May 12, 2017

Gary "Paul" Arnell, Administrator
Life Care Center of Treasure Valley
502 North Kimball Place
Boise, ID 83704-0608

Provider #: 135123

RE: FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER LETTER

Dear Mr. Arnell:

On May 2, 2017, a Facility Fire Safety and Construction survey was conducted at Life Care Center of Treasure Valley by the Department of Health & Welfare, Bureau of Facility Standards to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency to be a widespread deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required.

Enclosed is a Statement of Deficiencies and Plan of Correction, Form CMS-2567, listing Medicare and/or Medicaid deficiencies. If applicable, a similar State Form will be provided listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. Please provide ONLY ONE completion date for each federal and state tag in column (XS) Completion Date to signify when
you allege that each tag will be back in compliance. **NOTE:** The alleged compliance date must be after the "Date Survey Completed" (located in field X3) and on or before the "Opportunity to Correct" (listed on page 2). After each deficiency has been answered and dated, the administrator should sign the Statement of Deficiencies and Plan of Correction, CMS-2567 Form in the spaces provided and return the originals to this office. If a State Form with deficiencies was issued, it should be signed, dated and returned along with the CMS-2567 Form.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **May 25, 2017.** Failure to submit an acceptable PoC by **May 25, 2017,** may result in the imposition of civil monetary penalties by **June 14, 2017.**

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;

- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

- Include dates when corrective action will be completed.

- The administrator must sign and date the first page of both the federal survey report, Form CMS-2567. If a State Form was issued as well, it should also be signed, dated and returned.

All references to federal regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Remedies will be recommended for imposition by the Centers for Medicare and Medicaid Services (CMS) if your facility has failed to achieve substantial compliance by **June 6, 2017,** (Opportunity to Correct). Informal dispute resolution of the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate) on **June 6, 2017.** A change in the seriousness of the deficiencies on **June 6, 2017,** may result in a change in the remedy.
The remedy, which will be recommended if substantial compliance has not been achieved by June 6, 2017, includes the following:

Denial of payment for new admissions effective August 2, 2017.

42 CFR §488.417(a)

If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on November 2, 2017, if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

If you believe these deficiencies have been corrected, you may contact Nate Elkins, Supervisor, Facility Fire Safety and Construction, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0009, Phone #: (208) 334-6626, option 3; Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance. We may accept the written allegation of compliance and presume compliance until substantiated by a revisit or other means. In such a case, neither the CMS Regional Office nor the State Medicaid Agency will impose the previously recommended remedy, if appropriate.

If, upon the subsequent revisit, your facility has not achieved substantial compliance, we will recommend that the remedies previously mentioned in this letter be imposed by the CMS Regional Office or the State Medicaid Agency beginning on May 2, 2017, and continue until substantial compliance is achieved. Additionally, the CMS Regional Office or State Medicaid Agency may impose a revised remedy(ies), based on changes in the seriousness of the non-compliance at the time of the revisit, if appropriate.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:
Go to the middle of the page to Information Letters section and click on State and select the following:

BFS Letters (06/30/11)

2001-10 Long Term Care Informal Dispute Resolution Process
2001-10 IDR Request Form

This request must be received by May 25, 2017. If your request for informal dispute resolution is received after May 25, 2017, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626, option 3.

Sincerely,

Nate Elkins, Supervisor
Facility Fire Safety and Construction

NE/lj
Enclosures
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:

135123

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - ENTIRE BUILDING

B. WING

(X3) DATE SURVEY COMPLETED

05/02/2017

**NAME OF PROVIDER OR SUPPLIER**

LIFE CARE CENTER OF TREASURE VALLEY

**STREET ADDRESS, CITY, STATE, ZIP CODE**

502 NORTH KIMBALL PLACE

BOISE, ID 83704

**SUMMARY STATEMENT OF DEFICIENCIES**

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>INITIAL COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 000</td>
<td>This plan of correction is submitted as required under Federal and State regulations and statutes applicable to long-term care facilities. The plan of Correction does not constitute agreement by the facility that the surveyors findings constitute a deficiency and/or that the scope and severity of the deficiencies cited are correct applied.</td>
</tr>
</tbody>
</table>

**K 161**

1. **SPECIFIC ISSUE:**

   The northeast 100 hall smoke barrier and the service corridor smoke barrier penetrations have been sealed on or before 5/31/2017 by Director of Maintenance.

2. **OTHER RESIDENTS:**

   All smoke barriers were inspected and repaired for additional penetrations on or before 5/31/2017 by Director of Maintenance.

3. **SYSTEMIC CHANGES:**

   Staff educated on or before 5/31/2017 by Executive Director or designee regarding preventative maintenance policy and smoke barrier penetration policy.

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**LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**

Executive Director

**TITLE**

5/22/17

**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.
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 161</td>
<td>Continued From page 1</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>II (000)</td>
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<tr>
<td></td>
<td>Not allowed</td>
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<tr>
<td>4</td>
<td>III (211)</td>
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<tr>
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<td>Maximum 2 stories</td>
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<td>5</td>
<td>IV (2HH)</td>
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<tr>
<td>6</td>
<td>V (111)</td>
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<td>7</td>
<td>III (200)</td>
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<td>Not allowed</td>
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<tr>
<td>8</td>
<td>V (000)</td>
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</tr>
<tr>
<td></td>
<td>Maximum 1 story</td>
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</tbody>
</table>

Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)

Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.

This Standard is not met as evidenced by:

Based on observation, the facility failed to ensure that the fire and smoke resistive properties of the structure were maintained. Failure to seal penetrations in smoke barriers could allow fire, smoke and dangerous gases to pass between compartments during a fire. This deficient practice affected 17 residents in 1 of 8 smoke compartments, staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 100 on the day of the survey.

Findings include:

During the facility tour conducted on May 2, 2017 from approximately 11:00 AM to 3:30 PM, above the ceiling inspections at the northeast 100 hall smoke barrier and the service corridor smoke

**MONITOR:**

Executive Director or designee will ensure that all future construction that penetrates a fire wall will be sealed with material that is capable of maintaining the smoke resistance of the smoke barrier. Additional education will be provided as necessary.

Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated.

5. **Date of Compliance:** 5/31/2017
## LIFE CARE CENTER OF TREASURE VALLEY

### Statement of Deficiencies and Plan of Correction

#### (1) Provider/Supplier/CUA Identification Number:

135123

#### (2) Multiple Construction

- A. Building 01 - Entire Building
- B. Wing ____________

#### (3) Date Survey Completed:

05/02/2017

### Name of Provider or Supplier

LIFE CARE CENTER OF TREASURE VALLEY

### Street Address, City, State, Zip Code

502 NORTH KIMBALL PLACE

BOISE, ID 83704

### Summary Statement of Deficiencies

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

#### (X4) ID PREFIX TAG

<table>
<thead>
<tr>
<th>K 161</th>
<th>Continued From page 2</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>barrier revealed the following unsealed penetrations:</td>
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<tr>
<td></td>
<td>1) An approximately 1-1/2&quot; unsealed penetration at the smoke barrier separating compartments at the Northeast 100 hall.</td>
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<tr>
<td></td>
<td>2) An approximately 2&quot; unsealed penetration between compartments at the smoke barrier separating the service corridor to the main facility.</td>
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<tr>
<td></td>
<td>Actual NFPA standard:</td>
</tr>
<tr>
<td></td>
<td>19.1.6 Minimum Construction Requirements.</td>
</tr>
<tr>
<td></td>
<td>19.1.6.1 Health care occupancies shall be limited to the building construction types specified in Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7. (See 8.2.1.)</td>
</tr>
</tbody>
</table>

#### (X5) Completion Date

05/11/2017

### Provider's Plan of Correction

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

#### K 161

- **Specific Issue:** The two corroded pendants over the washers in the laundry room and the additional drop pendant replacement heads were replaced/purchased on or before 5/31/2017 by Director of Maintenance.

#### K 353

1. **Specific Issue:**
   The two corroded pendants over the washers in the laundry room and the additional drop pendant replacement heads were replaced/purchased on or before 5/31/2017 by Director of Maintenance.

2. **Other Residents:**
   All sprinkler heads were inspected and repaired as needed on or before 5/31/2017 by Director of Maintenance.

3. **Systemic Changes:**
   Staff educated on or before 5/31/2017 by Executive Director or designee regarding preventative maintenance policy and applicable NFPA standards.

4. **Monitor:**
   Executive Director or designee will monitor sprinkler head corrosion and proper stock of spare sprinklers for facility weekly x 4, then monthly x 3. Additional education will be provided as necessary.
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(K1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 135123

<table>
<thead>
<tr>
<th>K 353 Continued From page 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>c) Water system supply source</td>
</tr>
<tr>
<td>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.</td>
</tr>
<tr>
<td>9.7.5, 9.7.7, 9.7.8, and NFPA 25</td>
</tr>
<tr>
<td>This Standard is not met as evidenced by:</td>
</tr>
<tr>
<td>Based on observation and interview, the facility failed to ensure that fire suppression systems were maintained in accordance with NFPA 25.</td>
</tr>
<tr>
<td>Failure to maintain fire suppression sprinklers free of obstructions and provide the correct replacement type, could result in a lack of system performance and potentially leave the facility unsprinklered during an isolated fire event. This deficient practice affected residents, staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 100 on the day of the survey.</td>
</tr>
<tr>
<td>Findings include:</td>
</tr>
<tr>
<td>1) During the facility tour conducted on May 2, 2017 from approximately 11:00 AM to 3:30 PM, observation of the Laundry revealed two corroded pendants over the washers.</td>
</tr>
<tr>
<td>2) During the facility tour conducted on May 2, 2017 from approximately 11:00 AM to 3:30 PM, observation of the fire suppression system spare sprinkler box, revealed the box did not contain any drop pendant replacement heads of any temperature rating. Further observation of installed pendants throughout the facility revealed drop-style pendants ranging in temperature response between 155 degrees to 212 degrees. Interview of the Maintenance Supervisor revealed he was not aware of the lack of drop pendant style sprinklers in the box prior to the survey.</td>
</tr>
</tbody>
</table>

Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated. 

5. Date of Compliance: 5/31/2017
K 353 Continued From page 4

Actual NFPA standard:

5.2.1 Sprinklers.

5.2.1.1* Sprinklers shall be inspected from the floor level annually.

5.2.1.1.1* Sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., upright, pendent, or sidewall).

5.2.1.1.2 Any sprinkler that shows signs of any of the following shall be replaced:
   (1) Leakage
   (2) Corrosion
   (3) Physical damage
   (4) Loss of fluid in the glass bulb heat responsive element
   (5)*Loading
   (6) Painting unless painted by the sprinkler manufacturer

5.4.1.5 The stock of spare sprinklers shall include all types and ratings installed and shall be as follows:
   (1) For protected facilities having under 300 sprinklers-no fewer than 6 sprinklers
   (2) For protected facilities having 300 to 1000 sprinklers - no fewer than 12 sprinklers
   (3) For protected facilities having over 1000 sprinklers - no fewer than 24 sprinklers

K 355

1. SPECIFIC ISSUE:
The fire extinguishers in the activities room, general storage, and the laundry room were adjusted to the proper height on or before 5/31/2017 by Director of Maintenance.

2. OTHER RESIDENTS:
All fire extinguishers were inspected and modified as needed on or before 5/31/2017 by Director of Maintenance.

3. SYSTEMIC CHANGES:
Staff educated on or before 5/31/2017 by Executive Director or designee regarding preventative maintenance policy and applicable NFPA standards.

4. MONITOR:
Executive Director or designee will monitor appropriate height of extinguishers weekly x 4, then monthly x 3. Additional education will be provided as necessary.
**Portable Fire Extinguishers**

Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10. This Standard is not met as evidenced by:

Based on observation, the facility failed to ensure fire extinguishers were installed in accordance with NFPA 10. Failure to install fire extinguishers at the correct height could hinder staff access during a fire. This deficient practice affected staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 100 on the day of the survey.

Findings include:

During the facility tour conducted on May 2, 2017 from approximately 10:00 AM to 3:30 PM, observation of installed portable fire extinguishers revealed the following extinguishers were installed over 60" to the top of the extinguisher when measured from the floor:

- **Activities room:** the extinguisher top was 64-1/2 inches from the floor.
- **General Storage in the Maintenance corridor:** the extinguisher top was 63-1/2 inches from the floor.
- **Laundry:** the extinguisher top was 63 inches from the floor.

Actual NFPA standard:

NFPA 10

6.1.3.8 Installation Height. 6.1.3.8.1 Fire extinguishers having a gross weight not exceeding 40 l (18.14 kg) shall be installed so that the top of the fire extinguisher is not more than 5 ft (1.53 m) above the floor.

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**Provider's Plan of Correction**

Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated.

5. **Date of Compliance:** 5/31/2017
### Summary Statement of Deficiencies

<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
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<tbody>
<tr>
<td>K 911</td>
<td>Continued From page 6</td>
<td>K 911</td>
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<tr>
<td>K 911</td>
<td>NFPA 101 Electrical Systems - Other</td>
<td>K 911</td>
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<tr>
<td>SS=F</td>
<td>Electrical Systems - Other</td>
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</table>

**K 911**

1. **SPECIFIC ISSUE:**
   
The trash compactor circuit was taken off of the primary essential circuits of the Life Safety Branch of the EES on or before 5/31/2017 by Certified Electrician.

2. **OTHER RESIDENTS:**
   
   All circuits were inspected and modified as needed on or before 5/31/2017 by Certified Electrician.

3. **SYSTEMIC CHANGES:**
   
   Staff educated on or before 5/31/2017 by Executive Director or designee regarding preventative maintenance policy and applicable NFPA standards.

4. **MONITOR:**
   
   In the event the facility needs to change any details of the Life Safety circuits, we will ensure all NFPA standards are followed. Additional education will be provided as necessary.
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**Provider/Supplier/Clinical Identification Number:**

<table>
<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
</table>
| K 911         | Continued From page 7  
6.4.2.2 Branches.  
6.4.2.2.1* General.  
6.4.2.2.1.1 The essential electrical system shall be divided into the following three branches:  
(1) Life safety  
(2) Critical  
(3) Equipment  
6.4.2.2.3 Life Safety Branch.  
6.4.2.2.3.1 The life safety branch shall be limited to circuits essential to life safety.  
6.4.2.2.3.2 The life safety branch shall supply power for lighting, receptacles, and equipment as follows:  
(1) Illumination of means of egress in accordance with NFPA 101, Life Safety Code  
(2) Exit signs and exit directional signs in accordance with NFPA 101, Life Safety Code  
(3)*Hospital communications systems, where used for issuing instruction during emergency conditions  
(4) Generator set location as follows:  
(a) Task illumination  
(b) Battery charger for emergency battery-powered lighting unit(s)  
(c) Select receptacles at the generator set location and essential electrical system transfer switch locations  
(5) Elevator cab lighting, control, communications, and signal systems  
(6) Electrically powered doors used for building egress  
(7) Fire alarms and auxiliary functions of fire alarm combination systems complying with NFPA 72, National Fire Alarm and Signaling Code | K 911 | Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated. | 5/31/2017 |
| K 927         | NFPA 101 Gas Equipment - Transfilling Cylinders  
Gas Equipment - Transfilling Cylinders  
Transfilling of oxygen from one cylinder to | K 927 | | |

* * *

**Date of Compliance:** 5/31/2017
**K 927**

Continued From page 8

another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)

This Standard is not met as evidenced by:

Based on observation, operational testing and interview, the facility failed to ensure liquid oxygen transfilling was conducted in accordance with NFPA 99. Failure to transfill liquid oxygen with mechanical ventilation could result in creating a oxygenated environment, increasing the potential for combustion. This deficient practice affected 9 residents, staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 100 on the day of the survey.

Findings include:

During the facility tour conducted on May 2, 2017 from approximately 10:00 AM to 3:30 PM, observation and operational testing of the fan for the oxygen storage/transfill area in the northeast 200 hall revealed the fan was operational, but did not do not exhibit any airflow against a standard sheet of note paper placed within six inches of the exhaust.

Interview of the Maintenance Supervisor revealed he was not aware of the lack of exhaust and thought it may be due to a bird's nest as they have had this issue before.

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**1. SPECIFIC ISSUE:**

The exhaust fan in the oxygen storage room was updated to the current NFPA 99 code to ensure proper exhaust function on or before 5/31/2017 by a Certified HVAC Technician.

**2. OTHER RESIDENTS:**

No other oxygen storage is found in the facility.

**3. SYSTEMIC CHANGES:**

Staff educated on or before 5/31/2017 by Executive Director or designee regarding preventative maintenance policy and applicable NFPA standards

**4. MONITOR:**

Executive Director or designee will audit oxygen room for appropriate exhaust per NFPA standard weekly x 4 then monthly x 3. Additional education will be provided as necessary.
### Summary Statement of Deficiencies

**K 927**

Continued From page 9

Actual NFPA standard:

**NFPA 99**

11.5.2.3 Transfilling Liquid Oxygen. Transfilling of liquid oxygen shall comply with 11.5.2.3.1 or 11.5.2.3.2, as applicable.

11.5.2.3.1 Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following:

1. A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction.
2. The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring.
3. The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted.
4. The individual transfilling the container(s) has been properly trained in the transfilling procedures.

9.3.7.5.3.2 Mechanical exhaust shall be at a rate of 1 L/sec of airflow for each 300 L (1 cfm per 5 ft³ of fluid) designed to be stored in the space and not less than 24 L/sec (50 cfm) nor more than 235 L/sec (500 cfm).

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**Results of Audit**

Results of audit will be reviewed in PI to ensure systems being followed. Plan to be updated as indicated.

**Date of Compliance:** 5/31/2017