

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

PRINTED: 05/16/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185419	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  05/02/2014
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1800 WESTEN AVENUE BOWLING GREEN, KY 42104	
(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  A Recertification Survey was conducted on 04/29/14 through 05/02/14 with no deficiencies cited.	F 000		



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

*Heather Oberdorfer*

TITLE

*Administrator*

(X6) DATE

*5/20/14*

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	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1995</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: Two (2) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1995 with 28 smoke detectors and no heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1995.</p> <p>GENERATOR: Type II generator installed in 1995. Fuel source is Diesel.</p> <p>A standard Life Safety Code Survey was conducted on 04/30/14. The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for twenty-eight (28) beds with a census of twenty-five (25) 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</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Maureen O'Rourke</i>	TITLE <i>Administrator</i>	(X6) DATE <i>5/20/14</i>
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K 000	Continued From page 1 Fire).	K 000	K038	5/3/14	
K 038 SS=E	Deficiencies were cited with the highest deficiency identified at "F" level. 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  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the exits were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficient practice has the potential to affect one (1) of two (2) smoke compartments, ten (10) residents, staff and visitors. The facility has the capacity for twenty-eight (28) beds and at the time of the survey, the census was twenty-five (25).  The findings include:  Observation, on 04/30/14 at 9:50 AM with the Administrator, revealed the exit that was leading into the new construction project did not have a sidewalk to the public way.  Interview, on 04/30/14 at 9:51 AM with the Administrator, revealed the facility had educated	1. No resident was affected by this alleged deficiency. On 5/1/14, the Administrator received approval from Deputy State Fire Marshall, Buddy Steele, and Life Safety Code Inspector, Jeremy Taylor, to close down the 200 Hall Exit leading into the new construction. On 5/2/14, this exit was shut down temporarily through the duration of the construction project. On 5/2/14, the Housing Manager covered all exit signs on the 200 Hall and made sure that the appropriate signage was in place, to indicate "this is not an exit".  2. All residents were identified to have the potential to be affected by this alleged deficiency. In addition to the 200 Hall Exit being closed, the			

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K 038	<p>Continued From page 2</p> <p>the construction company to keep the walkway free and clear but she was unaware the durable surface was required during the project.</p> <p>The census of twenty-five (25) was verified by the Administrator on 04/30/14. The findings were acknowledged by the Administrator and verified by the Housing Manager at the exit interview on 04/30/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times.</p> <p>7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way.</p> <p>Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2.</p> <p>Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6.</p> <p>Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23.</p>	K 038	<p>evacuation floor plan was also revised on 5/2/14 to indicate that the 200 Hall is not an exit.</p> <p>3. The maintenance staff were inserviced on 5/2/14 by the Housing Manager, reviewing the appropriate means of egress. On 5/2/14, all employees were inserviced that the 200 Hall Exit is closed and that the new evacuation floor plan has the updated changes.</p> <p>4. Monthly an inspection of all exit doors/means of egress will be completed by the maintenance staff and presented to the Housing Manager; this will continue on a monthly basis for the entirety of the construction project, this will not exceed the next 12 months. The Housing Manager will forward these inspections to the Administrator. The Administrator will present</p>		

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K 038	Continued From page 3	K 038	these inspections to QA for review and recommendations for changes.	
K 056 SS=E	<p>CMS S&amp;C letter 5-38 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>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with National Fire Protection Agency (NFPA) Standards. The deficient practice has the potential to affect one (1) of two (2) smoke compartments, fifteen (15) residents, staff and visitors. The facility has the capacity for twenty-eight (28) beds and at the time of the survey, the census was twenty-five (25). According to CMS S&amp;C 13-55-LSC the enforcement implication would be a fully sprinklered facility with minor problems</p> <p>The findings include:</p>	K 056	<p>K056</p> <p>1. No resident was affected by this alleged deficiency. All identified wardrobe areas in all identified rooms (103, 104, 105, 106, and 107) will be corrected to ensure that adequate sprinkler protection is maintained. Sprinklers will be added to the wardrobe areas of rooms 103, 104, 105, 106, and 107; this work will be done on 5/27/14 by Eagle Fire Protection.</p> <p>2. All residents were identified to have the potential to be affected by this alleged deficiency. The Housing Manager will assure that all fire sprinklers provide</p>	5/29/14

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K 056	<p>Continued From page 4</p> <p>Observation, on 04/30/14 at 10:52 AM with the Housing Manager and Administrator, revealed resident rooms 103-107 did not have proper sprinkler protection at the wardrobe area of the room.</p> <p>Interview, on 04/30/14 at 10:55 AM with the Housing Manager and Administrator, revealed they were unaware the resident rooms were not properly sprinkler protected.</p> <p>The census of twenty-five (25) was verified by the Administrator on 04/30/14. The findings were acknowledged by the Administrator and verified by the Housing Manager at the exit interview on 04/30/14.</p> <p>Actual NFPA Standard:</p> <p>NFPA 13 (1999 Edition) 5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.</p> <p>Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:</p> <p>(1) Sprinklers installed throughout the premises</p>	K 056	<p>adequate sprinkler coverage on 5/28/14 after the new sprinkler heads are added.</p> <p>3. An inservice reviewing NFPA sprinkler coverage standards was completed by the Housing Manager on 5/2/14, all maintenance staff were present.</p> <p>4. Evaluation of all sprinklers and adequate protection will be completed every quarter by the maintenance staff and submitted to the Housing Manager. These inspections will be submitted to the Administrator and forwarded to the QA committee on a quarterly basis for the next one (1) year for review and recommendations for changes.</p>	

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K 056	Continued From page 5 (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.	K 056		
K 062 SS=F	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  This STANDARD is not met as evidenced by: Based on sprinkler record review, and interview it was determined the facility failed to maintain the sprinkler system in accordance with National Fire Protection (NFPA) standards. The deficient practice has the potential to affect two (2) of two (2) smoke compartments, all residents, staff and visitors. The facility has the capacity for twenty-eight (28) beds and at the time of the survey, the census was twenty-five (25).  The findings include:  Sprinkler record review, on 04/30/14 at 9:50 AM with the Housing Manager, revealed the facility failed to provide documentation that the back flow preventer had been checked within the last year.  Interview, on 04/30/14 at 9:51 AM with the Housing Manager, revealed he was aware the black flow preventer wasn't being checked but was unaware it had to be checked annually. He stated they had received bids to gain access to	K 062	K062  1. No resident was affected by this alleged deficiency. There will be a vault installed around the existing back flow to ensure that the back flow preventer is checked annually. This work is scheduled to be completed by Eagle Fire Protection and will be completed on or before 6/13/14.  2. All other residents have the potential to be affected by this deficient practice. The Housing Manager will ensure that back flow is working correctly on 6/14/14 following the work that has to be completed.  3. The back flow preventer will be inspected in June 2014, once the work is completed; and	6/15/14

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K 062	<p>Continued From page 6</p> <p>the back flow preventer, but there had been no work started on the project.</p> <p>The census of twenty-five (25) was verified by the Administrator on 04/30/14. The findings were acknowledged by the Administrator and verified by the Housing Manager at the exit interview on 04/30/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 25 (1998 Edition). 2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance. Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance</p> <table border="1"> <thead> <tr> <th>Item</th> <th>Activity</th> <th>Frequency</th> <th>Reference</th> </tr> </thead> <tbody> <tr> <td>Gauges (dry, preaction deluge systems)</td> <td>Inspection</td> <td>Weekly/monthly</td> <td>2-2.4.2</td> </tr> <tr> <td>Control valves</td> <td>Inspection</td> <td>Weekly/monthly</td> <td>Table 9-1</td> </tr> <tr> <td>Alarm devices</td> <td>Inspection</td> <td>Quarterly</td> <td>2-2.6</td> </tr> <tr> <td>Gauges (wet pipe systems)</td> <td>Inspection</td> <td>Monthly</td> <td>2-2.4.1</td> </tr> <tr> <td>Hydraulic nameplate</td> <td>Inspection</td> <td>Quarterly</td> <td>2-2.7</td> </tr> <tr> <td>Buildings</td> <td>Inspection</td> <td>Annually (prior to freezing)</td> <td></td> </tr> </tbody> </table>	Item	Activity	Frequency	Reference	Gauges (dry, preaction deluge systems)	Inspection	Weekly/monthly	2-2.4.2	Control valves	Inspection	Weekly/monthly	Table 9-1	Alarm devices	Inspection	Quarterly	2-2.6	Gauges (wet pipe systems)	Inspection	Monthly	2-2.4.1	Hydraulic nameplate	Inspection	Quarterly	2-2.7	Buildings	Inspection	Annually (prior to freezing)		K 062	<p>then annually the back flow preventer will be inspected to ensure NFPA standards are followed related to routine inspection of sprinkler systems.</p> <p>4. The entire sprinkler system, including the back flow preventer will be checked in June of 2014 and this inspection will be completed annually thereafter. This inspection will be submitted to the Housing Manager and then forwarded to the Administrator. The Administrator will forward the inspection to the QA Committee on an annual review and recommendations.</p>	
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K 062	<p>Continued From page 7 weather) 2-2.5 Hanger/seismic bracing Inspection Annually 2-2.3 Pipe and fittings Inspection Annually 2-2.2 Sprinklers Inspection Annually 2-2.1.1 Spare sprinklers Inspection Annually 2-2.1.3 Fire department connections Inspection Table 9-1 Valves (all types) Inspection Table 9-1 Alarm devices Test Quarterly 2-3.3 Main drain Test Annually Table 9-1 Antifreeze solution Test Annually 2-3.4 Gauges Test 5 years 2-3.2 Sprinklers - extra-high temp. Test 5 years 2-3.1.1 Exception No. 3 Sprinklers - fast response Test At 20 years and every 10 years thereafter 2-3.1.1 Exception No. 2 Sprinklers Test At 50 years and every 10 years thereafter 2-3.1.1 Valves (all types) Maintenance Annually or as needed Table 9-1 Obstruction investigation Maintenance 5 years or as needed Chapter 10</p> <p>Table 9-1 Summary of Valves, Valve Components, and Trim Inspection, Testing, and Maintenance Component Activity Frequency Reference Control Valves Sealed Inspection Weekly 9-3.3.1 Locked Inspection Monthly 9-3.3.1 Exception No. 1 Tamper switches Inspection Monthly 9-3.3.1 Exception No. 1 Alarm Valves Exterior Inspection Monthly 9-4.1.1 Interior Inspection 5 years 9-4.1.2</p>	K 062		

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K 062	Continued From page 8 Strainers, filters, orifices Inspection 5 years 9-4.1.2 Check Valves Interior Inspection 5 years 9-4.2.1 Preaction/Deluge Valves Enclosure (during cold weather) Inspection Daily/weekly 9-4.3.1 Exterior Inspection Monthly 9-4.3.1.2 Interior Inspection Annually/5 years 9-4.3.1.3 Strainers, filters, orifices Inspection 5 years 9-4.3.1.4 Dry Pipe Valves/Quick-Opening Devices Enclosure (during cold weather) Inspection Daily/weekly 9-4.4.1.1 Exterior Inspection Monthly 9-4.4.1.3 Interior Inspection Annually 9-4.4.1.4 Strainers, filters, orifices Inspection 5 years 9-4.4.1.5 Pressure Reducing and Relief Valves Sprinkler systems Inspection Quarterly 9-5.1.1 Hose connections Inspection Quarterly 9-5.2.1 Hose racks Inspection Quarterly 9-5.3.1 Fire pumps Casing relief valves Inspection Weekly 9-5.5.1, 9-5.5.1.1 Pressure relief valves Inspection Weekly 9-5.5.2, 9-5.5.2.1 Backflow Prevention Assemblies Reduced pressure Inspection Weekly/monthly 9-6.1 Reduced pressure detectors Inspection Weekly/monthly 9-6.1 Fire Department Connections Inspection Quarterly 9-7.1 Main Drains Test Annually 9-2.6, 9-3.4.2 Waterflow Alarms Test Quarterly 9-2.7 Control Valves Position Test Annually 9-3.4.1	K 062		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185419	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  04/30/2014
NAME OF PROVIDER OR SUPPLIER  CHRISTIAN HEALTH CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1800 WESTEN AVENUE BOWLING GREEN, KY 42104	
(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 062	Continued From page 9 Operation Test Annually 9-3.4.1 Supervisory Test Semiannually 9-3.4.3 Preaction/Deluge Valves Priming water Test Quarterly 9-4.3.2.1 Low air pressure alarms Test Quarterly 9-4.3.2.10 Full flow Test Annually 9-4.3.2.2 Dry Pipe Valves/Quick-Opening Devices Priming water Test Quarterly 9-4.4.2.1 Low air pressure alarm Test Quarterly 9-4.4.2.6 Quick-opening devices Test Quarterly 9-4.4.2.4 Trip test Test Annually 9-4.4.2.2 Full flow trip test Test 3 years 9-4.4.2.2.1 Pressure Reducing and Relief Valves Sprinkler systems Test 5 years 9-5.1.2 Circulation relief Test Annually 9-5.5.1.2 Pressure relief valves Test Annually 9-5.5.2.2 Hose connections Test 5 years 9-5.2.2 Hose racks Test 5 years 9-5.3.2 Backflow Prevention Assemblies Test Annually 9-6.2 Control Valves Maintenance Annually 9-3.5 Preaction/Deluge Valves Maintenance Annually 9-4.3.3.2 Dry Pipe Valves/Quick-Opening Devices Maintenance Annually 9-4.4.3.2	K 062		
K 143 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Transferring of oxygen is:  (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;  (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring;	K 143	K143  1. No resident was affected by this alleged deficiency. Proper signage for indicating that transferring oxygen is occurring and that smoking is not permitted was put into place on 5/7/14 by the	6/11/14

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K 143	Continued From page 10 and  (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  This STANDARD is not met as evidenced by: Based on observation, interview and plan of correction review, it was determined the facility failed to assure the room being used to transfer liquid oxygen was rated per National Fire Protection Agency requirements. The deficient practice has the potential to affect two (2) of two (2) smoke compartments, all residents, staff and visitors. The facility has the capacity for twenty-eight (28) beds and at the time of the survey, the census was twenty-five (25).  The findings include:  Observation, on 04/30/14 at 11:05 AM with the Housing Manager and Administrator, revealed the oxygen trans-filling room had a fire rated door installed but it was unclear what the door was rated for. The door frame is steel but there is no fire rating tag installed on the door frame.  Interview, on 04/30/14 at 11:06 AM with the Housing Manager and Administrator, revealed they were under the impression that the door was okay because it had always been there. They	K 143	Housing Manager. The door and frame for the oxygen tras-filling room will be replaced with a one (1) hour fire rating. This work will be done on or before 6/9/14. This will make the door and frame in compliance with NFPA standards.  2. All other residents have the potential to be affected by this deficient practice. The door and frame to the oxygen trans-filling room will be inspected by the Housing Manager on 6/10/14, after the work is completed to ensure the door and frame has met all requirements.  3. Maintenance staff were inserviced on 5/6/14, all department managers on 5/12/14, and the nursing department on 5/15/14 this was completed by the Housing Manager which was an overview of the	

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K 143	<p>Continued From page 11</p> <p>were not aware of any tags that were removed from the door.</p> <p>Observation, on 04/30/14 at 11:07 AM with the Housing Manager and Administrator, revealed the oxygen trans-filling room was not equipped with any signage stating oxygen trans-filling was occurring.</p> <p>Interview, on 04/30/14 at 11:06 AM with the Housing Manager and Administrator, revealed they were unaware the signage was required on the room at all times.</p> <p>The census of twenty-five (25) was verified by the Administrator on 04/30/14. The findings were acknowledged by the Administrator and verified by the Housing Manager at the exit interview on 04/30/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 99 (1999 Edition). 8-6.2.5.2 Transferring Liquid Oxygen. Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:</p> <ol style="list-style-type: none"> <li>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; and</li> <li>The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and</li> <li>The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted.</li> </ol>	K 143	<p>requirements on transferring liquid oxygen, medical gas, and storage requirements. The preventative maintenance form "CHC Oxygen Room Audit" was revised to include monitoring of the one (1) hour fire rated door and frame, as well as proper signage.</p> <p>4. The oxygen room audit will be completed monthly by maintenance personnel and submitted to the Housing Manager. This audit will be forwarded to the Administrator for compliance. The Administrator will present to QA monthly for the next six (6) months for review and recommendations for changes.</p>	

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K 143	Continued From page 12 Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures. The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities.	K 143			