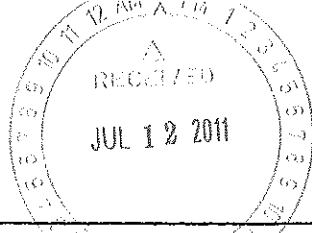


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 06/27/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345101	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/23/2011
NAME OF PROVIDER OR SUPPLIER  ENFIELD OAKS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 208 GARY ST ENFIELD, NC 27823	
(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 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to provide medications as ordered for 3 of 10 (residents #57, #67 and #35) sampled residents. Resident #57 did not receive a daily dose of Coumadin as ordered, resident #67 did not receive Lisinopril as ordered, and resident #35 did not receive the amounts of Ambien and Zoloft recommended during a psychiatric consult. Findings include:</p> <p>1. Resident #57 was re-admitted to the facility on 10/4/10 with diagnoses of cerebral vascular accident (CVA), diabetes mellitus (DM), bilateral below the knee amputations, coronary artery disease (CAD), and atrial fibrillation.</p> <p>Resident #57's quarterly Minimum Data Set (MDS) dated 4/7/11 indicated that the resident was cognitively aware and did not reject care.</p> <p>Review of Resident #57's medical record showed a Physician's Telephone Order dated 5/31/11 to repeat the International Normalized Ratio (INR) on 6/2/11 and call the physician with the results.</p>	F 309	<p><b>RESPONSE PREFACE</b></p> <p>Enfield Oaks Nursing and Rehabilitation Center acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality care of our residents. The plan of corrections is submitted as written allegation of compliance. Enfield Oaks Nursing and Rehabilitation Center's response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Enfield Oaks Nursing and Rehabilitation Center reserves the right to submit documentation to statement of deficiencies through informal dispute resolution, formal appeal procedures and/or any other legal proceedings.</p>	

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

TITLE

(X6) DATE

*Thomas W. ...*

*Administrator*

7-8-2011

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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F 309	<p>Continued From page 1</p> <p>Review of Resident #57's medical record showed that the INR (a laboratory test measure of blood coagulation) was drawn on 6/2/11. The results were 2.0 with a normal range being 0.8-1.2. The results were faxed to the facility on 6/4/11. There was an unsigned handwritten note on the lab result dated 6/7/11 at 1:25 PM which read, "called in to [name of physician] nurse [name of nurse]." A large hash mark separated the next statement which was, "Coumadin 5mg at night once a day."</p> <p>Review of Resident #57's Medication Administration Record (MAR) for June did not show any entry for the Coumadin order from 6/7/11.</p> <p>Review of the Nurse's Notes dated 6/7/11 at 2:02 PM read, Lab results for (PT) called in to physician's nurse. Also faxed results (2). The note was signed by Nurse #4.</p> <p>In an interview on 6/21/11 at 2:20 PM, nurse #1 indicated that when a laboratory result came into the facility the physician should be called with the result. If any changes to medications were needed a physician's telephone order should be written and then transcribed onto the MAR. The order should then be faxed to the pharmacy so the medication could be delivered and administered. A secondary check would be done by the nurse responsible for reviewing the labs to make sure nothing was missed.</p> <p>In an interview on 6/21/11 at 2:30 PM, the Director of Nursing (DON) indicated that it was her expectation that a nurse receiving a telephone order would write the order on a telephone order sheet and transcribe the order</p>	F 309	<p><b>F 309 493.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b></p> <p>Resident #57 was assessed by the DON. The physician was notified of Coumadin held and failure to transcribe an order to restart Coumadin. An order was obtained to "obtain a PT/INR and call physician with results".</p> <p>100% chart audit has been completed (to include resident # 57) by the DON/assigned RN on all active residents to ensure all orders have been transcribed on the telephone order form, faxed to the pharmacy, and transcribed onto the MAR.</p> <p>100% chart audit will be conducted by the DON/charge nurse utilizing a QI tool twice a week for 4 weeks and then once weekly for 4 weeks to ensure all orders have been transcribed and faxed to the pharmacy. Any areas of concern will be followed with physician notification and interventions as indicated by the physician.</p> <p>Nursing staff have been in-serviced on the procedure of transcribing and following physician orders.</p>	07/21/2011	

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F 309	<p>Continued From page 2</p> <p>onto the MAR. She would expect the nurse to fax the order to the pharmacy so the medication could be delivered and administered as ordered.</p> <p>In an interview on 6/23/11 at 2:50 PM, the DON indicated that Nurse #4 who took the order for the Coumadin was no longer employed by the facility. Nurse #5 who would have done the secondary check on the laboratory results was also no longer employed at the facility.</p> <p>2. Resident #67 was admitted to the facility on 02/28/11. The resident's documented diagnoses included hypertension, end stage renal disease with hemodialysis, and diabetes.</p> <p>The resident was admitted to the facility on 10 milligrams (mg) of Lisinopril every morning and 20 mg every evening.</p> <p>A 03/24/11 physician's order increased the resident's Lisinopril to 40 mg daily.</p> <p>Review of Resident #67's April 2011 Medication Administration Record (MAR) revealed the nursing staff documented the 10 mg AM and 20 mg PM doses of Lisinopril were "DC'd" (discontinued). Nursing staff hand wrote the order to administer 40 mg of Lisinopril daily at 9:00 AM on the last page of the MAR.</p>	F 309	<p><b>F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b></p> <p>Resident #67 was reviewed by the DON on 06/22/2011. The physician was notified of discontinuation of the Lisinopril. An order was obtained to start Lisinopril 20 mg po qd.</p> <p>Nursing staff have been in-serviced on the end of month MAR checks.</p> <p>100% of active MARs were audited by the DON/assigned nurse on all active residents (to include resident # 67) to ensure all orders are correct on the MAR.</p> <p>100% MAR audit will be conducted by the DON/assigned nurse utilizing a QI tool weekly X4 weeks, then biweekly X one month and then monthly X 2 to ensure all orders have been transcribed correctly with identified areas of concern corrected.</p> <p>Resident # 35 was reviewed by the DON. The orders for Zolof and Ambien were transcribed unto a telephone order form faxed to the pharmacy and placed on the MAR.</p> <p>100% chart audit has been completed (to include resident # 35) by the DON/assigned RN on all active residents to ensure all orders have been transcribed on the telephone order form, faxed to the pharmacy, and transcribed onto the MAR.</p> <p>100% chart audit will be conducted by the DON/charge nurse utilizing a QI tool twice a week for 4 weeks and then once weekly for 4 weeks to ensure all orders have been transcribed and faxed to the pharmacy. Any areas of concern will be followed with physician notification and interventions as indicated by the physician.</p>	07/21/2011

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F 309	Continued From page 3  Weekly blood pressures documented on Resident #67's April 2011 MAR included 128/68 on 04/06/11, 110/62 on 04/13/11, 112/60 on 04/20/2011, and 112/62 on 04/27/2011.  On the resident's May 2011 MAR the nursing staff documented the 40 mg dose of Lisinopril was "DC'd".  Review of Resident #67's May 2011 and June 2011 MARs revealed the resident did not receive any Lisinopril during these months.  Review of physician orders, physician progress notes, and dialysis documents revealed no order or recommendation to discontinue Resident #67's Lisinopril.  Weekly blood pressures documented on Resident #67's May 2011 MAR included 176/94 on 05/04/11, 134/76 on 05/11/11, 128/76 on 05/18/11, and 128/82 on 05/25/11.  Weekly blood pressures documented on Resident #67's June 2011 MAR included 122/70 on 06/08/2011 and 102/68 on 06/15/2011.  In an interview with the Director of Nursing (DON) on 06/22/11 at 3:49 PM, she stated she learned from a phone call to the facility's pharmacy that Resident #67's Lisinopril was not discontinued due to a physician order but due to the staff documenting the medication was discontinued on a previous month's MAR. The DON also reported she was unaware of any decision by Resident #67's primary physician to discontinue the use of the resident's Lisinopril, especially since the	F 309	Audits will be reviewed during monthly QI meetings to ensure continued compliance. Any identified areas of concern will be corrected. Areas of concern will be reviewed during the Quarterly Executive QI meeting to ensure systems continue to be compliant.	07/21/2011	

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F 309	<p>Continued From page 4</p> <p>resident had a documented diagnosis of hypertension.</p> <p>During a follow-up interview with the facility's DON on 06/23/11 at 9:33 AM she stated Lisinopril was important in keeping Resident #67's blood pressure stable as the resident was hemodialyzed due to end stage renal disease. According to the DON, each month two nurses, one who checked behind the other, compared physician orders and the previous MAR against the medications which appeared on the new MAR. She explained the way in which the nurses updated Resident #67's April 2011 MAR was acceptable, but a better method may have been to have crossed out the old orders for Lisinopril and noted "changed" or "rewritten", rather than documenting "DC'd.</p> <p>3. Resident #35 was admitted to the facility on 02/16/07 and readmitted on 03/28/11. The resident's documented diagnoses included depression, insomnia, anxiety, hypertension, and chronic obstructive pulmonary disease.</p> <p>The resident's care plan identified "Use of drugs r/t (in regard to) depression and anxiety" as a problem on 01/07/09. Approaches to this problem included "Administer meds (medications) as ordered".</p> <p>A 04/01/11 psychiatric consult documented Resident #35 "...with depression, moderate, continues to report depressed mood, hopelessness, and decreased (symbol used) motivation and energy... Sleep-difficulty..." Recommendations included increasing the resident's Zoloft from 100 milligrams (mg) daily to</p>	F 309			

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F 309	<p>Continued from page 5</p> <p>150 mg daily and increasing the resident's Ambien from 10 mg nightly to 12.5 mg nightly.</p> <p>A 04/04/11 notation from Resident #35's primary physician made on a faxed copy of the 04/01/11 consult documented, "Agree with Plan."</p> <p>In a 04/25/11 progress note Resident #35's primary physician documented the resident had "trouble sleeping."</p> <p>Review of Resident #35's April, May, and June 2011 Medication Administration Records revealed the increases to the resident's dosages of Zoloft and Ambien were never made.</p> <p>At 4:52 PM on 06/22/11 a nursing assistant (NA #1) who cared for Resident #35 on second shift stated the resident frequently appeared sad, was lethargic during the day at times, experienced occasional anxiety, and did not always sleep well at night.</p> <p>At 5:12 PM on 06/22/11 Nurse #2, who cared for Resident #35 on second shift, stated the resident suffered from some depression, anxiety, and insomnia.</p> <p>At 8:27 AM on 06/23/11 Nurse #3, who cared for Resident #35 on first shift, stated the resident experienced some sadness, but did not cry. She also reported the resident became anxious before dialysis treatments and anxious when he did not get regular smoke breaks. The nurse commented the resident yelled out at staff sometimes when he became anxious.</p> <p>At 8:47 AM on 06/23/11 NA #2, who cared for</p>	F 309		

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F 309	Continued From page 6 Resident #35 on first shift, stated the resident seemed sad, but she had never seen him cry. She also reported the resident became anxious before going to dialysis and when waiting to go smoke. According to the NA, she heard other staff members mention that Resident #35 did not always sleep well at night.  At 9:33 AM on 06/23/11 the Director of Nursing (DON) stated Resident #35 was diagnosed with depression, and experienced some anxiety related to dialysis and smoking. She commented, in addition, the resident frequently became anxious at night, yelling out and suffering from insomnia. The DON explained whenever she or the hall nurses received consult notes, these notes were reviewed for recommendations. She reported if recommendations were made, copies of the notes and recommendations were faxed to the primary physicians. If the primary physicians agreed with the consult recommendations, an order was written, the pharmacy was notified if any changes were made to medications, and the MAR was updated if necessary. The DON stated, unfortunately, these steps were not followed in regard to the medication changes recommended during Resident #35's psychiatric consult.	F 309		
F 332 SS=D	483.26(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by:	F 332	483.26(m)(1) FREE OF MEDICATION ERROR REATES OF 5% OR MORE  Medication Aide #1 has been assigned to duties within her scope of practice other than medication administration. Medication Aide #1 will be retrained by the Medication Aide Instructor by 07/21/2011.	07/21/2011

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F 332	<p>Continued From page 7</p> <p>Based on observations, record review and staff interview, the facility failed to obtain an medication error rate of less than 5% during medication pass observations as evidenced by 3 errors from 57 opportunities resulting in a 5.2% medication error rate. Findings include:</p> <p>1. During medication pass, on 06/22/11 at 8:20 AM, Medication Aide #1 (MA#1) was observed preparing medications for Resident #18. She poured Allopurinol 100 milligrams (mg), Aspirin 81 mg, Diovan 160 mg, Flomax 0.4 mg, KCl (potassium chloride) 10 milliequivalents (meq), Mapap (generic Tylenol) 325 mg 2 tablets, Toprol XL 50 mg, and Pataday 0.2% eye drops. She went into the room to administer the medications.</p> <p>Resident #18's physician's orders for June 2011 were verified and it was noted that there was an order for Colace 100 mg daily. This medication was not administered during the medication pass observation.</p> <p>During an interview with MA#1, on 06/22/11 at 9:20 AM, she stated she did not realize she did not administer the Colace medication. She poured the medication and went into Resident #18's room and administered the medication.</p> <p>The Director of Nurses (DON) stated during an interview on 06/22/11 at 2:45 PM that she expected the medication aide as well as the nurses to double check the medication administration record (MAR) before administering medications to residents to ensure accuracy. The DON stated that if this was done, there would be no medications overlooked or missed. She commented that she was in the process of</p>	F 332	<p>F 332 483.26(m)(1) FREE OF MEDICATION ERROR REATES OF 5% OR MORE</p> <p>Random medication pass audit will be performed by Consultant Pharmacist monthly indefinitely with areas of concern reported to the DON. The DON will assure retraining and/or in-services are completed as appropriate. Areas of concern (medication errors) will be followed with physician notification.</p> <p>Audits will be reviewed during monthly QI meetings to ensure continued compliance. Any identified areas of concern will be corrected. Areas of concern will be reviewed during the Quarterly Executive QI meeting to ensure systems continue to be compliant.</p>	07/21/2011	



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F 332	<p>Continued From page 8 providing an inservice for staff on medication administration.</p> <p>2. a. During medication pass, on 06/22/11 at 8:50 AM, Medication Aide #1 was observed preparing medication for administration to Resident #40. She poured Aspirin 81 milligrams (mg), Aggrenox 25/200 mg, stool softener (generic for Colace) 100 mg, Coreg 12.5 mg, Isosorb 10 mg, Norvasc 5 mg, Lovaza 1 gram (gm), Guaifenesin ER (generic for Mucinex extended release) and Zantac 150 mg. She removed the Lovaza, the stool softener and the Aggrenox from the medication cup. She crushed the remaining medications including the Guaifenesin. She mixed the medications in pudding, went into Resident #40's room and administered the medications.</p> <p>Upon verification of Resident #40's physician's orders for June 2011, it was noted that the order for Guaifenesin included instructions of "Swallow whole, do not crush, break or chew".</p> <p>During an interview with MA#1, on 06/22/11 at 9:20 AM, she stated she did not notice that the instructions were not to crush.</p> <p>The Director of Nurses (DON) stated during an interview on 06/22/11 at 2:45 PM that she expected the medication aide as well as the nurses to double check the medication administration record (MAR) before administering medications to residents to ensure accuracy. The DON stated that if this was done, there would be no medications overlooked or missed. The DON added that there was a "Do Not Crush" list for medications available for the nurses. She</p>	F 332			

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F 332	<p>Continued From page 9</p> <p>commented that she was in the process of providing an inservice for staff on medication administration.</p> <p>b. During medication pass, on 06/22/11 at 8:50 AM, Medication Aide #1 was observed preparing medication for administration to Resident #40. She poured Aspirin 81 milligrams (mg), Aggrenox 25/200 mg, stool softener (generic for Colace) 100 mg, Coreg 12.5 mg, Isosorb 10 mg, Norvasc 5 mg, Lovaza 1 gram (gm), Gualfenasin ER (generic for Mucinex extended release) and Zantac 150 mg. She removed the Lovaza, the stool softener and the Aggrenox from the medication cup. She crushed the remaining medications. She mixed the medications in pudding, went into Resident #40's room and administered the medications.</p> <p>Upon verification of Resident #40's physician's orders for June 2011, it was noted that there was an order for Kombiglyze XR 2.5/1000mg twice daily. This medication was not administered during the medication pass observation.</p> <p>During an interview with MA#1, on 06/22/11 at 9:20 AM, she stated she did not realize she did not administer the Kombiglyze XR medication. She commented that she had several big bottles of medications in her drawer as she picked up the Kombiglyze SR. She poured the medication and went into Resident #18's room and administered the medication.</p> <p>The Director of Nurses (DON) stated during an interview on 06/22/11 at 2:45 PM that she expected the medication aide as well as the nurses to double check the medication</p>	F 332			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345101	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  06/23/2011
NAME OF PROVIDER OR SUPPLIER  ENFIELD OAKS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 208 CARY ST ENFIELD, NC 27823		
(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 332	Continued From page 10 administration record (MAR) before administering medications to residents to ensure accuracy. The DON stated that if this was done, there would be no medications overlooked or missed. She commented that she was in the process of providing an inservice for staff on medication administration.	F 332			

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

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NAME OF PROVIDER OR SUPPLIER  ENFIELD OAKS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 208 CARY ST ENFIELD, NC 27823		
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K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 7/14/2011 there was a build up of lint and dust found in the combustion chamber of dryers in the laundry.	K 029	<b>RESPONSE PREFACE</b> Enfield Oaks Nursing and Rehabilitation Center acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality care of our residents. The plan of correction is submitted as written allegation of compliance. Enfield Oaks Nursing and Rehabilitation Center's response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Enfield Oaks Nursing and Rehabilitation Center reserves the right to submit documentation to the statement of deficiencies through informal dispute resolution, formal appeal procedures and/or any other administration of legal proceeding.		
K 076 SS=E	CFR# 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD  Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076	K 029 Combustion Chambers of dryers in the laundry were cleaned on 7/18/2011. Combustion chambers of dryers in the laundry were inspected daily X 1 week. The combustion chambers of dryers in the laundry will be checked and cleaned weekly indefinitely.  K076 All gas cylinders were individually chained or supported on 07/15/2011 in the outside oxygen storage area. Placement of gas cylinders will be monitored once a week for the next eight weeks with areas of concern corrected. Finding will be reviewed monthly by the environmental QI committee.	07/30/2011        07/30/2011	

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

TITLE

(X6) DATE

*Johnny Kerner*

*Administrator*

7-29-2011

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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NAME OF PROVIDER OR SUPPLIER  ENFIELD OAKS NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 208 GARY ST ENFIELD, NC 27823		
(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 076	Continued From page 1	K 076			
K 144 SS=E	<p>This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 7/14/2011 the facility had oxygen cylinders that were not properly individually chained or supported in the outside oxygen storage area.</p> <p>CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99, 3.4.4.1.</p>	K 144	<p>K144 Maintenance manager has initiated the use of a weekly generator testing log. Weekly inspections of the emergency generator will be conducted indefinitely (with documentation in generator testing log) to maintain compliance. Log of weekly inspection of the emergency generator will be reviewed monthly by the environmental QI committee to ensure log is maintained and to ensure facility is in compliance.</p>	07/30/2011	
K 211 SS=D	<p>This STANDARD is not met as evidenced by: Based on the observations and staff interview during the documentation review on 7/14/2011 it was noted that the the facility was not documenting the weekly inspection of the emergency generator.</p> <p>CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor; o The corridor is at least 6 feet wide</p>	K 211	<p>K211 100% audit to all hand sanitizer dispensers (to include hand sanitizers in the therapy room, room 26, and room 19) was completed on 7/19/2011. All areas of concern were corrected as evidenced by relocating all hand sanitizer dispensers found to be within 6 inches of any light switch. All hand sanitizer dispensers were placed more than 6 inches below the light switch to be in compliance.</p>	07/30/2011	

*MEST*

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K 211	<p>Continued From page 2</p> <ul style="list-style-type: none"> <li>o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)</li> <li>o The dispensers have a minimum spacing of 4 ft from each other</li> <li>o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.</li> <li>o Dispensers are not installed over or adjacent to an ignition source.</li> <li>o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623</li> </ul> <p>This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 7/14/2011 the Alcohol Based Hand Rub (ABHR) dispenser was found to be adjacent to an ignition source. The ABHR was found within six inches of a light switch at the following locations:</p> <ol style="list-style-type: none"> <li>1. Therapy</li> <li>2. Room 26</li> <li>3. Room 19</li> </ol> <p>CFR#: 42 CFR 483.70 (a)</p>	K 211			