors have been in the building and report findings to the QA Committee monthly.		

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K0029 SS=E	<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 provide automatic door closers on 5 of 10 doors providing access to hazardous areas. Sprinklered hazardous areas are required to be equipped with self closing doors or with doors that close automatically upon activation of the fire alarm system. This deficient practice could affect visitors, staff and and 4 or more staff in the service corridor and 49 residents in the center, and station 2 and 3 smoke compartments.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on</p>	K0029	<p>CORRECTIVE ACTIONThe Director of Plant Operations installed 4 door closures on the 4 areas identified during survey.</p> <p>IDENTIFY OTHER RESIDENTSThe Director of Plant Operations will test all door closures to ensure proper closure. MEASURES/SYSTEMIC CHANGESThe Director of Plant Operations will test all door closures one time per month for proper closure. CORRECTIVE ACTIONSThe Director of Plant Operations will test all door closures and report findings to the QA Committee one time per month x six months.</p>	09/20/2012	

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	<p>08/21/12 at 1:00 p.m., the 66 square foot storage room near room 114 contained cardboard and plastic wrapped supplies. The door had no self closer. The maintenance director confirmed at the time of observation, the door was not self closing.</p> <p>b. Based on observation with the maintenance director on 08/21/12 between 1:05 p.m. and 2:15 p.m., the soiled linen and trash storage room in the northwest smoke compartment and utility room near Nurses Desk 2 each contained two 32 gallon rubber barrels which were more than half full. The access doors had no self closers. The maintenance director confirmed at the time of observations, the doors were not self closing.</p> <p>c. Based on observation with the maintenance director on 08/21/12 at 2:20 p.m., the access door to the 120 square foot clean linen storage room near Nurses Desk 3 had no self closer. The maintenance director acknowledged at the time of observation, the door was not self closing.</p> <p>d. Based on observation with the</p>			

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	<p>maintenance director on 08/21/12 at 2:00 p.m., the kitchen access door from the center corridor had no self closer. The maintenance director confirmed at the time of observation, the door closer had not been installed.</p> <p>3.1-19(b)</p>			

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K0048 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to include the evacuation of the smoke compartment, the types of fire extinguishers available, or the use of the K-class fire extinguisher in conjunction with the overhead hood system in the written fire plan for the protection of 58 of 58 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan shall provide for the following:</p> <ol style="list-style-type: none"> <li>(1) Use of alarms</li> <li>(2) Transmission of alarm to the fire department</li> <li>(3) Response to alarms</li> <li>(4) Isolation of fire</li> <li>(5) Evacuation of immediate area</li> <li>(6) Evacuation of smoke compartment</li> <li>(7) Preparation of floors and building for evacuation</li> <li>(8) Extinguishment of fire</li> </ol> <p>The plan should include each type of fire extinguisher available and any special requirement for their usage.</p>	K0048	<p><b>CORRECTIVE ACTION</b>The facility emergency manual was updated to include evacuation of the smoke compartment, types of fire extinguishers available, and use of k class extinguisher. <b>IDENTIFY OTHER RESIDENTS</b>All residents have the potential to be affected by the deficient practice. The facility emergency manual was updated to include evacuation of the smoke compartment, types of fire extinguishers available, and use of k class extinguisher. <b>MEASURES/SYSTEMIC CHANGES</b>The Director of Plant Operations will inservice all staff regarding updated policies in the emergency manual. <b>CORRECTIVE ACTION</b>The Director of Plant Operations will review the new policies in the emergency manual for approval of the QA Committee.</p>	09/20/2012			

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	<p>This deficient practice could affect all occupants.</p> <p>Findings include:</p> <p>Based on review of the Fire Procedure with the maintenance director on 08/21/12 at 2:50 a.m., the plan did not address internal evacuation from one smoke compartment to another. In addition, the fire safety plan did not identify available fire extinguishers and address the K-class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. The maintenance director acknowledged at the time of record review, these elements were not addressed in the fire plan.</p> <p>3.1-19(b)</p>			

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K0050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at 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. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>Based on record review and interview, the facility failed to ensure fire drills were conducted quarterly on each shift for 1 of the last 4 quarters. This deficient practice could effect all residents, staff and visitors in the event of an emergency.</p> <p>Findings include:</p> <p>Based on review of the facility's Fire Drill Reports and interview with the maintenance director on 08/21/12 at 2:55 p.m., there was no record of a first shift fire drill for the second quarter of 2012. The maintenance drill acknowledged at the time of record review, the fire drill had not been done.</p> <p>3.1-9(b)</p>	K0050	<p>CORRECTIVE ACTIONThe finding cannot be corrected. The Director of Plant Operations has conducted a fire drill on the first shift during the 3rd quarter.</p> <p>IDENTIFY OTHER RESIDENTSAll residents have the potential to be affected by the deficient practice. The Director of Plant Operations has conducted a fire drill on the first shift during the 3rd quarter.</p> <p>MEASURES/SYSTEMIC CHANGESThe Director of Plant Operations conducted an audit of the remaining scheduled 2012 fire drills to ensure that fire drills are conducted on all three shifts quarterly.</p> <p>CORRECTIVE ACTIONThe Director of Plant Operations provided a copy of the scheduled 2012 fire drills to the QA Committee.</p>	09/20/2012			

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K0056 SS=E	<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>1. Based on observation and interview, the facility failed to provide complete sprinkler coverage for 1 of 10 smoke compartments in a one story building of Type V (111) construction. LSC 19.1.6.2 requires one story facilities of Type V (111) construction be provided with complete sprinkler protection. This deficient practice affects residents, staff, and 30 or more residents in the central smoke compartment which includes the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on</p>	K0056	<p>CORRECTIVE ACTIONThe Director of Plant Operations has scheduled contract services to move the identified sprinkler heads. IDENTIFY OTHER RESIDENTSAll residents have potential to be affected by the deficient practice. The Director of Plant Operations has scheduled contract services to move the identified sprinkler heads. MEASURES/SYSTEMIC CHANGESThe Director of Plant Operations will inspect all sprinkler heads to ensure that sprinkler heads meet requirements for Water-Based Fire Protections Systems. CORRECTIVE ACTIONThe Director of Plant Operations will report findings of sprinkler inspection to the QA Committee.</p>	09/20/2012			

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	<p>08/21/12 between 12:10 and 12:20 p.m., sprinkler protection was not provided for shower stalls in resident rooms 106 and 109. The maintenance director acknowledged at the time of observation, the areas were not protected by the another sprinkler in the rooms.</p> <p>3.1-19(b)</p> <p>2. Based on observation and interview, the facility failed to insure 1 of 10 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. NFPA 13, 4-7.3.3 requires sprinklers shall be located a minimum of four inches from a wall. This deficient practice could affect visitors, staff and 8 or more residents in the Physical Therapy smoke compartment.</p> <p>Findings include:</p> <p>a. Based on observation on 08/21/12 at 1:15 p.m. with the</p>						

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	<p>maintenance director, two pendant sprinkler heads in the physical therapy room measured five feet apart. The maintenance director confirmed at the time of observation, the separation of the sprinkler heads was less than six feet apart.</p> <p>b. Based on observation with the maintenance director on 08/21/12 at 1:35 p.m., the pendant sprinkler head in the Legacy Spa abutted a wall partition. The maintenance director acknowledged at the time of observation, the minimum four inch clearance between the wall and sprinkler did not exist.</p> <p>3.1-19(b)</p>			

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K0062 SS=E	<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>Based on observation and interview, the facility failed to ensure sprinkler heads providing protection for 1 of 10 smoke compartments were maintained. This deficient practice could affect staff, visitors and 27 residents on Legacy hall.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/21/12 between 12:05 p.m. and 3:05 p.m.:</p> <p>a. The pendant sprinkler head escutcheon in the Legacy linen storage room near 210 had a one inch annular gap into the attic above;</p> <p>b. No escutcheon was provided for the activities storage room on the Legacy hall and the sprinkler head was coated with a white powdery material. The maintenance director acknowledged the condition of sprinklers in these areas at the</p>	K0062	<p>CORRECTIVE ACTIONThe Director of Plant Operations fire caulked the sprinkler head in the Legacy Linen storage near room # 210 and installed a new escutcheon and cleaned the sprinkler head in the Legacy storage room. IDENTIFY OTHER RESIDENTSAll residents have the potential to be affected by the same deficient practice. The Director of Plant Operations fire caulked the sprinkler head in the Legacy Linen storage near room # 210 and installed a new escutcheon and cleaned the sprinkler head in the Legacy storage room. MEASURES/SYSTEMIC CHANGESThe Director of Plant Operations will inspect all sprinkler heads to ensure all sprinkler heads are properly secured with escutcheon, and are clean.CORRECTIVE ACTIONThe Director of Plant Operations will report findings to the QA Committee.</p>	09/20/2012			

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	time of observations.  3.1-19(b)			

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K0074 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.</p> <p>Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13</p> <p>Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3</p> <p>Based on observation and interview, the facility failed to ensure loosely hanging fabric in 1 of 10 smoke compartments was rendered flame resistant. LSC 19.7.5.1 requires draperies and other loosely hanging fabrics to be in accordance with 10.3.1. LSC 10.3.1 requires draperies, curtains, and other similar loosely hanging furnishings and decorations to have flame resistance as demonstrated by testing in accordance with NFPA 701, Standard Methods of Fire Tests for Flame Propagation of Textiles and Films. This deficient</p>	K0074	<p>CORRECTIVE ACTIONThe Director of Plant Operations will spray flame control coating on the curtain identified during survey. IDENTIFY OTHER RESIDENTSAll residents have the potential to be affected by the same deficient practice. The Director of Plant Operations will spray flame control coating on the curtain identified during survey. MEASURES/SYSTEMIC CHANGESThe Director of Plant Operations will inspect all bulletin boards for loosely hanging furnishings to ensure they are treated with flame resistant chemicals. MONITORING CORRECTIVE ACTIONSThe Director of Plant Operations will report findings of the inspection to</p>	09/20/2012			

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	<p>practice affects visitors, staff and 10 or more residents using the corridor in the south kitchen smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/21/12 at 2:05 p.m., flame resistance labeling was not found on the twelve foot satiny fabric draped on the bulletin board in the south corridor outside the kitchen. The maintenance director said at the time of observation, he had no evidence the material was treated to render it flame resistant.</p> <p>3.1-19(b)</p>		the QA Committee.		

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K0076 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4</p> <p>Based on observation and interview, the facility failed to ensure 2 of 8 cylinders of nonflammable gases were properly stored; chained or supported in a cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraints shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect visitors, staff and 10 or more residents in the center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the</p>	K0076	<p><b>CORRECTIVE ACTION</b>The Director of Plant Operations installed chains to secure extra cylinders in the oxygen room.</p> <p><b>IDENTIFY OTHER RESIDENTS</b>All residents have the potential to be affected by the same deficient practice. The Director of Plant Operations installed chains to secure extra cylinders in the oxygen room.</p> <p><b>MEASURES/SYSTEMIC CHANGES</b>The Director of Plant Operations will inservice all nursing staff regarding the requirement to have oxygen cylinders secured at all times. The Director of Plant Operations or designee will monitor oxygen storage room for proper oxygen storage one time per week for six months.</p> <p><b>MONITORING CORRECTIVE ACTION</b>The Director of Plant Operations will report findings of oxygen storage audit to the QA Committee monthly for six months.</p>	09/20/2012

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	<p>maintenance director on 08/21/12 at 1:58 p.m., two oxygen e-cylinders were stored without support in the oxygen supply storage room with four liquid oxygen containers. The maintenance director agreed at the time of observation, the cylinders had not been properly secured.</p> <p>3.1-19(b)</p>			

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K0143 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 liquid oxygen stored in 1 of 1 sprinklered oxygen storage/transfer locations was stored in an area where electrical fixtures were at least 5 feet above the floor. NFPA 99, 8-3.1.11.1 requires that storage for nonflammable gases shall comply with 4-3.1.1.2. NFPA 99, 4-3.1.1.2(a)(4) requires electrical fixtures, switches and outlets in oxygen storage locations be installed in fixed locations not less than 5 feet (60 inches) above the floor to avoid physical damage. This deficient practice could affect</p>	K0143	<p>CORRECTIVE ACTIONThe Director of Plant Operations has repaired the light switch to meet electrical fixture code. IDENTIFY OTHER RESIDENTSAll residents have the potential to be affected by the same deficient practice. The Director of Plant Operations has repaired the light switch to meet electrical fixture code. MEASURES/SYSTEMIC CHANGESThe Director of Plant Operations will correct deficiency to ensure continued compliance and meets electrical fixture code. MONITORING CORRECTIVE ACTIONThe Director of Plant Operation will correct deficiency and report compliance to the QA Committee.</p>	09/20/2012

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	<p>staff, visitors and 10 or more residents in the center smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 08/21/12 at 1:58 p.m., the oxygen storage room had four 181 liter capacity liquid oxygen storage tanks stored in the room. One electric light switch on the wall measured 46 inches above the floor. The maintenance director said at the time of observation, he was unaware the light switch was lower than the code permitted.</p> <p>3.1-19(b)</p>						