| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185087 | A. BUILDING _____ B. WING _____ | R 04/12/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN RIVERS NURSING AND REHAB CENTER | 2420 W. 3RD ST. OWENSBORO, KY 42301 |

| (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 |
|---|---|---|---|---|
| {F 000} | INITIAL COMMENTS<br><br>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, on 04/12/14 as alleged. | {F 000} | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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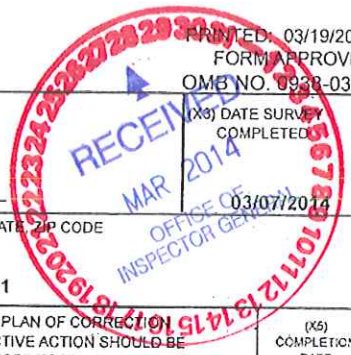


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| | 185087 | A. BUILDING _____ B. WING _____ | 03/07/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 000 | INITIAL COMMENTS<br><br>A Recertification Survey was conducted on 03/05/14 through 03/07/14 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest scope and severity of a "D". | F 000 | Submission of this plan of correction is not a legal admission that a deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator, or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of receipt of the statement of deficiencies as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements. | |
| F 164 SS=D | 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS<br><br>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.<br><br>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.<br><br>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.<br><br>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.<br><br>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. | F 164 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shelly Mollo LD, MSN MBA, NHA — TITLE — (X6) DATE: 3/28/14

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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| | 185087 | A. BUILDING _____ B. WING _____ | 03/07/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 164 | Continued From page 1<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and review of the facility's policies and procedures, it was determined the facility failed to ensure one (1) unsampled resident's (Resident A) medical record was kept confidential. Resident #A's Medication Administration Record (MAR) was observed unattended and exposed to public view on 03/07/14.<br><br>The findings include:<br><br>Review of the facility policy titled, "BILL OF RESIDENT RIGHTS", dated 07/01/09, revealed the resident has a right to personal privacy and confidentiality of their personal and clinical records.<br><br>Review of the facility policy and procedure titled, "Medication Administration", dated 2013, revealed staff should observe each resident's privacy and rights in accordance with applicable law.<br><br>Observation, on 03/07/14 at 8:40 AM, revealed an unattended medication cart on the hall by the nursing station. The MAR book was open and Resident #A's MAR was in plain view. Two Certified Nurse Aides (CNA), two residents and an unidentified person were observed to pass by the medication cart.<br><br>Interview with Licensed Practical Nurse (LPN) #1, on 03/07/14 at 8:45 AM, revealed she had been administering medications from the unattended cart prior to transferring to another medication cart to administer medications to residents on the other end of the hall. She stated she knew | F 164 | F164<br><br>1. On 03/07/14, the Administrator identified Resident #A's Medication Administration Record (MAR) was unattended and exposed to public view and immediately closed the MAR book to ensure privacy of the resident information.<br><br>2. On 03/07/14, after identifying the open Medication Administration Record (MAR), the Administrator completed a round of the entire facility to ensure no Medication Administration Records (MARs) were left unattended and exposed to public view. No other Medication Administration Records (MARs) were identified to be unattended and exposed to public view.<br>3. All licensed nurses and certified medication aides were re-educated by the Education and Training Director on or before 04/04/2014 regarding the requirement to keep Medication Administration Records (MARs) closed when unattended to maintain privacy of resident information. No licensed nurse or certified medication aide will work past 04/04/2014 without receiving the education.<br>4. The Director of Nursing, Assistant Director of Nursing, and/or Unit Managers will conduct daily audits on all three shifts for five (5) days, then daily audits Monday thru Friday | |

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| F 164 | Continued From page 2<br>residents' MARs were to be confidential and she usually kept the MAR book closed or the MAR itself covered. The LPN revealed she was responsible for ensuring privacy of the residents' MARs which were part of the clinical record.<br><br>Interviews with Unit Managers #1 and #2, conducted on 03/07/14 at 10:55 AM and 11:05 AM revealed they expected MARs to be kept closed to keep information private. The Unit Managers stated when staff walked away from the medication cart they should ensure the MAR book is closed or the MAR is covered with a cover sheet.<br><br>Interview with the Assistant Director of Nursing (ADON), on 03/07/14 at 10:40 AM, revealed MARs were supposed to be covered at all times so visitors and residents could not walk by and see the information on the MAR. The ADON stated the MARs left in plain view would be a Health Insurance Portability and Accountability Act (HIPAA) violation. | F 164 | for two (2) weeks, then weekly audits for eights (8) weeks. The results of the audits will be reviewed with the Quality Assurance Committee, at a minimum, monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a<br><br>minimum the Director of Nursing, the Administrator, the Assistant Director of Nursing and the Social Services Director, with the Medical Director attending at least quarterly. | 4/12/14 |

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| {K 000} | INITIAL COMMENTS<br><br>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, on 04/12/14 as alleged. | {K 000} | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | 185087 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 03/06/2014 |

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| K 000 | INITIAL COMMENTS<br><br>CFR: 42 CFR 483.70(a)<br><br>BUILDING: 01<br><br>PLAN APPROVAL: 1969, 1992<br><br>SURVEY UNDER: 2000 Existing<br><br>FACILITY TYPE: SNF/NF<br><br>TYPE OF STRUCTURE: One (1) story, Type III (211)<br><br>SMOKE COMPARTMENTS: Seven (7) smoke compartments<br><br>FIRE ALARM: Complete fire alarm system upgraded in 2008 with five (5) heat and (42) smoke detectors<br>.<br>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.<br><br>GENERATOR: Type II generator. Fuel source is propane.<br><br>A standard Life Safety Code survey was conducted on 03/05/14 to 03/06/14. Twin Rivers Nursing and Rehab Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for one-hundred thirty-two (132) beds with a census of one-hundred twenty-four (124) on the day of the survey.<br><br>The findings that follow demonstrate noncompliance with Title 42, Code of Federal | K 000 | Submission of this plan of correction is not a legal admission that a deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator, or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. IN addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within ten (10) days of receipt of the statement of deficiencies as a condition to participate in Title 18 and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Shelly Moffitt | RN, MSN, MBA, NHA | 03/28/14 |

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| K 000 | Continued From page 1<br>Regulations, 483.70(a) et seq. (Life Safety from Fire)<br><br>Deficiencies were cited with the highest deficiency identified at "F" level. | K 000 | | |
| K 025 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4<br><br>This STANDARD is not met as evidenced by:<br>Based on observations and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect seven (7) of seven (7) smoke compartments, all residents, staff and visitors. The facility is certified for one-hundred thirty-two (132) beds with a census of one-hundred twenty-four (124) on the day of the survey. The facility failed to ensure five (5) smoke barriers were properly sealed around pipes, wires and complete to the roof to resist the passage of smoke. | K 025 | K025<br><br>1. The identified five (5) smoke barriers will be properly sealed around pipes, wires and complete to the roof to resist the passage of smoke by 04/11/2014.<br><br>2. On 03/27/14, Maintenance Director completed audit of all seven (7) smoke compartments to ensure no other areas identified that were not properly sealed around pipes, wires, or incomplete to the roof to resist the passage of smoke. No other areas were identified.<br><br>3. The Maintenance Director was re-educated by the Administrator on 3/27/14 related to the requirement to ensure that smoke barriers are properly sealed around pipes, wires, and complete to the roof to resist the passage of smoke. | |

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| K 025 | Continued From page 2<br>The findings include:<br><br>Observations, on 03/05/14 between 02:30 PM and 03:30 PM with the Maintenance Supervisor, revealed the smoke partitions, extending above the ceiling located at room #217 and 115 were constructed of concrete block and drywall mud was used as a sealant on the barrier. Further observation revealed the smoke partitions at room #340 and the Administrator's office were not constructed from outside wall to outside wall to the roof decking. The final observation revealed the smoke partition at the rehab was penetrated by wiring with no sealant.<br><br>Interview, on 03/05/14 between 02:30 PM and 03:30 PM with the Maintenance Supervisor, revealed he was unaware the drywall mud could not be used as a sealant on a block wall. Further interview revealed he was unaware the walls were not properly constructed in the attic and trusted the contractors to do the job correctly last year.<br><br>Reference: NFPA 101 (2000 Edition).<br><br>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:<br>(a) The space between the penetrating item and the smoke barrier shall<br>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or<br>2. Be protected by an approved device designed for the specific purpose.<br>(b) Where the penetrating item uses a sleeve to | K 025 | 4. The Maintenance Director will audit all smoke barriers monthly to ensure they remain properly sealed and maintain resistant to the passage of smoke. The results of the audits will be reviewed with the Quality Assurance Committee, at a minimum, monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, the Administrator, the Assistant Director of Nursing and the Social Services Director, with the Medical Director attending at least quarterly.<br><br>04/12/14 | 4/12/14 |

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| K 025 | Continued From page 3<br>penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall<br>1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or<br>2. Be protected by an approved device designed for the specific purpose.<br>(c) Where designs take transmission of vibration into consideration, any vibration isolation shall<br>1. Be made on either side of the smoke barrier, or<br>2. Be made by an approved device designed for the specific purpose.<br><br>8.3.6.2 Openings occurring at points where floors or smoke<br>barriers meet the outside walls, other smoke barriers, or fire<br>barriers of a building shall meet one of the following conditions:<br>(1) It shall be filled with a material that is capable of maintaining<br>the smoke resistance of the floor or smoke barrier.<br>(2) It shall be protected by an approved device that is<br>designed for the specific purpose. | K 025 | | |
| K 056<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler | K 056 | K056<br><br>1. Sprinklers will be installed in the closets of room's # 342-467 and the business closet and the air handler room by 04/11/14.<br><br>2. On 03/27/14, the Administrator and Maintenance Director conducted an audit of closets to ensure they have proper sprinkler coverage. No other closets were identified. | |

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| K 056 | Continued From page 4<br>systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards. The deficiency had the potential to affect three (3) of seven (7) smoke compartments, fifty-two (52) residents, staff and visitors. The facility is certified for one-hundred thirty-two (132) beds with a census of one-hundred twenty-four (124) on the day of the survey. The facility failed to ensure all closets of the building had proper sprinkler coverage. According to CMS S&C 13-55-LSC the enforcement implication would be a fully sprinklered facility with minor problems<br><br>The findings include:<br><br>Observation, on 03/06/14 between 08:30 AM and 11:00 AM with the Maintenance Supervisor, revealed the closets in resident rooms #342-467 did not have sprinkler protection. Further observation revealed the closets were built in the facility with the top of the closet opened up 10 inches from the ceiling and the sprinkler in the room was over 5 feet from the closets. Further observation revealed the business closet and the air handler room were not properly protected by sprinklers.<br><br>Interview, on 03/06/14 between 08:30 AM and 11:00 AM with the Maintenance Supervisor, | K 056 | 3. The Maintenance Director was re-educated by the Administrator on 3/27/14 related to the requirement that all closets of the building must have sprinkler coverage.<br><br>4. The Maintenance Director will conduct monthly observations of all closets in the facility to ensure they have proper sprinkler coverage. The results of the audits will be reviewed with the Quality Assurance Committee, at a minimum, monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, The Administrator, The Assistant Director of Nursing and the Social Services Director, with the Medical Director attending at least quarterly<br><br>04/12/14 | 4/12/14 |

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| K 056 | Continued From page 5<br>revealed he was aware of the closets not having sprinklers placed inside of them. He also stated he believed the closets weren't protected because the cut out was not down 18 " from the ceiling.<br><br>Reference: NFPA 13 (1999 Edition)<br><br>5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.<br>Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.<br>Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.<br>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:<br>(1) Sprinklers installed throughout the premises<br>(2) Sprinklers located so as not to exceed maximum protection area per sprinkler<br>(3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution. | K 056 | | |
| K 143 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Transferring of oxygen is: | K 143 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185087 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 03/06/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TWIN RIVERS NURSING AND REHAB CENTER | 2420 W. 3RD ST.<br>OWENSBORO, KY 42301 |

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| K 143 | Continued From page 6<br><br>(a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction;<br><br>(b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and<br><br>(c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, Interview and plan of correction review, it was determined the facility failed to ensure the room being used to transfer liquid oxygen was rated per NFPA requirements. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, thirty-two (32) residents, staff and visitors. The facility is certified for one-hundred thirty-two (132) beds with a census of one-hundred twenty-four (124) on the day of the survey. The facility failed to ensure the oxygen transferring room had an operational mechanical fan and separation from the rest of the facility.<br><br>The findings include: | K 143 | K143<br><br>1. On 03/18/14, a new circulating vent was installed in the oxygen transfilling room on skilled b that provides separate ventilation for the room.<br><br>2. On 03/18/14, the Maintenance Director completed audit to ensure all oxygen transfilling rooms have operational mechanical fan and separation from rest of the facility. No other oxygen transfilling rooms were identified without proper ventilation.<br><br>3. On 03/27/14, the Maintenance Director was re-educated by the Nursing Home Administrator on the requirement that oxygen transfilling rooms have operational mechanical fans and separation from the rest of the facility. | |

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| K 143 | Continued From page 7<br>Observation, on 03/06/14 at 9:23 AM with the Maintenance Supervisor, revealed the oxygen transfilling room on skilled b in which oxygen was being transferred did not have proper ventilation. The rooms were mechanically ventilated to the attic but the mechanical fan was not functioning. Further observation revealed the vent for the oxygen room was connected the vents in the corridor and did not provide separation for the room.<br><br>Interview, on 03/06/14 at 9:23 AM with the Maintenance Supervisor, revealed he was aware the fan was not working properly as he checked it weekly. He was unaware the room could not be connected to other vents in the facility.<br><br>Reference: NFPA 99 (1999 Edition).<br><br>8-6.2.5.2 Transferring Liquid Oxygen.<br>Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:<br>a. Separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and<br>b. The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring; and<br>c. The area is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted.<br>Transferring shall be accomplished utilizing equipment designed to comply with the performance requirements and producers of CGA | K 143 | 4. The Maintenance Director will conduct weekly inspections of oxygen transfilling rooms to ensure they maintain operational mechanical fans and separation from the rest of the facility. The results of the audits will be reviewed with the monthly Quality Assurance Committee for a minimum of three (3) months. If at any time concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum the Director of Nursing, The Administrator, The Assistant Director of Nursing and the Social Services Director, with the Medical Director attending at least quarterly.<br><br>04/12/2014 | 4/12/14 |

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| K 143 | Continued From page 8<br>Pamphlet P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, and adhering to those procedures.<br>The use and operation of small portable liquid oxygen systems shall comply with the requirements of CGA Pamphlet P-2.7, Guide for the Safe Storage, Handling and Use of Portable Liquid Oxygen Systems in Health Care Facilities. | K 143 | | |