



IDAHO DEPARTMENT OF  
**HEALTH & WELFARE**

C.L. "BUTCH" OTTER – Governor  
RICHARD M. ARMSTRONG – Director

TAMARA PRISOCK-- ADMINISTRATOR  
DIVISION OF LICENSING & CERTIFICATION  
DEBRA RANSOM, R.N., R.H.I.T., Chief  
BUREAU OF FACILITY STANDARDS  
3232 Elder Street  
P.O. Box 83720  
Boise, ID 83720-0009  
PHONE 208-334-6626  
FAX 208-364-1888

June 7, 2017

**REVISED COPY**

Jeremy Tolman, Administrator  
Life Care Center of Post Falls  
460 North Garden Plaza Court  
Post Falls, ID 83854-6437

Provider #: 135135

RE: **FACILITY FIRE SAFETY & CONSTRUCTION SURVEY REPORT COVER  
LETTER**

Dear Mr. Tolman:

On **May 17, 2017**, a Facility Fire Safety and Construction survey was conducted at **Life Care Center of Post Falls** 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 **revised** 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 (X5) Completion Date to signify when

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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 **June 8, 2017**. Failure to submit an acceptable PoC by **June 8, 2017**, may result in the imposition of civil monetary penalties by **June 28, 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 21, 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 21, 2017**. A change in the seriousness of the deficiencies on **June 21, 2017**, may result in a change in the remedy.

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The remedy, which will be recommended if substantial compliance has not been achieved by **June 21, 2017**, includes the following:

Denial of payment for new admissions effective **August 17, 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 17, 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 17, 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:

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<http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/NursingFacilities/tabid/434/Default.aspx>

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 **June 8, 2017**. If your request for informal dispute resolution is received after **June 8, 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,



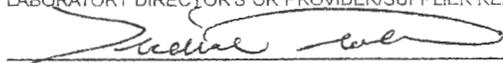
Nate Elkins, Supervisor  
Facility Fire Safety and Construction

NE/lj  
Enclosures

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

PRINTED: 06/07/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  135135	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - LIFE CARE POST FALLS SNF  B. WING _____	(X3) DATE SURVEY COMPLETED  05/17/2017
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF POST FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854	
(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 000	INITIAL COMMENTS  The facility is a single story type V (111) construction of approximately 64000 square feet with multiple exits to grade. The facility is divided into five smoke compartments and is protected throughout by a NFPA 13 Fire Sprinkler System, corridor smoke detection and manual fire alarm system. There is piped medical gas to 49 rooms, which meets NFPA 99 standards and a Type 1 essential electrical system. The facility is currently licensed for 120 SNF/NF beds.  The following deficiencies were cited during the annual fire/life safety survey conducted on May 17, 2017. The facility was surveyed under the LIFE SAFETY CODE, 2012 Edition, Existing Health Care Occupancy, in accordance with 42 CFR, 483.70.  The surveyor conducting the survey was:  Sam Burbank Health Facility Surveyor Facility Fire Safety and Construction	K 000	<i>"This Plan of Correction constitutes this facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusions contained in the Department's inspection report"</i>  <b>RECEIVED JUN 12 2017 FACILITY STANDARDS</b>	
K 211 SS=D	NFPA 101 Means of Egress - General  Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to ensure rated smoke doors were maintained in accordance with NFPA 105. Failure to	K 211		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE Executive Director (X6) DATE 6/8/17

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 211	<p>Continued From page 1</p> <p>repair/replace gaskets for smoke rated doors decreases the smoke resistive capabilities, allowing smoke to pass between compartments and reducing the ability to defend in place. This deficient practice affected 34 residents, staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 95 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on May 17, 2017 from approximately 10:00 AM to 3:00 PM, observation of installed corridor doors revealed the labeling on both the frame and door of each assembly, was marked with the identifier "S", indicating the assembly as a smoke rated assembly and tested for positive pressure when equipped with a listed gasket.</p> <p>1) The door to the conference room was missing approximately seven feet of the listed smoke gasket.</p> <p>2) The door to resident room 220 had a damaged smoke gasket of approximately 3/4" on the strike side, approximately twelve to eighteen inches from the floor.</p> <p>Actual NFPA standard:</p> <p>NFPA 101 19.2.2.2 Doors. 19.2.2.2.1 Doors complying with 7.2.1 shall be permitted.</p> <p>7.2.1.15.2 Fire-rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening</p>	K 211	<p>K211</p> <p>1. No residents were found to be affected by this.</p> <p>2. All residents have the potential to be affected by this.</p> <p>3. An audit was conducted of the doors in the facility to ensure the smoke gaskets were in proper working order. Any damaged gaskets were replaced.</p> <p>Training was done with maint department to teach the requirements of NFPA 101 regulation in regards to door gaskets.</p> <p>Maint Director or designee will conduct inspection monthly of door smoke gaskets to determine proper working order.</p> <p>4. Inspection details will be reviewed at QAPI meeting monthly x3</p>	6/21/17	

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K 211	Continued From page 2 Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives.  NFPA 105  5.1.4* Repairs. Damage and impairments to smoke door assemblies shall be corrected.	K 211		
K 300 SS=F	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.  This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure installed fire dampers were tested in accordance with NFPA 80. Failure to test fire dampers as required could result in a lack of system performance during a fire. This deficient practice affected 95 residents, staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 95 on the day of the survey.  Findings include:  During review of facility maintenance and inspection records conducted on May 17, 2017	K 300	K300  1. No residents were found to be affected.  2. All residents have the potential to be affected.  3. An inspection has been scheduled of the fire dampers to determine proper functionality.  Training was completed with maint department regarding the requirements of NFPA's standard on fire damper testing.  Maint Director or designee will conduct audit monthly to determine upcoming needed inspections to determine compliance.  4. Inspection results will be reviewed at QAPI meeting monthly x3	6/21/17

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K 300	Continued From page 3 from approximately 9:00 AM to 10:30 AM, provided fire damper testing records indicated 271 installed fire dampers, had not been tested during an inspection conducted on June 27, 2015 due to inaccessibility. When asked, the Director of Maintenance stated the facility was aware of the report.  Actual NFPA standard:  NFPA 80  Chapter 19 Installation, Testing, and Maintenance of Fire Dampers  19.4* Periodic Inspection and Testing. 19.4.1 Each damper shall be tested and inspected 1 year after installation. 19.4.1.1 The test and inspection frequency shall then be every 4 years, except in hospitals, where the frequency shall be every 6 years.	K 300		
K 325 SS=F	NFPA 101 Alcohol Based Hand Rub Dispenser (ABHR)  Alcohol Based Hand Rub Dispenser (ABHR) ABHRs are protected in accordance with 8.7.3.1, unless all conditions are met: * Corridor is at least 6 feet wide * Maximum individual dispenser capacity is 0.32 gallons (0.53 gallons in suites) of fluid and 18 ounces of Level 1 aerosols * Dispensers shall have a minimum of 4-foot horizontal spacing * Not more than an aggregate of 10 gallons of fluid or 135 ounces aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room * Storage in a single smoke compartment greater	K 325	K325  1.No residents were found to be affected  2.All residents have the potential to be affected.  3.An audit was conducted to determine the number of ABHR dispensers in the facility. Dispensers were labeled/identified and inspected for proper functionality.  Staff was trained in regards to the requirements of NFPA 101 standard on ABHR dispensers.  Audits will be conducted weekly x 2 months, then monthly thereafter by maint director or designee of ABHR dispensers to ensure compliance  4. Audits/inspections will be reviewed at QAPI meeting monthly.	6/21/17

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K 325	<p>Continued From page 4</p> <p>than 5 gallons complies with NFPA 30</p> <ul style="list-style-type: none"> <li>* Dispensers are not installed within 1 inch of an ignition source</li> <li>* Dispensers over carpeted floors are in sprinklered smoke compartments</li> <li>* ABHR does not exceed 95 percent alcohol</li> <li>* Operation of the dispenser shall comply with Section 18.3.2.6(11) or 19.3.2.6(11)</li> <li>* ABHR is protected against inappropriate access 18.3.2.6, 19.3.2.6, 42 CFR Parts 403, 418, 460, 482, 483, and 485</li> </ul> <p>This STANDARD is not met as evidenced by: Based on record review, observation and interview, the facility failed to ensure automatically operated Alcohol Based Hand Rub Dispensers (ABHR) were maintained in accordance with NFPA 101. Failure to test and document operation of automatic dispensing ABHR dispensers could result in inadvertently spilling flammable liquids increasing the risk of fires. This deficient practice affected 32 residents, staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF residents and had a census of 95 on the day of the survey.</p> <p>Findings include:</p> <p>1) During the review of facility inspection records conducted on May 17, 2017 from approximately 9:00 AM to 10:00 AM, no records were available indicating inspection and testing of ABHR dispensers, was performed in accordance with manufacturer's care and use instructions when refilling dispensers.</p> <p>2) During the facility tour conducted on November 9, 2016 from approximately 10:00 AM to 3:30 PM, observation of installed ABHR dispensers revealed automatic dispensers had been installed</p>	K 325		

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K 325	Continued From page 5 in five of five smoke compartments. When asked about automatic ABHR dispenser refill testing and documentation, the Housekeeping staff interviewed at room 208 stated she did not document testing of dispensers, and was not aware of the requirement for testing each time a refill was installed.  Actual NFPA standard:  NFPA 101  19.3.2.6* Alcohol-Based Hand-Rub Dispensers. Alcohol-based hand-rub dispensers shall be protected in accordance with 8.7.3.1, unless all of the following conditions are met:  (1) Where dispensers are installed in a corridor, the corridor shall have a minimum width of 6 ft (1830 mm). (2) The maximum individual dispenser fluid capacity shall be as follows:  (a) 0.32 gal (1.2 L) for dispensers in rooms, corridors, and areas open to corridors (b) 0.53 gal (2.0 L) for dispensers in suites of rooms  (3) Where aerosol containers are used, the maximum capacity of the aerosol dispenser shall be 18 oz. (0.51 kg) and shall be limited to Level 1 aerosols as defined in NFPA30B, Code for the Manufacture and Storage of Aerosol Products. (4) Dispensers shall be separated from each other by horizontal spacing of not less than 48 in. (1220 mm). (5) Not more than an aggregate 10 gal (37.8 L) of alcohol-based hand-rub solution or 1135 oz (32.2	K 325		

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K 325	Continued From page 6 kg) of Level 1 aerosols, or a combination of liquids and Level 1 aerosols not to exceed, in total, the equivalent of 10 gal (37.8 L) or 1135 oz (32.2 kg), shall be in use outside of a storage cabinet in a single smoke compartment, except as otherwise provided in 19.3.2.6(6). (6) One dispenser complying with 19.3.2.6 (2) or (3) per room and located in that room shall not be included in the aggregated quantity addressed in 19.3.2.6(5). (7) Storage of quantities greater than 5 gal (18.9 L) in a single smoke compartment shall meet the requirements of NFPA 30, Flammable and Combustible Liquids Code. (8) Dispensers shall not be installed in the following locations: (a) Above an ignition source within a 1 in. (25 mm) horizontal distance from each side of the ignition source (b) To the side of an ignition source within a 1 in. (25mm) horizontal distance from the ignition source (c) Beneath an ignition source within a 1 in. (25 mm) vertical distance from the ignition source (9) Dispensers installed directly over carpeted floors shall be permitted only in sprinklered smoke compartments. (10) The alcohol-based hand-rub solution shall not exceed 95 percent alcohol content by volume. (11) Operation of the dispenser shall comply with the following criteria: (a) The dispenser shall not release its contents except when the dispenser is activated, either manually or automatically by touch-free activation. (b) Any activation of the dispenser shall occur only when an object is placed within 4 in. (100 mm) of the sensing device.	K 325		

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K 325	Continued From page 7 (c) An object placed within the activation zone and left in place shall not cause more than one activation. (d) The dispenser shall not dispense more solution than the amount required for hand hygiene consistent with label instructions. (e) The dispenser shall be designed, constructed, and operated in a manner that ensures that accidental or malicious activation of the dispensing device is minimized. (f) The dispenser shall be tested in accordance with the manufacturer ' s care and use instructions each time a new refill is installed.	K 325			
K 923 SS=D	NFPA 101 Gas Equipment - Cylinder and Container Storag  Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.	K 923	K923  1.No residents were found to be affected.  2.All residents have the potential to be affected.  3. Racks were purchased and placed in oxygen supply room and sigus were made on each one to differentiate "Empty" and "Full" tanks.  Staff was trained on the purpose of the racks and explained the new system.  Audits will be conducted monthly by maint staff or designee to ensure compliace  4. Results of audits will be reviewed at QAPI meeting monthly.	6/21/17	

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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF POST FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 460 NORTH GARDEN PLAZA COURT POST FALLS, ID 83854	
(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 923	<p>Continued From page 8</p> <p>A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure medical gases were stored in accordance with NFPA 99. Failure to segregate empty oxygen cylinders from full could result in using incorrect cylinders during an emergency. This deficient practice affected residents in need of supplemental oxygen, staff and visitors on the date of the survey. The facility is licensed for 120 SNF/NF beds and had a census of 95 on the day of the survey.</p> <p>Findings include:</p> <p>During the facility tour conducted on May 17, 2017 from approximately 10:00 AM to 3:00 PM, observation of the oxygen storage room in the Physical Therapy wing revealed two racks of "E" sized cylinders. Further observation did not demonstrate any identification or signs demonstrating separation of cylinders as being full or empty.</p> <p>When asked how staff identified full from empty oxygen cylinders, the Licensed Practical Nurse</p>	K 923		

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

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K 923	Continued From page 9 (LPN) present at the Charting station abutting the transfill/storage room, stated the staff could either look at the plastic caps on the tanks, or open the valve to release oxygen to confirm the tank in question was either full or empty.  Actual NFPA standard:  NFPA 99  11.6.5 Special Precautions - Storage of Cylinders and Containers. 11.6.5.1 Storage shall be planned so that cylinders can be used in the order in which they are received from the supplier. 11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. 11.6.5.3 Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed in a rapid manner.	K 923		