

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/29/2015  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING: JUL 2015 OFFICE OF INSPECTOR GENERAL B. WING:		(X3) DATE SURVEY COMPLETED  06/16/2015
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 282 W. 6TH ST LA CENTER, KY 42058		
(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	
F 000	INITIAL COMMENTS	F 000	"The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws."		
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility policy, it was determined the facility failed to ensure the resident environment remains as free of accident hazards as is possible as evident by a green "E" oxygen cylinder being stored in a standing position on the floor unsecured behind a motorized wheelchair on one (1) of three (3) resident halls (hall 300). The motorized wheelchair was blocking the fire extinguisher and the emergency fire pull alarm outside Room #301 and a standard wheelchair was blocking the fire extinguisher and emergency fire pull station at the opposite end of the hall by Room #320.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Oxygen Use, General", dated 02/2011, revealed oxygen cylinders must be stored in racks with chains, sturdy portable carts, and/or approved stands.</p>	F 323	<p>F 323 The facility must ensure that the resident environment remains as free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>1. Resident(s) affected by alleged deficient practice:</p> <ul style="list-style-type: none"> <li>No residents were affected by the improper storage of the oxygen tank or improper placement of wheelchairs. Upon notification of the findings, the Maintenance Director removed the green "E" size oxygen cylinder and placed in proper storage container in the oxygen storage room. Wheelchairs stored in the hallway outside resident room #301 as well as room #320, were removed and stored properly.</li> </ul> <p>2. Residents with potential to be affected by alleged deficient practice:</p> <ul style="list-style-type: none"> <li>All residents residing in the facility have the potential to be affected by improper storage. The Executive Director completed an audit of all hallways on 06/14/15 to identify any "E" oxygen tanks not stored per</li> </ul>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Singer Attkins*

TITLE

*Executive Director*

(X6) DATE

07-09-15

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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F 323	Continued From page 1 Additionally, Oxygen cylinders may not be stored in any resident's room or living area and cylinders may not be left freestanding, they must be securely fastened all times.  Observation during general tour of the 300 Hallway, on 06/14/15 at 12:03 PM, revealed a green "E" size oxygen cylinder standing freely on the floor and unsecured behind a motorized wheelchair outside resident room #301. The wheelchair was blocking the emergency fire pull station and the fire extinguisher. Further observation revealed a standard manual wheelchair was stored at the opposite end of the hall by resident room #320 which was blocking the fire extinguisher and emergency fire pull station.  Interview, on 06/14/15 at 2:02 PM with the Maintenance Director, revealed the oxygen tank stored at the end of the (300) hallway by resident room #301 should not be there. The Maintenance Director stated the oxygen must be secured at all times. Additionally, he revealed the wheelchairs should not be stored in a manner that blocked the emergency fire pull station or fire extinguisher.  Interview, on 06/14/15 at 2:05 PM with the Administrator, revealed she expected all oxygen cylinders to be secured and never left free standing and there should never be anything blocking the emergency fire pull station or fire extinguisher.	F 323	policy and to identify if any emergency fire pull station/fire extinguisher was blocked by a wheelchair or any item. No issues were identified.  3. Systems to ensure alleged deficient practice does not recur: <ul style="list-style-type: none"> <li>The Executive Director / Staff Development Coordinator (SDC) to re-educate all staff regarding policy to keep all emergency fire pull stations and fire extinguishers free of anything that blocks them, as well as proper storage of wheelchairs, "E" oxygen tanks, and not storing any items in the hallway. This will be completed by 07/14/15 and will include a written exam, with a 90% score expected for passing to verify competency and understanding.</li> <li>The Executive Director / Maintenance Director and/or Nursing Supervisor to audit all hallways to ensure no item is stored or blocking the fire pull station and/or the fire extinguisher, 3 x weekly x 6 weeks, then 1 x weekly x 2 weeks, beginning 07/15/15.</li> <li>The Executive Director / Maintenance Director and/or Nursing Supervisor to audit the proper storage of wheelchairs, equipment and/or "E" oxygen tanks, 3 x weekly x 6 weeks, then 1 x weekly x 2 weeks to begin 07/15/15.</li> <li>Any new hire will be educated by Staff Development Coordinator/Director of Nursing/ or</li> </ul>		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an	F 441			



Charge Nurse regarding policy for storage of equipment, wheelchairs, oxygen, as well as keeping area clear for extinguishers and pull stations, beginning 07/15/15 and will be ongoing. A written exam will be administered with score of 90% to pass.

4. Monitoring to ensure alleged deficient practice does not recur:
  - PI team consisting of at least Executive Director, Director of Nursing, Maintenance Director, Staff Development Coordinator, Social Worker and Medical Director, to meet every 2 weeks x 6 weeks beginning week of 07/06/15, then monthly ongoing to review all audits, revise plan as needed and make recommendations. This will be completed until the issue is considered resolved, then audits will be completed quarterly by Executive Director / Maintenance Director ongoing to ensure compliance.

Completion  
date

07/20/15

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F 441	<p>Continued From page 2</p> <p>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p><b>F 441 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</b></p> <ol style="list-style-type: none"> <li>Resident(s) affected by alleged deficient practice: <ul style="list-style-type: none"> <li>No specific resident was identified. No resident was affected related to staff not washing hands during tray pass on 06/14/15 or 06/15/15. All residents have the potential to be affected. The Executive Director made the Medical Director aware of the handwashing issue identified during tray pass of 06/14/15 and 06/15/15.</li> </ul> </li> <li>Residents with potential to be affected by alleged deficient practice: <ul style="list-style-type: none"> <li>Director of Nursing/Assistant Director of Nursing, Dietary Manager, and /or Staff Development Coordinator to complete an audit of at least 3 meals / 1 snack pass by 07/09/15 to identify if staff are washing/sanitizing hands between trays and are following infection control policy for handwashing. Any issue identified will be immediately corrected and physician notified.</li> </ul> </li> <li>Systems to ensure alleged deficient practice does not recur:</li> </ol>		

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F 441	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview and facility policy review, it was determined the facility failed to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection on one (1) of three (3) resident halls. Two (2) Certified Nurse Aides (CNAs) failed to sanitize their hands in between each tray passed during meal pass on the 300 hall.</p> <p>The findings include:</p> <p>Review of the facility policy titled, "Hand Hygiene", dated 05/01/12, revealed hand washing was to decrease the risk of transmission of infection. Visible dirty or contaminated hands should be washed with antimicrobial soap and water. If hands are not viably soiled, an alcohol-based hand sanitizer may be used.</p> <p>1. Observation of resident hallway 300 meal tray pass, on 06/15/15 at 7:38 AM, revealed Certified Nurse Aide (CNA) #1 passed resident meal trays into three (3) different resident rooms and failed to wash or sanitize her hands at anytime.</p> <p>Interview with CNA/Restorative Aide #1, revealed hand washing should occur between every passing of a resident meal tray. She stated the staff was allowed to use hand sanitizer between three (3) residents then they must wash their hands with soap and water. She stated she failed to follow this policy during the meal pass. She showed the surveyor she was carrying hand sanitizer in her pocket; however, indicated she failed to use any form of hand sanitizer.</p>	F 441	<ul style="list-style-type: none"> <li>• Staff Development Coordinator/ Assistant Director of Nursing/ Charge nurse to re-educate all staff regarding policy to wash hands/sanitize hands during meal/tray pass. This will be completed by 07/14/15 and competency to be verified by scoring 90% on a written examination.</li> <li>• Director of Nursing, Staff Development Coordinator, Dietary Manager or Charge Nurse to monitor tray pass both on the halls and dining room 3 meals weekly x 6 weeks, then 1 meal weekly x 2 weeks beginning 07/15/15, to ensure staff are washing /sanitizing hands per policy.</li> <li>• Director of Nursing / Charge Nurse to audit snack pass 1 x week x 6 weeks to ensure staff are washing/sanitizing hands per policy. This will begin 07/15/15.</li> <li>• Any new hire will be educated by Staff Development Coordinator/Director of Nursing/ or Charge Nurse regarding policy for washing/sanitizing during meal/snack pass beginning 07/15/15 and will be ongoing. A written exam will be administered with score of 90% to pass.</li> <li>4. Monitoring to ensure alleged deficient practice does not recur:             <ul style="list-style-type: none"> <li>• PI team consisting of at least Executive Director, Director of Nursing, Maintenance Director,</li> </ul> </li> </ul>		

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F 441	Continued From page 4  2. Observation of resident hallway 300 meal tray pass, on 06/14/15 at 12:33 PM, revealed CNA #2 passed resident meal trays into four (4) different resident's rooms and failed to sanitize or wash her hands at anytime.  Interview with Licensed Practical Nurse (#1), on 06/16/15 at 8:20 AM, revealed she expected any staff who was passing meal trays to sanitize their hands in between each tray pass.  Interview with the Assistant Director of Nursing (ADON), on 06/16/15 at 7:55 AM, revealed she expected the staff to use hand sanitizer with each meal pass and to wash with soap and water after each three (3) uses of the alcohol-based hand sanitizer. She stated not doing this could result in the spread of infection.  Interview with the Director of Nursing (DON), on 06/16/15 at 8:15 AM, revealed she expected staff to sanitize their hands in between each tray pass and after three (3) uses of the hand sanitizer she expected the staff to wash their hands with soap and water.	F 441	Staff Development Coordinator, Social Worker and Medical Director, to meet every 2 weeks x 6 weeks beginning the week of 07/06/15, then monthly ongoing to review all audits, revise plan as needed and make recommendations. This will be completed until the issue is considered resolved, then audits will be completed quarterly by Executive Director / Maintenance Director ongoing to ensure compliance.	07/20/15	

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1967</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Three (3) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1967, with 24 smoke detectors and 6 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1967.</p> <p>GENERATOR: Type II generator installed in 2006. Fuel source is Diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 06/16/15. The facility was found in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for seventy (70) beds with a census of fifty-one (51) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000	<p>"The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws."</p> <p>K018 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 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes.</p> <ol style="list-style-type: none"> <li>1. Corridor doors to room #201, #205 have been fitted with material to close any gap at the top of the door. Corridor door to room #107 has been assessed by an outside contractor and a replacement door has been ordered, with expected delivery and installation by 07/24/2015. Current door has had modification to ensure proper closure, until replacement occurs.</li> <li>2. All corridor doors were audited during annual life safety survey, no other issues were identified.</li> <li>3. The Maintenance Director was inserviced by the Administrator on July 7, 2015, on the standard for maintenance of corridor doors.</li> <li>4. Maintenance Director / Executive Director will audit proper closure of all corridor doors at a rate of 8 doors</li> </ol>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*James Atkins*

TITLE

*Executive Director*

(X6) DATE

07-09-15

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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K 000	Continued From page 1	K 000	per week x 3 months, then 5 doors per week ongoing. Results will be reported to the PI committee for recommendations.	
K 018 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "D" level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ 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>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors to resident rooms would latch properly in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, residents, staff and visitors. The facility has the capacity for seventy</p>	K 018		07/24/15

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K 018	<p>Continued From page 2</p> <p>(70) beds and at the time of the survey, the census was fifty-one (51).</p> <p>The findings include:</p> <p>1. Observation, on 06/16/15 at 10:35 AM, with the Director of Maintenance revealed the corridor door to room #205 had a gap at the top of the door that would not resist the passage of smoke. The top door edge was below the door stop.</p> <p>Interview, on 06/16/15 at 10:36 AM, with the Director of Maintenance revealed he was unaware of the door settling.</p> <p>2. Observation, on 06/16/15 at 10:37 AM, with the Director of Maintenance revealed the corridor door to room #201 had a gap at the top of the door that would not resist the passage of smoke. The top door edge was below the door stop.</p> <p>Interview, on 06/16/15 at 10:38 AM, with the Director of Maintenance revealed he was unaware of the door settling.</p> <p>3. Observation, on 06/16/15 at 11:10 AM, with the Director of Maintenance revealed the corridor door to room #109 would not close due to the door being split and the top hinge will not hold the screws tight allowing the door to sag and hit the door frame.</p> <p>Interview, on 06/16/15 at 11:11 AM, with the Director of Maintenance revealed he has worked on this particular door many times to try and keep the screws tight.</p> <p>The census of fifty-one (51) was verified by the</p>	K 018			

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K 018	<p>Continued From page 3</p> <p>Executive Director on 06/16/15. The findings were acknowledged by the Executive Director and verified by the Director of Maintenance at the exit interview on 06/16/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p> <p>19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is</p>	K 018			

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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
K 018	Continued From page 4 applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018	K069 NFPA 101 Life Safety Code Standard Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96	
K 069 SS=D	Reference: CMS: S&C-07-18 NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the hood suppression was inspected, in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, residents, staff, and visitors. The facility has the capacity for seventy (70) beds and at the time of the survey, the census was fifty-one (51).  The findings include:  Observation, on 06/16/15 at 9:50 AM, with the Maintenance Director revealed the extinguishing agent for the kitchen hood suppression system had not been hydrostatically tested since January of 2002.  Interview, on 06/16/15 at 9:51 AM, with the Maintenance Director revealed he was not aware the test was past due.  The census of fifty-one (51) was verified by the Administrator on 06/16/15. The findings were	K 069	1. Private contractor was contacted by the facility for completion of hydrostatic testing on the kitchen hood. Work was completed on June 18, 2015 2. All cooking facilities were audited during annual life safety survey, no other issues were identified. 3. The Maintenance Director was inserviced by the Administrator on July 7, 2015, on the standard for protection of cooking facilities. 4. Maintenance Director will ensure required maintenance of hood system ongoing. Results of annual requirements will be reported to PI committee for recommendations.	07/07/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 8TH ST. LA CENTER, KY 42058																	
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K 069	<p>Continued From page 5</p> <p>acknowledged by the Executive Director and verified by the Maintenance Director at the exit interview on 06/16/15.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 10 (1998 ed.) 5-2 Frequency. At intervals not exceeding those specified in Table 5-2, fire extinguishers shall be hydrostatically retested. The hydrostatic retest shall be conducted within the calendar year of the specified test interval. In no case shall an extinguisher be recharged if it is beyond its specified retest date. (For nonrechargeable fire extinguishers, see the exception to 4-4.3.</p> <p>Table 5-2 Hydrostatic Test Interval for Extinguishers</p> <table border="1"> <thead> <tr> <th>Extinguisher Type</th> <th>Test Interval(Years)</th> </tr> </thead> <tbody> <tr> <td>Stored-pressure water, loaded stream, and/or antifreeze</td> <td>5</td> </tr> <tr> <td>Wetting agent</td> <td>5</td> </tr> <tr> <td>AFFF (aqueous film-forming foam)</td> <td>5</td> </tr> <tr> <td>FFFP (film-forming fluoroprotein foam)</td> <td>5</td> </tr> <tr> <td>Dry chemical with stainless steel shells</td> <td>5</td> </tr> <tr> <td>Carbon dioxide</td> <td>5</td> </tr> <tr> <td>Wet chemical</td> <td>5</td> </tr> </tbody> </table>	Extinguisher Type	Test Interval(Years)	Stored-pressure water, loaded stream, and/or antifreeze	5	Wetting agent	5	AFFF (aqueous film-forming foam)	5	FFFP (film-forming fluoroprotein foam)	5	Dry chemical with stainless steel shells	5	Carbon dioxide	5	Wet chemical	5	K 069		
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K 069	Continued From page 6 Dry chemical, stored-pressure, with mild steel shells, 12 brazed brass shells, or aluminum shells  Dry chemical, cartridge- or cylinder-operated, with 12 mild steel shells Halogenated agents 12 Dry powder, stored-pressure, cartridge- or cylinder operated, 12 with mild steel shells	K 069			