

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	X3) DATE SURVEY COMPLETED 08/06/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-PARKWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052
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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
K0000	<p>A Life Safety Code Recertification, State Licensure and 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: 08/06/12</p> <p>Facility Number: 000468 Provider Number: 155378 AIM Number: 100290270</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>At this Life Safety Code survey, Kindred Transitional Care and Rehab -Parkwood was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, 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</p>	K0000		

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>determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in the corridors and spaces open to the corridors and Maplewood resident rooms 61 to 70. Battery powered smoke detectors were provided in all other resident rooms. The facility has the capacity for 138 residents and had a census of 113 at the time of this survey.</p> <p>The facility was found in compliance with state law in regard to sprinkler coverage and with state law in regard to smoke detector coverage.</p> <p>All areas where the residents have customary access and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/10/12.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</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.</p> <p>Based on observation and interview, the facility failed to ensure both doors protecting a corridor opening in 1 of 12 smoke compartments could latch into the door frame. This deficient practice affects staff, visitors and 16 residents in the Maplewood dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 08/06/12 at 1:20 p.m., the double door set between the Maplewood dining room and exit corridor required one door to latch into the door</p>	K0018	<p>K018 The corrective action taken for the residents found to have been affected by the deficient practice was: No residents were found to have been affected by the deficient practice. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: All residents have the potential to be affected by the deficient practice. The measures put in place and systemic change made to ensure the deficient practice does not recur is: A panic bar system was added so that each door will independently latch into the door frame. To ensure the deficient practice does not recur, the monitoring system established is: Maintenance supervisor and or designee will</p>	09/05/2012			

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	<p>frame before the second door would latch into the first door to secure them both tightly into the door frame. The maintenance supervisor acknowledged at the time of observations, each door could not latch independently into the door frame.</p> <p>3.1-19(b)</p>		<p>monitor and inspect smoke barrier doors on a monthly basis for proper placement and function. All findings will be corrected if needed reported to the safety committee for review. Completion Date: 9/5/12</p>		

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K0021 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of:</p> <p>a) the required manual fire alarm system;</p> <p>b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and</p> <p>c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 doors separating the kitchen from the main dining room was held open only by a device which would allow it to close automatically upon activation of the fire alarm system. This deficient practice could affect staff, visitors, and 20 or more residents using the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 08/06/12 at 11:45 a.m., one door separating the kitchen from the main dining</p>	K0021	<p>K021</p> <p>The corrective action taken for the residents found to have been affected by the deficient practice was:</p> <p>No residents were found to have been affected by the deficient practice.</p> <p>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</p> <p>All residents have the potential to be affected by the deficient practice.</p>	08/24/2012			

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	<p>room stood wide open. The maintenance director explained at the time of observation, the self closing device on the door was locked in the open position and would not self close until it was unlocked by staff.</p> <p>3.1-19(b)</p>		<p>The measures put in place and systemic change made to ensure the deficient practice does not recur is:</p> <p>The latch on the kitchen door separating it from the main dining room was replaced to ensure it would latch when the door closes.</p> <p>To ensure the deficient practice does not recur, the monitoring system established is:</p> <p>An audit was done of the entire building to verify that all doors properly latch to ensure resident safety. Maintenance supervisor and or designee will do weekly rounds to inspect that all doors properly latch for first 2 weeks, then monthly thereafter. Results will be corrected if needed and reported to safety committee monthly for review.</p>		

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K0025 SS=E	<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 2 of 12 corridor smoke barriers 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, be protected so that the space between the penetrating item and the smoke barrier shall be filled with an approved 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 81 residents in the Rosewood, Maplewood and Redwood smoke compartments.</p>	K0025	<p>K025</p> <p>The corrective action taken for the residents found to have been affected by the deficient practice was:</p> <p>No residents were found to have been affected by the deficient practice.</p> <p>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>The measures put in place and systemic change made</p>	08/17/2012	

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	<p>Findings include:</p> <p>1. Based on observation with the maintenance director and administrator on 08/06/12 at 11:30 a.m., three, four inch pipe penetrations allowing the passage of conduit and wiring in the smoke barrier fire wall near the unit manager's office were either filled with fiberglass insulation or unsealed. The maintenance director acknowledged at the time of observation, the penetrations had not been properly sealed when an inch thick rod was passed through the openings with no resistance.</p> <p>2. Based on observation with the maintenance director and administrator on 08/06/12 at 12:55 p.m., two pipe penetrations in the smoke barrier wall between the Redwood and Maplewood smoke compartments were unsealed leaving gaps of one inch. The maintenance director agreed at the time of observation, the wall penetrations should have been sealed.</p> <p>3.1-19(b)</p>		<p>to ensure the deficient practice does not recur is:</p> <p>The pipe penetrations in the smoke barrier walls will be properly sealed with an approved material that will maintain the integrity of the smoke barrier walls.</p> <p>To ensure the deficient practice does not recur, the monitoring system established is:</p> <p>An audit was done of all smoke barriers to ensure no other gaps or improperly sealed areas existed. The smoke barriers will be audited monthly to ensure there are no gaps or holes compromising the integrity of the smoke barrier. Results will be corrected if needed and reported to the safety committee for review.</p> <p>Completion Date:</p> <p>8/17/12</p>				

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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 1 of 8 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 and latch into the door frame when closed to keep the door tightly closed. This deficient practice could affect 17 residents in the Reflections North smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 08/06/12 at</p>	K0029	<p>K029</p> <p>The corrective action taken for the residents found to have been affected by the deficient practice was:</p> <p>No residents were found to have been affected by the deficient practice.</p> <p>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>The measures put in place</p>	08/24/2012	

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	<p>12:30 p.m., the Reflections North shower room was used for soiled linen and trash barrel storage when not in use. The barrels, with a capacity for 32 gallons or more, were half full. The door separating the shower rooms from the exit corridor had no latch. The maintenance director acknowledged at the time of observation, the door was not latching.</p> <p>3.1-19(b)</p>		<p>and systemic change made to ensure the deficient practice does not recur is:</p> <p>A lock will be added to the Reflections North shower room door to ensure it will latch properly when the door closes.</p> <p>To ensure the deficient practice does not recur, the monitoring system established is:</p> <p>An audit was done of the entire building to verify that all doors properly latch to ensure resident safety. Door latches will be audited on a monthly basis to ensure they are all latching properly when closed and all findings will be corrected if needed and reported to the safety committee for review.</p> <p>Completion Date:</p> <p>8/24/12</p>		

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K0038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>Based on observation and interview, the facility failed to ensure 2 of 19 doors in the Maplewood smoke compartment were provided with doors requiring a single operation to release latches and open the doors. LSC 7.2.1.5.4. requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release be one which is familiar to the average person. For example, a two step release, such as a knob and independent dead bolt, is not acceptable. In most occupancies, it is important that a single action unlatch the door. This deficient practice could affect visitors, staff and 16 residents in the Maplewood smoke compartment.</p> <p>Findings include: Based on observation with maintenance director and</p>	K0038	<p>K038</p> <p>The corrective action taken for the residents found to have been affected by the deficient practice was:</p> <p>No residents were found to have been affected by the deficient practice.</p> <p>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>The measures put in place and systemic change made to ensure the deficient practice does not recur is:</p> <p>The deadbolt latch was removed to allow the doors to be opened with a one step function.</p>	09/05/2012			

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	<p>administrator on 08/06/12 at 1:20 p.m., double doors between the Maplewood dining room and exit corridor were equipped with a door knob and dead bolt latch. If both were engaged the door knob and dead bolt latch would both have to be opened to open the doors. The maintenance director acknowledged at the time of observation, this would require an unacceptable two step function to open the doors.</p> <p>3.1-19(b)</p>		<p>To ensure the deficient practice does not recur, the monitoring system established is:</p> <p>Maintenance supervisor and or designee will monitor and inspect smoke barrier doors on a monthly basis for proper placement and function. All findings will be corrected if needed reported to the safety committee for review.</p> <p>Completion Date: 9/5/12</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</p> <p>Based on record review and interview, the facility failed to provide a written fire plan which includes the procedures for the use of all types of fire extinguishers in the facility for the protection 69 of 69 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan which shall provide policy and procedures for the following:</p> <ol style="list-style-type: none"> (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire <p>This deficient practice could affect all occupants, visitors and staff in the facility in the event of an emergency when the written fire plan should be immediately</p>	K0048	<p>K048</p> <p>The corrective action taken for the residents found to have been affected by the deficient practice was:</p> <p>No residents were found to have been affected by the deficient practice.</p> <p>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>The measures put in place and systemic change made to ensure the deficient practice does not recur is:</p> <p>The Fire Plan was updated to include the identification and types of fire extinguishers in the</p>	08/20/2012	

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-PARKWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052		
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	<p>available.</p> <p>Findings include:</p> <p>Based on record review with the maintenance director and administrator on 08/06/12 at 1:50 p.m., the written Fire Plan failed to identify the types of extinguishers in the facility, the fires they are to be used for and the procedures on how to use each type of extinguisher. The manual did not address the relationship of the use of the Class K extinguisher with the hood suppression system. At the time of record review, the administrator director said she was unaware of the requirement for the fire plan to include extinguisher availability and procedure.</p> <p>3.1-19(b)</p>		<p>facility, the fires they are to be used for and the procedures on how to use each type of extinguisher. It also now includes the use of the Class K extinguisher with the hood suppression system.</p> <p>To ensure the deficient practice does not recur, the monitoring system established is:</p> <p>The Fire Plan will be reviewed every six months times 2 and then annually to maintain updated information. All findings will be corrected if needed reported to the safety committee for review.</p> <p>Completion Date:</p> <p>8/20/12</p>		

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K0062 SS=F	<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 piping for 1 of 1 automatic sprinkler systems was maintained free of external loads. NFPA 25, 2-2.2.2 requires sprinkler piping shall be not be subjected to external loads by materials either resting on the pipe or hung from the pipe. This deficient practice affects all occupants.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and administrator on 08/06/12 at 11:35 a.m., sprinkler pipes above the laid in ceiling at the smoke barrier near the unit manager's office were used as hangers for other pipe and bundles of wire or cable. A pipe was secured to the sprinkler pipe by two zip ties and other wiring and cables were tied at intervals along the piping. The maintenance director said at the</p>	K0062	<p>K062</p> <p>The corrective action taken for the residents found to have been affected by the deficient practice was:</p> <p>No residents were found to have been affected by the deficient practice.</p> <p>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>The measures put in place and systemic change made to ensure the deficient practice does not recur is:</p> <p>Cables, wires, and zip tie attachments have been removed from the</p>	08/17/2012			

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	time of observation, he didn't know the sprinkler pipes had been used to carry these loads. 3.1-19(b) 3.1-19(ff)		sprinkler pipes to ensure the sprinkler piping is not subjected to external loads resting on or hung from the pipes. An audit was done of the entire building to ensure that all sprinkler piping is free of external loads resting on or hung from the pipes. To ensure the deficient practice does not recur, the monitoring system established is: Audits will be done monthly and findings will be corrected if needed and reported to the safety committee for review. Completion Date: 8/17/12		

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K0066 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 enforce the facility wide smoking regulations. This deficient practice affects any visitors and staff using the employee entrance and 14 or more residents on Rosewood north.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and</p>	K0066	<p>K066</p> <p>The corrective action taken for the residents found to have been affected by the deficient practice was:</p> <p>No residents were found to have been affected by the deficient practice.</p> <p>The corrective action taken for those residents having the potential to be affected</p>	08/31/2012	

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	<p>administrator on 08/06/12 at 11:45 a.m., a self closing ashtray was sitting on a table in the Rosewood Courtyard. On 08/06/12 at 11:50 a.m., a cigarette butt was observed in the trash can located outside the employee entrance. The administrator said at the time of observations, these were not designated smoking areas. She said the facility did not permit residents to smoke and employees were restricted to smoking in another designated area away from the building. She was unaware the ashtray had been in the resident courtyard.</p> <p>3.1-19(b)</p>		<p>by the same deficient practice is:</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>The measures put in place and systemic change made to ensure the deficient practice does not recur is:</p> <p>All ashtrays were removed from non-approved smoking areas. The staff was educated as to the location of approved smoking areas and the necessity of disposing all cigarettes within that location and only in smoke butt cans, not regular trash cans.</p> <p>To ensure the deficient practice does not recur, the monitoring system established is:</p> <p>Daily ground rounds will continue on an ongoing basis and findings will be corrected if needed and</p>		

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			<p>reported to the ED for further actions.</p> <p>Completion Date:</p> <p>8/31/12</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 1 of 1 oxygen transfer sites was provided with at least a 45 minute rated door in a fire barrier of 1 hour fire resistive construction to separate the site from any portion of the facility wherein residents are housed. This deficient practice affects staff, visitors and 20 or more residents in the main dining room smoke compartment.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director and</p>	K0143	<p>K143</p> <p>The corrective action taken for the residents found to have been affected by the deficient practice was:</p> <p>No residents were found to have been affected by the deficient practice.</p> <p>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</p> <p>All residents have the potential to be affected by</p>	09/05/2012	

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	<p>administrator on 08/06/12 at 12:00 p.m., the oxygen transfer and storage room identified by the maintenance director had a door labeled with a 30 minute door fire resistance rating. The maintenance director acknowledged at the time of observation, it did not meet the minimum 45 minute resistance required for the oxygen transfer room door.</p> <p>3.1-19(b)</p>		<p>the deficient practice.</p> <p>The measures put in place and systemic change made to ensure the deficient practice does not recur is:</p> <p>The door to the oxygen transfer room was replaced with a 90 minute rated door.</p> <p>To ensure the deficient practice does not recur, the monitoring system established is:</p> <p>The oxygen transfer room door will be monitored for proper functioning and fire rating on a monthly basis and findings will be corrected if needed and reported to the safety committee for review.</p> <p>Completion Date:</p> <p>9/5/12</p>		