





# Certified End Page

**MANATAWNY CENTER FOR REHABILITATION AND NURSING**

**STATE LICENSE NUMBER: 130802**

**SURVEY EXIT DATE: 01/15/2025**

**I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey**

  
Jeanne Parisi  
Deputy Secretary for Quality Assurance

  
Debra L. Bogen, MD, FAAP  
Secretary of Health



**Pennsylvania  
Department of Health**

THIS IS A CERTIFICATION PAGE

**PLEASE DO NOT DETACH**

THIS PAGE IS NOW PART OF THIS SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395319</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>01</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/15/2025</b>
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NAME OF PROVIDER OR SUPPLIER: <b>MANATAWNY CENTER FOR REHABILITATION AND NURSING</b>	STATE LICENSE NUMBER: <b>130802</b>	STREET ADDRESS, CITY, STATE, ZIP CODE: <b>30 OLD SCHUYLKILL ROAD POTTSTOWN, PA 19465</b>
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K 0000	<p>INITIAL COMMENT</p> <p>Facility ID #130802 Component 01 Main Building</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on January 15, 2025, it was determined that Manatawny Center for Rehabilitation and Nursing was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a).</p> <p>This is a two-story, Type III (200), unprotected ordinary structure, with a partial basement, which is fully sprinklered.</p>	K 0000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

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K 0161  SS=C	<p>NFPA 101 Building Construction Type and Height</p> <p>Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5</p> <p>Construction Type</p> <p>1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered</p> <p>2 II (111) One story non-sprinklered Maximum 3 stories sprinklered</p> <p>3 II (000) Not allowed non-sprinklered</p> <p>4 III (211) Maximum 2 stories sprinklered</p> <p>5 IV (2HH)</p> <p>6 V (111)</p> <p>7 III (200) Not allowed non-sprinklered</p> <p>8 V (000) Maximum 1 story sprinklered</p> <p>Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5)</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0161	1.The facility is requesting DSI to complete an FSES inspection	Completion Date: <b>02/11/2025</b> Status: <b>APPROVED</b> Date: <b>02/06/2025</b>

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K 0161  SS=C	Continued from page 2  Based on observation and interview, it was determined the facility failed to maintain building construction requirements, affecting two of two floors within the component.  Findings include:  1. Observation on January 15, 2025, at 10:00 AM, revealed the building was a two-story, Type III (200), unprotected ordinary structure, which is fully sprinklered. This type of construction is limited to one story in height.  Interview with the Facilities Director on January 15, 2025, at 10:00 AM, confirmed the construction type is not allowed in health care.	K 0161		
K 0225  SS=D		K 0225		

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K 0225  SS=D	Continued from page 3  NFPA 101 Stairways and Smokeproof Enclosures  Stairways and Smokeproof Enclosures Stairways and Smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4, 7.2  This REQUIREMENT is not met as evidenced by:	K 0225	<p>1. The Maintenance Director/designee will repair or replace the basement door to Stair Tower 1 to ensure it positively latches within the door frame, maintaining the fire resistance of the exit stair tower enclosure.</p> <p>2. The Maintenance Director and relevant staff members will receive training on NFPA 101 Standard - Stairways and Smokeproof Enclosures, focusing on the importance of maintaining the fire resistance of exit stair tower enclosures and ensuring proper door functionality.</p> <p>3. The Maintenance Director/designee will inspect all stair tower doors within the facility to verify they positively latch within the door frame and maintain the required fire resistance. Monthly audits of stair tower doors will be conducted to ensure continued compliance with positive latching requirements.</p>	Completion Date: <b>02/11/2025</b> Status: <b>APPROVED</b> Date: <b>02/06/2025</b>

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K 0225  SS=D	Continued from page 4  Based on observation and interview, it was determined the facility failed to maintain the fire resistance of exit stairtower enclosures, affecting one of eleven smoke compartments within the component.  Findings include:  1. Observation on January 15, 2025, at 1:27 PM, revealed the basement door to Stairtower 1 failed to positively latch within the door frame.  Interview with the Facilities Director on January 15, 2025, at 1:27 PM, confirmed the stairtower door did not positively latch within the door frame.	K 0225	4. Findings will be reviewed at the Quality Assurance Performance Improvement meeting.	
K 0293  SS=C		K 0293		

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K 0293  SS=C	Continued from page 5  NFPA 101 Exit Signage  Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)  This REQUIREMENT is not met as evidenced by:	K 0293	<p>1. The Maintenance Director will conduct a thorough inspection of all exit signs within the facility to ensure proper functionality and compliance with NFPA 101 Standard - Exit Signage.</p> <p>2. The Maintenance Director and relevant staff members will be trained on the NFPA 101 Standard - Exit Signage requirements, focusing on the importance of conducting and documenting monthly visual inspections.</p> <p>3. The Maintenance Director/designee will establish a log or binder specifically for exit signage inspections, where they will document the date and findings of each monthly inspection. The log will be stored in the Life Safety Book located in the NHA's office. The Maintenance Director/designee will perform monthly visual inspections of exit signs and update the log accordingly. The NHA/designee will review the log during monthly audits to verify documentation and</p>	Completion Date: <b>02/11/2025</b> Status: <b>APPROVED</b> Date: <b>02/05/2025</b>

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K 0293  SS=C	Continued from page 6  Based on document review and interview, it was determined the facility failed to provide documentation verifying monthly visual inspections of exit signage had occurred within the previous twelve months, affecting the entire component.  Findings include:  1. Review of documentation on January 15, 2025, at 11:13 AM, revealed the facility failed to provide documentation verifying exit signs within the facility had been visually inspected since 8/28/24.  Interview with the Facilities Director on January 15, 2025, at 11:13 AM, confirmed the lack of documentation verifying exit signage had been visually inspected on a monthly basis since 8/28/24.	K 0293	compliance with the inspection requirements.  4. Findings will be reviewed at the Quality Assurance Performance Improvement meeting	

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K 0363  SS=D	<p>NFPA 101 Corridor - Doors</p> <p>Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material.</p> <p>Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.</p> <p>19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc.</p>	K 0363	<p>1. The Maintenance Director/designee will repair or replace the door coordinator on the double doors to the Kitchen Dry Storage Room to ensure proper closing and latching within the door frame.</p> <p>2. The Maintenance Director and relevant staff members will receive training on NFPA 101 Standard - Corridor Doors, focusing on the importance of maintaining positive latching of corridor doors within smoke compartments.</p> <p>3. The Maintenance Director/designee will inspect all corridor doors in the facility to verify proper latching within door frames. Special attention will be given to doors with coordinating devices. Monthly audits of corridor doors will be conducted to ensure continued compliance with positive latching requirements. Findings will be documented and reported for further action, if necessary.</p> <p>4. Findings will be reviewed at the Quality Assurance Performance Improvement meeting.</p>	<p>Completion Date: <b>02/11/2025</b> Status: <b>APPROVED</b> Date: <b>02/05/2025</b></p>

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K 0363  SS=D	Continued from page 8  This REQUIREMENT is not met as evidenced by:  Based on observation and interview, it was determined the facility failed to maintain the positive latching of corridor doors, affecting one of eleven smoke compartments within the component.  Findings include:  1. Observation on January 15, 2025, at 12:15 PM, revealed the double doors to the Kitchen Dry Storage Room failed to automatically close in the required order, and therefore failed to latch within the frame, due to the associated door coordinator failing to function.  Interview with the Facilities Director on January 15, 2025, at 12:15 PM, confirmed the doors failed to latch within the door frame due to the failure of the associated door coordinator.	K 0363		

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K 0920  SS=E	<p>NFPA 101 Electrical Equipment - Power Cords and Extens</p> <p>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) assemblies 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</p> <p>This REQUIREMENT is not met as evidenced by:</p>	K 0920	<p>1. The Maintenance Director has eliminated the daisy-chained surge suppressor powering the D.O.N. office and disconnected the surge suppressor supplying electricity to the refrigerator and microwave in the Medical Records room.</p> <p>2. The Maintenance Director and relevant staff members will receive comprehensive training on NFPA 101 Standard Electrical Equipment - Power Cords and Extension Cords, with a focus on the appropriate use of power strips in patient care vicinities and non-patient care rooms.</p> <p>3. The Maintenance Director/designee will conduct routine inspections of patient care vicinities and non-patient care rooms to ensure compliance with electrical equipment standards for power cords, extension cords, and surge suppressors. Monthly audits will be performed to verify ongoing adherence to these standards.</p> <p>4. Findings will be reviewed at the Quality Assurance Performance Improvement meeting.</p>	<p>Completion Date: <b>02/11/2025</b> Status: <b>APPROVED</b> Date: <b>02/05/2025</b></p>

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K 0920  SS=E	Continued from page 10  Based on observation and interview, it was determined the facility failed to monitor the use of surge suppressors, affecting two of eleven smoke compartments within the component.  Findings include:  1. Observation on January 15, 2025, at 12:40 PM, revealed a surge suppressor supplying electrical power to another surge suppressor, located within the 1st floor D.O.N. Office.  Interview with the Facilities Director on January 15, 2025, at 12:40 PM, confirmed the daisy-chained surge suppressors.  2. Observation on January 15, 2025, at 1:16 PM, revealed a surge suppressor supplying electrical power to a refrigerator and a microwave, located within the basement Medical Records Room.  Interview with the Facilities Director on January 15,	K 0920		

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K 0920  SS=E	Continued from page 11  2025, at 1:16 PM, confirmed the high draw devices were plugged into a surge suppressor.	K 0920			



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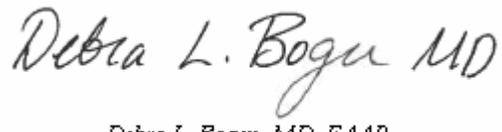
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>395319</b>	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>02</u> B. WING: _____	(X3) DATE SURVEY COMPLETED:  <b>01/15/2025</b>
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NAME OF PROVIDER OR SUPPLIER: <b>MANATAWNY CENTER FOR REHABILITATION AND NURSING</b>  STATE LICENSE NUMBER: <b>130802</b>	STREET ADDRESS, CITY, STATE, ZIP CODE: <b>30 OLD SCHUYLKILL ROAD POTTSTOWN, PA 19465</b>
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K 0293  SS=C		K 0293		

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K 0293  SS=C	Continued from page 2  NFPA 101 Exit Signage  Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)  This REQUIREMENT is not met as evidenced by:	K 0293	1. The Maintenance Director will conduct a thorough inspection of all exit signs within the facility to ensure proper functionality and compliance with NFPA 101 Standard - Exit Signage.  2. The Maintenance Director and relevant staff members will be trained on the NFPA 101 Standard - Exit Signage requirements, focusing on the importance of conducting and documenting monthly visual inspections.  3. The Maintenance Director/designee will establish a log or binder specifically for exit signage inspections, where they will document the date and findings of each monthly inspection. The log will be stored in the Life Safety Book located in the NHA's office. The Maintenance Director/designee will perform monthly visual inspections of exit signs and update the log accordingly. The NHA/designee will review the log during monthly audits to verify documentation and	Completion Date: <b>02/11/2025</b> Status: <b>APPROVED</b> Date: <b>02/05/2025</b>

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K 0293  SS=C	Continued from page 3  Based on document review and interview, it was determined the facility failed to provide documentation verifying monthly visual inspections of exit signage had occurred within the previous twelve months, affecting the entire component.  Findings include:  1. Review of documentation on January 15, 2025, at 11:13 AM, revealed the facility failed to provide documentation verifying exit signs within the facility had been visually inspected since 8/28/24.  Interview with the Facilities Director on January 15, 2025, at 11:13 AM, confirmed the lack of documentation verifying exit signage had been visually inspected on a monthly basis since 8/28/24.	K 0293	compliance with the inspection requirements.  4. Findings will be reviewed at the Quality Assurance Performance Improvement meeting.	



# Certified End Page

**MANATAWNY CENTER FOR REHABILITATION AND NURSING**

**STATE LICENSE NUMBER: 130802**

**SURVEY EXIT DATE: 01/15/2025**

**I Certify This Document to be a True and Correct Statement of Deficiencies and Approved Facility Plan of Correction for the Above-Identified Facility Survey**

  
Jeanne Parisi  
Deputy Secretary for Quality Assurance

  
Debra L. Bogen, MD, FAAP  
Secretary of Health



**Pennsylvania  
Department of Health**

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K 0000	<p>INITIAL COMMENT</p> <p>Facility ID #130802 Component 03 B-C Addition</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on January 15, 2025, it was determined that Manatawny Center for Rehabilitation and Nursing was not in compliance with the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a).</p> <p>This is a two-story, Type II (111), protected noncombustible structure, without a basement, which is fully sprinklered.</p>	K 0000		

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

TITLE:

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K 0293  SS=C	Continued from page 2  NFPA 101 Exit Signage  Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)  This REQUIREMENT is not met as evidenced by:	K 0293	1. The Maintenance Director will conduct a thorough inspection of all exit signs within the facility to ensure proper functionality and compliance with NFPA 101 Standard - Exit Signage.  2. The Maintenance Director and relevant staff members will be trained on the NFPA 101 Standard - Exit Signage requirements, focusing on the importance of conducting and documenting monthly visual inspections.  3. The Maintenance Director/designee will establish a log or binder specifically for exit signage inspections, where they will document the date and findings of each monthly inspection. The log will be stored in the Life Safety Book located in the NHA's office. The Maintenance Director/designee will perform monthly visual inspections of exit signs and update the log accordingly. The NHA/designee will review the log during monthly audits to verify documentation and	Completion Date: <b>02/11/2025</b> Status: <b>APPROVED</b> Date: <b>02/05/2025</b>

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K 0293  SS=C	Continued from page 3  Based on document review and interview, it was determined the facility failed to provide documentation verifying monthly visual inspections of exit signage had occurred within the previous twelve months, affecting the entire component.  Findings include:  1. Review of documentation on January 15, 2025, at 11:13 AM, revealed the facility failed to provide documentation verifying exit signs within the facility had been visually inspected since 8/28/24.  Interview with the Facilities Director on January 15, 2025, at 11:13 AM, confirmed the lack of documentation verifying exit signage had been visually inspected on a monthly basis since 8/28/24.	K 0293	compliance with the inspection requirements.  4.Findings will be reviewed at the Quality Assurance Performance Improvement meeting.	

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K 0511  SS=F	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 REQUIREMENT is not met as evidenced by:	K 0511	<p>1. The Maintenance Director installed a cover plate for the electrical junction box to ensure the wiring is properly protected and secure.</p> <p>2. The Maintenance Director and relevant staff members will receive training on NFPA 70, National Electric Code, with a focus on proper installation and maintenance of electrical wiring and equipment.</p> <p>3. The Maintenance Director/designee will conduct a thorough inspection of electrical junction boxes and wiring throughout the facility to verify compliance with NFPA 70 standards. Any additional areas of concern will be addressed immediately. Monthly audits of electrical junction boxes and wiring will be conducted by the Maintenance Director/designee to ensure continued compliance with NFPA 70. Findings will be documented and reported for further action, if necessary.</p> <p>4. Findings will be reviewed at the Quality Assurance Performance Improvement meeting.</p>	Completion Date: <b>02/11/2025</b> Status: <b>APPROVED</b> Date: <b>02/05/2025</b>

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K 0511  SS=F	Continued from page 5  Based on observation and interview, it was determined the facility failed to install hardware components of electrical wiring, affecting the entire component.  Findings include:  1. Observation on January 15, 2025, at 11:02 AM, revealed exposed electrical wiring within an electrical junction box lacked a cover plate, located above the suspended ceiling, by the cross corridor double doors to Component 01.  Interview with the Facilities Director on January 15, 2025, at 11:02 AM, confirmed the exposed electrical wiring.	K 0511		



# Certified End Page

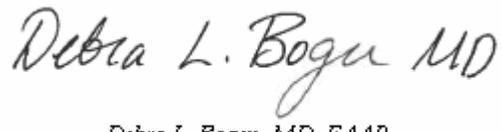
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**STATE LICENSE NUMBER: 130802**

**SURVEY EXIT DATE: 01/15/2025**

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Deputy Secretary for Quality Assurance

  
Debra L. Bogen, MD, FAAP  
Secretary of Health



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K 0000	<p>INITIAL COMMENT</p> <p>Facility ID #130802 Component 04 Adult Day Care Building</p> <p>Based on a Medicare/Medicaid Recertification Survey completed on January 25, 2025, it was determined that Manatawny Center for Rehabilitation and Nursing had deficiencies that have the potential for minimal harm as related to the following requirements of the Life Safety Code for an existing health care occupancy. Compliance with the National Fire Protection Association's Life Safety Code is required by 42 CFR 483.90(a).</p> <p>This is a one-story, Type III (211), protected ordinary structure, without a basement, which is fully sprinklered.</p>	K 0000		

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

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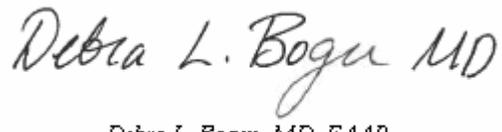
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