STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105730	A. BUILDING **01, 05** B. WING _____	**02/11/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING LAKE REHABILITATION CENTER	**1540 6TH ST NW** **WINTER HAVEN, FL 33881**

(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
E 000	Initial Comments During the Fire & Life Safety recertification survey conducted on 02/11/2025 at Spring Lake Rehabilitation Center, a nursing home, Emergency Preparedness was reviewed. Spring Lake Rehabilitation Center is in compliance with Emergency Preparedness per Code of Federal Regulations (CFR) 42, Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
K 000	INITIAL COMMENTS An unannounced Fire & Life Safety recertification survey was conducted 02/11/2025 at Spring Lake Rehabilitation Center, a nursing home in Winter Haven, Florida. The Facility is not in compliance with 42 CFR 483.90(a), and National Fire Protection Association (NFPA) 101 (2012 Edition), NFPA 99 (2012 Edition) requirements for nursing homes. Initial Plan Review: 1986 New or Existing: Existing NFPA 220 Construction Type: III (211) Number of beds: 132 Census: 122 The following is a description of the deficiencies found at the time of the visit.	K 000		
K 222 SS=D	Egress Doors CFR(s): NFPA 101 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	K 222		3/13/25

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/07/2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105730	A. BUILDING **01, 05** B. WING _____	**02/11/2025**

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 222	Continued From page 1 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 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	K 222		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105730	A. BUILDING **01, 05** B. WING _____	**02/11/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING LAKE REHABILITATION CENTER	**1540 6TH ST NW** **WINTER HAVEN, FL 33881**

(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 222	Continued From page 2 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 REQUIREMENT is not met as evidenced by: Based on observation and interview, it was found the facility failed to maintain delayed egress exit doors in accordance with NFPA 101. Findings included: On 02/11/2025 between the hours of 1:00 p.m. and 4:00 p.m. during the facility tour with the maintenance director, it was observed the delayed egress exit door from the main dining room failed to close and latch when tested. The maintenance director was interviewed concurrent with the facility tour and he stated the door should have closed and latched but did not without assistance. These findings were reviewed with the maintenance director and the administrator during the exit conference on 02/11/2025 at 4:15 p.m.	K 222	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the items alleged or conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared solely because it is required by the provision of Federal and State Laws code section 1280 and 42 CFR 483.1. 1. Identified doors repaired, currently closing/latching as intended. 2. Maintenance Director/Designee completed observation of other facility exit doors to verify delayed egress maintained. 3. Administrator provided education for current facility Maintenance Department regarding egress doors. 4. Maintenance Director/Designee to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105730	A. BUILDING **01, 05** B. WING _____	**02/11/2025**

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K 222	Continued From page 3 per NFPA 101 (2012 Edition) 19.2.2.2.1, 7.2.1, 7.2.1.5.10	K 222	complete monthly preventative maintenance testing of exit doors to verify delayed egress maintained. Findings to be reviewed at the monthly QAPI Committee Meeting. Modifications as indicated based on findings.	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was found the facility failed to maintain the continuity of smoke barriers in accordance with NFPA 101. Findings included: On 02/11/2025 between the hours of 1:00 p.m. and 4:00 p.m. during the facility tour with the maintenance director, it was observed: 1.) There was an unsealed penetration and smoke barrier above the smoke door by room 106. 2.) There was an untested blowout patching in	K 372	1. Identified unsealed penetration & smoke barrier has been sealed. Identified untested blowout patching in the smoke barrier above the ceiling has been removed/repaired. 2. Maintenance Director/Designee completed observation of other facility smoke barriers to verify they are maintained in accordance with NFPA 101. 3. The administrator provided education for current facility Maintenance	3/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105730	A. BUILDING **01, 05** B. WING _____	**02/11/2025**

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K 372	Continued From page 4 smoke barrier above the ceiling by room 106. (Photographic Evidence Obtained) The maintenance director was interviewed concurrent with the facility tour and he stated he already removed several blowout patches but acknowledged this one, and he acknowledged the barrier was not sealed to the deck. These findings were reviewed with the maintenance director and the administrator during the exit conference on 02/11/2025 at 4:15 p.m. per NFPA 101 (2012 Edition) 19.3.7.3, 8.5.2.1, 8.5.2.2	K 372	Department regarding smoke barrier maintenance. 4. Maintenance Director/Designee to complete monthly observation of smoke barriers to verify they are maintained in accordance with NFPA 101. Findings to be reviewed at the monthly QAPI Committee Meeting. Modifications as indicated based on findings.	
K 921 SS=D	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily	K 921		3/13/25

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K 921	Continued From page 5 available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was found the facility failed to maintain patient care related electrical equipment (PCREE) in accordance with NFPA 99. Findings included: On 02/11/2025 between the hours of 1:00 p.m. and 4:00 p.m. during the facility tour with the maintenance director, it was observed an oxygen concentrator in Rehab had an out of date PCREE certification of 07/2021. (Photographic Evidence Obtained) The maintenance director was interviewed concurrent with the facility tour and he stated the concentrator had been provided by a rental company. These findings were reviewed with the maintenance director and the administrator during the exit conference on 02/11/2025 at 4:15 p.m. per NFPA 99 (2012 Edition) 10.5.2.1.1, 10.5.2.7	K 921	1. Identified concentrator was removed from service, PCREE certification service completed. 2. Maintenance Director/Designee completed observation of other facility concentrators to verify PCREE certification is completed as required. 3. The administrator provided education for current facility Maintenance Department regarding PCREE maintenance requirements. 4. Maintenance Director/Designee to complete monthly observation of facility concentrators to ensure PCREE certification is completed as required. Findings to be reviewed at the monthly QAPI Committee Meeting. Modifications as indicated based on findings.	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65316	A. BUILDING: **01, 05** B. WING _____	**02/11/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING LAKE REHABILITATION CENTER	**1540 6TH ST NW** **WINTER HAVEN, FL 33881**

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K 000	INITIAL COMMENTS An unannounced Fire & Life Safety re-licensure survey was conducted on 02/11/2025 at Spring Lake Rehabilitation Center, a nursing home in Winter Haven, Florida in accordance with National Fire Protection Association (NFPA) 1 and 101 (2021 Edition) and applicable requirements of Florida State Fire Marshal's Rules and Regulations, Florida Administrative Code (F.A.C) 69A-3, F.A.C. 69A-53, F.A.C. 59A-4, and Florida Statutes (F.S.) 400 Part II, and F.S. 633.0215, adopting National Fire Protection Association (NFPA) 1 and 101 (2021 Edition) known as the Florida Fire Prevention Code and all NFPA referenced standards and requirements adopted per NFPA 101, Chapter 2. The following is a description of the deficiencies found at the time of the visit.	K 000		
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	K 222		3/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65316	A. BUILDING: **01, 05** B. WING _____	**02/11/2025**

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SPRING LAKE REHABILITATION CENTER	**1540 6TH ST NW** **WINTER HAVEN, FL 33881**

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K 222	Continued From page 1 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 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	K 222		

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K 222	Continued From page 2 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 Statute or Rule is not met as evidenced by: Based on observation and interview, it was found the facility failed to maintain delayed egress exit doors in accordance with NFPA 101. Findings included: On 02/11/2025 between the hours of 1:00 p.m. and 4:00 p.m. during the facility tour with the maintenance director, it was observed the delayed egress exit door from the main dining room failed to close and latch when tested. The maintenance director was interviewed concurrent with the facility tour and he stated the door should have closed and latched but did not without assistance. These findings were reviewed with the maintenance director and the administrator during the exit conference on 02/11/2025 at 4:15 p.m. per NFPA 101 (2021 Edition) 19.2.2.2.1, 7.2.1, 7.2.1.5.10 Class III	K 222	Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the items alleged or conclusions set forth in the statement of deficiencies. This Plan of Correction is prepared solely because it is required by the provision of Federal and State Laws code section 1280 and 42 CFR 483.1. 1. Identified doors repaired, currently closing/latching as intended. 2. Maintenance Director/Designee completed observation of other facility exit doors to verify delayed egress maintained. 3. Administrator provided education for current facility Maintenance Department regarding egress doors. 4. Maintenance Director/Designee to complete monthly preventative maintenance testing of exit doors to verify delayed egress maintained. Findings to be reviewed at the monthly QAPI Committee Meeting. Modifications as indicated based on findings.	
K 372 SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie	K 372		3/13/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 372	Continued From page 3 Subdivision of Building Spaces - Smoke Barrier Construction 2015 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. 2015 NEW Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations of fully ducted HVAC systems. 18.3.7.3, 18.3.7.4, 18.3.7.5, 8.3 Describe any mechanical smoke control system in REMARKS. This Statute or Rule is not met as evidenced by: Based on observation and interview, it was found the facility failed to maintain the continuity of smoke barriers in accordance with NFPA 101. Findings included: On 02/11/2025 between the hours of 1:00 p.m. and 4:00 p.m. during the facility tour with the maintenance director, it was observed: 1.) There was an unsealed penetration and smoke barrier above the smoke door by room	K 372	1. Identified unsealed penetration & smoke barrier has been sealed. Identified untested blowout patching in the smoke barrier above the ceiling has been removed/repaired. 2. Maintenance Director/Designee completed observation of other facility smoke barriers to verify they are maintained in accordance with NFPA 101.	

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K 372	Continued From page 4 106. 2.) There was an untested blowout patching in smoke barrier above the ceiling by room 106. (Photographic Evidence Obtained) The maintenance director was interviewed concurrent with the facility tour and he stated he already removed several blowout patches but acknowledged this one, and he acknowledged the barrier was not sealed to the deck. These findings were reviewed with the maintenance director and the administrator during the exit conference on 02/11/2025 at 4:15 p.m. per NFPA 101 (2021 Edition) 19.3.7.3, 8.5.2.1, 8.5.2.2 Class III	K 372	3. The administrator provided education for current facility Maintenance Department regarding smoke barrier maintenance. 4. Maintenance Director/Designee to complete monthly observation of smoke barriers to verify they are maintained in accordance with NFPA 101. Findings to be reviewed at the monthly QAPI Committee Meeting. Modifications as indicated based on findings.	
K 921 SS=D	NFPA 99 Electrical Equipment - Testing and Maintenanc Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as	K 921		3/13/25

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K 921	Continued From page 5 required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 (NFPA 99) This Statute or Rule is not met as evidenced by: Based on observation and interview, it was found the facility failed to maintain patient care related electrical equipment (PCREE) in accordance with NFPA 101. Findings included: On 02/11/2025 between the hours of 1:00 p.m. and 4:00 p.m. during the facility tour with the maintenance director, it was observed an oxygen concentrator in Rehab had an out of date PCREE certification of 07/2021. (Photographic evidence obtained) The maintenance director was interviewed concurrent with the facility tour and he stated the concentrator had been provided by a rental company. These findings were reviewed with the maintenance director and the administrator during the exit conference on 02/11/2025 at 4:15 p.m.	K 921	1. Identified concentrator was removed from service, PCREE certification service completed. 2. Maintenance Director/Designee completed observation of other facility concentrators to verify PCREE certification is completed as required. 3. The administrator provided education for current facility Maintenance Department regarding PCREE maintenance requirements. 4. Maintenance Director/Designee to complete monthly observation of facility concentrators to ensure PCREE certification is completed as required. Findings to be reviewed at the monthly QAPI Committee Meeting. Modifications as indicated based on findings.	

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	65316	A. BUILDING: **01, 05** B. WING _____	**02/11/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING LAKE REHABILITATION CENTER	**1540 6TH ST NW** **WINTER HAVEN, FL 33881**

(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) COMPLETE DATE
K 921	Continued From page 6 Per NFPA 101 (2021 Edition) 19.7.6, 4.6.12 per NFPA 99 (2021 Edition) 10.5.2.1.1, 10.5.2.6 Class III	K 921		