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

PRINTED: 11/17/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535031	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER REHABILITATON AND WELLNESS	1002 FOREST DRIVE RIVERTON, WY 82501

(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 Requirements for Long Term Nursing Homes Section 42 CFR 483.70 (a) except as otherwise provided in the section, the facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code, Existing Health Care of the National Fire Protection Association. The facility was q fully sprinkled, single story building of Type V (111) construction built in 1966. The building was equipped with a supervised automatic wet sprinkler system with a zoned fire alarm system. The facility had a capacity of 90 certified Medicare and Medicaid beds with a census of 74.	K 000	This Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the 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 provisions of federal and state laws. Initial Comments: The facility licensed bed capacity is 81.	
K 222 SS=D	NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the safety needs of the patient are used, all of the Clinical or Security Locking requirements are	K 222	K222 1-Observed Rear East exit door adjacent to room 31 will have a delayed egress force of three (3) seconds to activate by 11.28.16. 2- Observed kitchen rear exit door will be adjusted to activate the delayed egress when constant force is applied by 11.28.16. Identification of Others: Doors equipped with a delayed egress alarm will be assessed to ensure a delayed egress force of three (3) seconds to activate is present. Alarm on identified doors will be set	12-2-16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: E.D — (X6) DATE: 12.15.16

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.

Corrected per Request, original dated 12.28.16

ACCEPTED PLAN OF CORRECTION VIA PHONE CALL WITH ADMINISTRATOR JO ANN ALDRICH ON 12-21-2016.
36540

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K 222	Continued From page 1 being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation. 18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted. 18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system. 18.2.2.2.4, 19.2.2.2.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide delayed egress doors in	K 222	K222 Cont'd: to a delayed egress force of three (3) seconds to activate by 11.28.16. Systemic Changes: Director of Building Plant and Safety and/or designee will provide education relating to the requirement of the three second pressure. Testing of the egress doors will be placed on maintenance weekly rounds. Monitoring: Maintenance Director and/or designee will complete an audit of doors equipped with a delayed egress randomly weekly for one month. Results of the audit will be brought to the quality assurance meeting at least monthly until the correction is sustained. K227 The observed areas at the kitchen rear exit ramp, the west exit adjacent to Room 40, the SCU East exit, and West exit adjacent to room 25 will have handrails installed. Identification of Others: Maintenance Director and/or designee will assess all exits to ensure handrails are present and appropriate. Auditing of the	12-2-16

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K 222	Continued From page 2 accordance with NFPA 101. The findings were: 1. Observation on 11/02/2016 at 8:22 AM located at the Rear East exit door adjacent to room 31 revealed a delayed egress door that would not operate unless the force is applied continuously for approximately 15 seconds. Interview with the Facility Maintenance Manager at the time of observation indicated that is how the delayed egress is supposed to work and was unaware of the requirement that does not allow more than 3 seconds of force to activate a delayed egress. 2. Observation on 11/02/2016 at 9:20 AM located at the Kitchen rear exit door revealed a delayed egress door that did not activate when force was applied to the door. The only way to get out was through a key code. Interview with the Facility Maintenance Manager at the time of observation acknowledged that the door was out of operation and was unaware that the door was malfunctioning. Ref: 2012 NFPA 101, Sections 19.2.2.2.4 and 7.2.1.6.1	K 222	K227 Cont'd: handrails will be placed on maintenance monthly rounds. Systemic Changes: Director of Building Plant and Safety and/or designee will provide education to staff relating to handrails required on exit steps and/or ramps. Handrails being present will be added to maintenance monthly rounds. Monitoring: Maintenance Director and/or designee will audit exit steps and ramps relating to handrails randomly monthly. Such audits will be added to the maintenance routine monthly rounds. Results of the audit will be brought to the quality assurance meeting at least monthly until the correction is sustained . Due to the scope of this project, a request for a time limited waiver is being requested until April 28, 2017.	
K 227 SS=D	NFPA 101 Ramps and Other Exits Ramps and Other Exits Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with the provisions 7.2.5 through 7.2.12, 18.2.2.6 to 18.2.2.10 or 19.2.2.6 to 19.2.2.10	K 227	K321 Oxygen storage room door will be evaluated for fire rating or replaced. Oxygen storage room door plate shall be reduced to below the 48 inch requirement. PT Storage room and	1-1-17

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K 227	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide ramps in accordance with NFPA 101. The findings were: 1. Observation on 11/02/2016 at 9:22 AM located at the Kitchen rear exit ramp revealed that the ramp had a handrail that had been damaged. Further observation revealed that the damage to the handrail was sufficient enough to render it un usable. Interview with the Facility Maintenance Manager at the time of observation acknowledged the damaged handrail was caused by a vehicle collision. 2. Observation on 11/02/2016 at 8:57 AM and at 10:22 AM located at the West exit adjacent to Room 40 and at the SCU East exit, respectively, revealed a step at each location that went to the public way outside of the building. Further observation revealed that each step was missing handrails. Interview with the Facility Maintenance Manager at the time of observation indicated that they were unaware of the requirement. 3. Observation on 11/02/2016 at 10:08 AM located at the West exit adjacent to room 25 revealed a ramp (outside to the public way) that had a rise greater than 6 inches. Further observation revealed that the ramp did not have hand rails on either side. Interview with the Facility Maintenance Manager at the time of observation indicated they were unaware of the requirement. Ref: 2012 NFPA 101, Section 19.2.2.6 to 19.2.2.10 and 7.2.5	K 227	K321 Cont'd: Medical Records Office will have a self closing device installed. Identification of Others: Identification of hazardous areas will be made by the Maintenance Director and/or designee.. Audits will be conducted relating to the self closing devise fire rating, and the plate being less than 48 inches for the doors for the identified hazardous areas. Systemic Changes: Director of Building Plant and Safety will provide education to maintenance staff relating to the self closing devises and plate height requirement. Inspection of the hazardous areas having a closing device in place, fire rating and the plate being less than 48 inches will be added to the monthly maintenance rounds. Monitoring: Maintenance Director and/or designee shall audit hazardous areas relating to self closing doors devises in place and door plates not over 48 inches in height randomly monthly for one month. Results of the audit	

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K 321 K 321 SS=D	Continued From page 4 NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Seperation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K3220) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to protect hazardous areas in accordance with NFPA 101. The findings were: 1. Observation on 11/02/2016 at 8:32 AM located at the Oxygen Storage Room revealed that there	K 321 K 321	K321 Cont'd: shall be brought to the quality assurance meeting at least monthly until the correction is sustained. Due to the scope of this project, a request for a time limited waiver is being requested until April 28, 2017. K342 Manual alarm box operable parts will be adjusted to a reduced height from the floor to within 48 inches from the floor. Identification of Others: Maintenance Director and/or designee will complete an audit relating to manual alarm box operable parts being at a height of no more than 48 inches from the floor. Systemic Changes: Director of Building Plant and Safety and/or designee will provide staff education relating to manual alarm box operable parts requirements. Audits of the manual alarm box will be added to the monthly maintenance rounds.	1-1-17

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K 321	Continued From page 5 was no indication that the door to the room was fire-rated. Interview with the Facility Maintenance Manager at the time of observation indicated that the room was once used as a shower for patients and was not sure if the door was fire-rated. 2. Observation on 11/02/2016 at 8:33 AM located at the Oxygen Storage Room revealed that there was a plate on the door that extended above 48 inches from the bottom of the door. Further observations revealed several storage room doors having a plate that extended above 48 inches from the bottom of the door. Interview with the Facility Maintenance Manager at the time of observation was unaware of the requirement. 3. Observation on 11/02/2016 at 9:30 AM of the PT Storage Room and Medical Records Office revealed that the storage room was greater than 50 squared feet and that the room was used for storing an excessive amount of combustible material. Further observation revealed that the storage room door was not provided with a self closing or automatic closing device. Interview with the Facility Maintenance Manager at the time of observation acknowledged that they were unaware of the requirement and further interview indicated that the facility had not identified the medical records office as a storage room. Ref: 2012 NFPA 101, Section 19.3.2.1	K 321	K342 Cont'd: Monitoring: Audits of manual alarm box height being no more than 48 inches from the floor will be conducted by the Maintenance Director and/or designee randomly monthly for one month. Results of the audit will be brought to the quality assurance meeting at least monthly until the correction is sustained . K351 Required sprinkler coverage will be provided in built-in closets in resident rooms. Identification of others: All built-in closets in resident room will be assessed to ensure all such closets are identified by Maintenance Director and/or designee. Sprinkler protection will be placed in any observed such closets. Systemic Changes: Director of Building Plant and Safety and/or designee will provide education to staff relating to built-in closets in resident rooms requiring sprinkler devises. Auditing of	12.2.16
K 342 SS=D	NFPA 101 Fire Alarm System - Initiation Fire Alarm System - Initiation Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system.	K 342		

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K 342	Continued From page 6 Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200' travel distance is not exceeded. 18.3.4.2.1, 18.3.4.2.2, 19.3.4.2.1, 19.3.4.2.2, 9.6.2.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a fire alarm system in accordance with NFPA 72. The findings were: Observation on 11/02/2016 at 9:32 AM located adjacent to Room 6, Room 24, the Main Entrance, and all manual alarm boxes throughout the facility revealed that the manual alarm boxes were measured (from operable part of the fire alarm box to the finished floor) at approximately 56 inches. Interview with the Facility Maintenance Manager at the time of observation indicated they were unaware of the 48 inch height requirement from the operable parts of the manual fire alarm box. Ref: 2012 NFPA 101, Section 19.3.4.2.2 and 9.6.2.5 2010 NFPA 72, Section 17.14.4	K 342	K351 Cont'd: sprinkler devises in built-in closets in resident rooms will be added to the maintenance monthly rounds. Monitoring: Maintenance Director and/or designee will audit fire sprinklers being placed in built-in closets in resident rooms randomly monthly. Results of the audit will be brought to the quality assurance meeting at least monthly until the correction is sustained . Due to the scope of this project, a request for a time limited waiver is being requested until April 28, 2017. K353 The sprinkler gauges was be tested for accuracy and replaced by 11.25.16. The escutcheon for the sprinkler head on the brick wall located at the West exit adjacent to room 40 will be installed. Identification of others: Maintenance Director and/or designee will request testing and/or replacement by an authorized source	12.2.16
K 351 SS=E	NFPA 101 Sprinkler System - Installation Sprinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the	K 351		

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K 351	Continued From page 7 Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.6, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to protect the building throughout by an approved, supervised automatic sprinkler system in 4 of 5 smoke compartments. The findings were: Observation on 11/02/2016 at 8:25 AM - 10:40 AM revealed built-in closets that were located in all resident rooms in the facility. Additional observation revealed that the closets included a bar for hanging clothing, and that the top of the closet enclosure was continuous to the ceiling of the room. Further observation revealed that the closets were not provided with sprinkler protection within each closet. Interview with the Facility Maintenance Manager during the observation indicated that they were unaware of the requirement and that the sprinkler contractor said it would not be required based off square footage of each room. Ref: 2012 NFPA 101, Sections 19.3.5.1 and 9.7.1.1 1999 NFPA 13, Section 1-6.1 S&C Letter 13-55	K 351	K353 Cont'd: any such fire sprinkler gauges within the regulated time frames. All sprinkler escutcheons will be audited to ensure placement. Systemic Changes: Director of Building Plant and Safety and/or designee will provide education to staff relating to fire sprinkler gauges and sprinkler escutcheons regulations. Such inspections will be placed on the monthly maintenance rounds Monitoring: Maintenance Director and/or designee will audit fire sprinkler gauges relating to testing gauges per requirements randomly monthly. Maintenance Director and/or designee will conduct audits of sprinkler escutcheons placement monthly. Results of the audits will be brought to the quality assurance meeting at least monthly until the correction is sustained. K511 A non-ground-fault circuit-interrupter receptacle was be	12.2.16

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K 353 SS=D	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the automatic sprinkler system in accordance with NFPA 25. The findings were: 1. Observation on 11/02/2016 at 9:40 AM located in the Sprinkler Riser Room revealed that the sprinkler gauges had been marked with a date of 01/28/2011. Further observation revealed that the date had passed to either test the gauges or replace the gauges. Interview with the Facility Maintenance Manager at the time of observation indicated that they had missed the date to replace the gauges. 2. Observation on 11/02/2016 at 8:57 AM located at the West exit adjacent to room 40 revealed a	K 353	K511 Cont'd: installed in the SCU staff bathroom by 11.15.16. Identification of others: A facility audit of electrical outlets within six feet of a sink will be conducted to ensure such outlets are a ground-fault circuit-interrupter by Maintenance Director and/or designee. Any identified lack of ground-fault circuit-interrupter will be corrected. Systemic Changes: Director of Building Plant and Safety and/or designee will provide education to staff relating to the requirement of ground-fault circuit-interrupters within 6 feet of a sink. This will be added to maintenance monthly rounds. Monitoring: Maintenance Director and/or designee will audit electrical outlets randomly monthly. Results of the audits will be brought to the quality assurance meeting at least monthly until the correction is sustained and the committee determines the monitoring can be retired.	

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K 353	Continued From page 9 missing sprinkler escutcheon for the sprinkler head on the brick wall. Interview with the Facility Maintenance Manager at the time of observation acknowledged the missing escutcheon and indicated that they had missed checking that escutcheon. Ref: 2012 NFPA 101, Section 9.7.5 2011 NFPA 25, Section 5.3.2.1	K 353	K920 Oxygen concentrator in room 40 will be plugged directly into the wall or a power strip that is UL 1363A will be used. Identification of Others: An audit will be conducted relating to oxygen concentrators being plugged into the wall or a power strip that is UL 1363A by the Maintenance Director and/or designee. Any such observations will be corrected immediately. Systemic Changes: Director of Building Plant and Safety and/or designee will provide education to staff relating to the oxygen concentrators being plugged into the wall or power strip that is UL1363A. Audits will be placed on maintenance weekly rounds. Monitoring: Maintenance Director and/or designee will conduct audits of oxygen concentrators being plugged into the wall or a power strip of UL 1363A weekly for one month.	12.2.16
K 511 SS=D	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide electrical panels in accordance with NFPA 70. The findings were: Observation on 11/02/2016 at 10:25 AM located in the SCU Staff Bathroom revealed a non-ground-fault circuit-interrupter receptacle within 6 feet of a sink. Interview with the Facility Maintenance Manager at the time of observation indicated that they overlooked the missing ground-fault circuit-interrupter. Ref:	K 511		

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	535031	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WIND RIVER REHABILITATON AND WELLNESS	1002 FOREST DRIVE RIVERTON, WY 82501

(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 511	Continued From page 10 2012 NFPA 101, Sections 19.5.1.1 and 9.1.2 2011 NFPA 70, Section 210.8(B)(5)	K 511	K920 Cont'd: Results of the audits will be brought to the quality assurance meeting at least monthly until the correction is sustained.	
K 920 SS=D	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provided power strips in accordance with NFPA 99. The findings were: Observation and staff interview on 11/02/2016 at 8:53 AM located in room 40 revealed an oxygen concentrator plugged into a power strip that was not UL 1363A. Interview with the Facility	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535031	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 920	Continued From page 11 Maintenance Manager at the time of observation said that the oxygen concentrator should be plugged into the wall. Ref: 2012 NFPA 99, Section 10.2.3.6	K 920		