OCT 09 2012

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345354	A. BUILDING _____ B. WING _____	09/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY GROVE NURSING AND REHABILITATION CENTER	728 PINEY GROVE RD KERNERSVILLE, NC 27284

(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 172 SS=D	483.10(j)(1)&(2) RIGHT TO/FACILITY PROVISION OF VISITOR ACCESS The resident has the right and the facility must provide immediate access to any resident by the following: Any representative of the Secretary; Any representative of the State; The resident's individual physician; The State long term care ombudsman (established under section 307 (a)(12) of the Older Americans Act of 1965); The agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act); The agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act); Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident. The facility must provide reasonable access to any resident by any entity or individual that	F 172	Piney Grove Nursing and Rehab Ctr. 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 the applicable rules and provisions of quality care of the residents. The Plan of Correction is submitted as a written allegation of compliance. Piney Grove's response to the 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, Piney Grove reserves the right to submit documentation to refute any of the stated deficiencies on the Statement of Deficiencies through informal dispute resolution, formal appeal process and or any other administrative or legal proceeding.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kim V. Smith — TITLE: Administrator — (X6) DATE: 10/4/12

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 172	Continued From page 1 provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews the facility failed to ensure that 2 of 2 sampled residents (Resident #38 and Resident #39) knew who the Ombudsman was and how to contact the Ombudsman. The findings include: Resident #38 was admitted to the facility on 11/30/09 with diagnoses that included Coronary Artery Disease, Congestive Heart Failure, Hypertension, Diabetes Mellitus, Arthritis, Dementia, and Depression. The most recent Annual Minimum Data Set dated 7/9/12 indicated that Resident #38 was cognitively intact. A review of the Resident Council Minutes for June, July, and September 2012 found that at each meeting residents were asked if they wanted to go over resident rights and the residents said they did not. The August minutes indicated that the Social Worker went over resident rights. None of the minutes included a discussion of the Ombudsman. On 9/14/2012 at 11:28 am Resident #38, the Resident Council President, was asked during an interview if she knew who the Ombudsman was and how to contact the Ombudsman. She responded "what's an Ombudsman." When the role of the Ombudsman was explained to	F 172	On 10/1/12, Resident # 38, Resident #39, and all other alert and oriented residents were informed of the current Ombudsman, his contact information and his role as an advocate for LTC residents. -The admissions packet and information board will be updated to reflect the current Ombudsman and current contact information. -Each Resident's Council meeting will include Resident's Rights and Ombudsman reviews. -On 9/28/12, The current Ombudsman was invited to the next Resident's Council meeting. -Social Worker, Activities Director and Activities Assistant were re-trained on Resident's Rights, the role of the Ombudsman, and his contact information. Social Worker will conduct random audits and a monthly QI to assure residents are informed about the Ombudsman's role and contact information. The QI Committee will review results of audits monthly.	10/12/12

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F 172	Continued From page 2 Resident #38, she said she didn't know who it was or how to get in touch with them. She stated "If I had a problem, I guess I would just go to Patricia (Director of Nurses)." During an interview on 9/14/12 at 11:34 am the Activity Director stated that she attended the Resident Council meetings when she was there and wrote the minutes for the meetings. If she was not in the facility her assistant attended and wrote the minutes. The Activity Director stated that they told residents where the resident rights were posted. In addition she indicated that each room had a printed list of the rights with the Ombudsman listed at the bottom. At that time she showed me a copy of the 8 ½ x 11 typed rights with a name and number at the bottom of the page for the Ombudsman. The name was incorrect. The number was one of two numbers where the current Ombudsman could be contacted. The Activity Director also stated that in the past they had asked the residents what and who the Ombudsman was. She indicated that a month or two ago the Ombudsman came to the facility to get to know the residents better. At 11:40 am on 9/14/12 Resident #38 was asked if she was aware of a list of resident rights posted in her room. She said she was not and asked where they were. The sheet with resident rights and Ombudsman's number was attached to the top of her bulletin board approximately 1 ½ feet above her eye level while sitting in her wheel chair. In an interview at 11:55 am on 9/14/2012 the Social Worker stated that when she started working at the facility, she read the resident rights	F 172		

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F 172	Continued From page 3 to the residents at the August Resident Council meeting. She told the residents that if they needed to contact the Ombudsman to come to her and she would help them. The Social Worker said she knew the phone number for the Ombudsman was correct, but wasn't sure about the name. At 12:30 pm on 9/14/2012 the Activity Director and I observed the posted resident rights on a bulletin board at the front of the facility. It had taped in place the current Ombudsman's name and the same number listed on the Activity Director's sheet. There was a business card stapled to the board with the Ombudsman's name and a different number to call. Asked why there were two different numbers she did not know. The number on the bulletin board was called and the person answering relayed that two offices had combined and the current Ombudsman worked out of both offices and could be reached each of the numbers depending on where he was that day. The Administrator stated in an interview at 1:05 pm on 9/14/12 that the Ombudsman's number was posted on the bulletin board near the front of the facility. He also indicated that about a month ago the Ombudsman came to the facility to introduce himself to the residents. The Administrator said that it was his expectation that the residents be informed who the Ombudsman was and how to contact him. Resident #39 was admitted to the facility on 1/30/2012 with diagnoses that included Hypertension, Diabetes Mellitus, Alzheimers	F 172		

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F 172	Continued From page 4	F 172		

disease, Anxiety and Depression. The most recent Minimum Data Set (MDS) dated 7/2/2012 was for Significant Change. The MDS indicated that Resident #39 was cognitively intact.

A review of the Resident Council Minutes for June, July, and September 2012 found that at each meeting residents were asked if they wanted to go over resident rights and the residents said they did not. The August minutes indicated that the Social Worker went over resident rights. None of the minutes included a discussion of the Ombudsman.

During an interview on 9/14/12 at 11:34 am the Activity Director stated that she attended the Resident Council meetings when she was there and wrote the minutes for the meetings. If she was not in the facility her assistant attended and wrote the minutes. The Activity Director stated that they told residents where the resident rights were posted. In addition she indicated that each room had a printed list of the rights with the Ombudsman listed at the bottom. At that time she showed me a copy of the 8 ½ x 11 typed rights with a name and number at the bottom of the page for the Ombudsman. The name was incorrect. The number was one of two numbers where the current Ombudsman could be contacted. The Activity Director also stated that in the past they had asked the residents what and who the Ombudsman was. She indicated that a month or two ago the Ombudsman came to the facility to get to know the residents better.

In an interview at 11:55 am on 9/14/2012 the Social Worker stated that when she started working at the facility, she read the resident rights

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F 172	Continued From page 5 to the residents at the August Resident Council meeting. She told the residents that if they needed to contact the Ombudsman to come to her and she would help them. The Social Worker said she knew the phone number for the Ombudsman was correct, but wasn't sure about the name. At 12:30 pm the Activity Director and I observed the posted resident rights on a bulletin board at the front of the facility. It had taped in place the current Ombudsman's name and the same number listed on the Activity Director's sheet. There was a business card stapled to the board with the Ombudsman's name and a different number to call. Asked why there were two different numbers, she did not know. The number on the bulletin board was called and the person answering relayed that two offices had combined and the current Ombudsman worked out of both offices and could be reached at each number depending on where he was that day. The Administrator stated in an interview at 1:05 pm on 9/14/12 that the Ombudsman's number was posted on the bulletin board near the front of the facility. He also indicated that about a month ago the Ombudsman came to the facility to introduce himself to the residents. The Administrator said that it was his expectation that the residents be informed who the Ombudsman was and how to contact him. At 1:25 pm on 9/14/12 Resident #39 stated in an interview that she regularly attended the Resident Council meetings. Asked if she knew who the Ombudsman was or how to contact him, she replied she knew there was one, but not who it	F 172		

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F 172	Continued From page 6 was or how to contact him. There was not a list of resident ' s rights or Ombudsman's name and number posted in Resident #39's room.	F 172		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and interviews with the Pharmacy Representatives, the facility pharmacy failed to correctly label the expiration date on a stored medication in 1 of 3 medication carts. Findings included: Observations of the medications in the drawers of Cart # 2 on the middle hall with Nurse #1 were	F 425	The Lexapro was removed from the medication cart by Patricia Nifong,DON, and returned to the pharmacy on 9/14/12. Administrative Nurses audited all medication rooms and carts for expired medications with no further issues identified on 9/14/12. Pharmacy Nurse ,Ellen Walsh, performed an audit for expired medications in all medication rooms and carts with no issues identified on 9/18/12. In-service training was provided for all nurses and Medication Aides regarding checking for expiration of medications when arriving from the Pharmacy and prior to administration of medication by Staff Facilitator beginning on 9/18/12. This training will be provided for newly hired nurses and Medication Aides during orientation.	10/12/12

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F 425	Continued From page 7 observed on 09/14/12 at 11:00 AM for expired medications. Lexapro 1/2 tabs 2.5 mg was found in a box with an expiration date of 09/01/13 on the outer edge of the box. The actual individual tablets x 8 had an expiration date of 9/01/12 printed on the packages. A staff interview with the Director of Nurses (DON) was conducted on 9/14/12 at 2:15 PM. The Director of Nurses stated her expectation was for the Nurses to check expiration dates for all the medications. The facility ' s provider Pharmacy faxed a note to the facility on 09/14/12 at 11:30 AM which read, "The wrong expiration date was put on the repacking of Lexapro 1/2 tabs 5 mg lot Y20941; expires on 3/2014 and we should have put an expiration date of 9/1/13." An interview was conducted with the facility Pharmacy Representative #1 on 9/14/12 at 11:30 AM regarding the reason the medication packets had the wrong date. The Pharmacy Representative indicated," We pack that medication about every other day. We dispensed that on September 1st. There is no way that medication could be expired 9/01/12. The person that typed that in made a mistake. " When asked what the Pharmacy Representative's expectations were regarding the packaging of the medications, the Pharmacy Representative stated, "I expect it to be correct. We are checking with all the facilities we have to make sure all the expiration dates are correct on the medications." An interview was conducted on 9/14/12 at 5:00 PM with Pharmacy Representative #2 who	F 425	The pharmacy nurse or consultant pharmacist will audit the facility monthly X three months to inspect all med carts and med rooms to confirm that expiration dating is printed accurately on dispensed products and that expired medications are removed. The pharmacy nurse or consultant pharmacist Will take appropriate action as necessary upon the identification of potential concerns. The DON or QI Nurse will complete weekly audits utilizing a QI tool of med carts and med rooms to check for expired medications. The DON or QI Nurse will take appropriate follow up action as necessary for potential concerns upon identification. The results of these audits will be forwarded to the Executive QI Committee monthly for analysis, trending, and further follow action as deemed necessary and to determine the necessity for and /or frequency of continued monitoring.	

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F 425	Continued From page 8 indicated, "When we typed it (referring to the medication packet label) it was keyed wrong."	F 425		

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	345354	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	An access door to be provided for inspection of the smoke detector unit located on the middle hall HVAC. Maintenance Director to inspect the HVAC units on each hall checking that an access door is provided on the smoke detector units. Any issues to be reported to the Administrator for appropriate action.	11/16/12
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation on Tuesday 10/2/12 at approximately 9:00 AM onward the following was noted: 1) An access door was not provided for inspection of the smoke duct detector unit located in the middle hall HVAC system. 42 CFR 483.70(a)	K 067	Re-trained Maintenance Director on Life Safety Code regarding access doors for inspection of the smoke duct detector. 10/8/12 Maintenance Director to audit each HVAC unit monthly and and initiate a monthly QI to assure that each HVAC system has an access door for inspection of the smoke detector unit according to Life Safety Code standards. Any deviation from the standard to be reported to the Administrator for appropriate action. QI committee to review the results of the audits monthly.	
K 104 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.	K 104		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kim V. Snider | TITLE: Administrator | (X6) DATE: 10/18/12

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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K 104	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation on Tuesday 10/2/12 at approximately 9:00 AM onward the following was noted: 1) The smoke damper located in the smoke wall on Middle Hall did not operate upon activation of the fire alarm system. 42 CFR 483.70(a)	K 104	Will replace smoke damper located in the smoke wall on the middle hall. Maintenance Director and Administrator to inspect all smoke dampers checking operation upon activation of the fire alarm system. Any issues to be corrected as appropriate. Re-trained Maintenance Director regarding smoke damper operation and the Life Safety Code standard. 10/8/12. Monthly QI and audit initiated. The Maintenance Director to inspect each damper monthly and report any issues to the Administrator for appropriate action. The QI committee will review the results of the audit monthly.	

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	345354	A. BUILDING 02 - ADDITION B. WING _____	10/02/2012

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000		
K 029 SS=F	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 observation on Tuesday 10/2/12 at approximately 9:00 AM onward the following was noted: 1) The kitchen dry storage room door did not close latch and seal when checked. 2) The janitor closet in the kitchen did not close latch and seal when checked. 3) The wheel chair storage room corridor door on 700 hall did not close, latch and seal.	K 029	Kitchen dry storage, Janitor's closet, and the Wheelchair storage room doors were repaired to close, latch, and seal on 10/9/12. Administrator and Maintenance Director inspected all doors facility wide checking that each closes, latches, and seals on 10/10/12. Any door not meeting the standard was repaired. Re-trained Maintenance Director regarding door standards on 10/10/12. Maintenance Director will conduct monthly audits and a monthly QI to assure that all facility doors close, latch, and seal. Will report any issues to the Administrator who will direct immediate action as necessary. The QI committee will review results of the monthly audit.	11/16/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kim V. Quick
TITLE: Administrator
(X6) DATE: 10/18/12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345354	A. BUILDING 02 - ADDITION B. WING _____	10/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEY GROVE NURSING AND REHABILITATION CENTER	728 PINEY GROVE RD KERNERSVILLE, NC 27284

(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 029	Continued From page 1 42 CFR 483.70(a)	K 029		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on Tuesday 10/2/12 at approximately 9:00 AM onward the following was noted: 1) The sprinkler head located in the freezer in the kitchen was cracked and missing the heat sensitive fluid from the sprinkler head.	K 056	Will replace the sprinkler head located in the freezer with a new head that meets standards. Maintenance Director and Administrator to inspect all sprinkler heads facility wide checking that each is free of cracks and contains the heat sensitive fluid. Any issues found will be addressed ap propriately. Re-trained Maintenance Director regarding the sprinkler head standards on 10/2/12. Maintenance Director will conduct monthly audits and a monthly QI to assure that all sprinkler heads meet Life Safety Code Standards. Any issues to be reported to the Administrator and QI committee for appropriate action as necessary. The QI committee will review results of the monthly audit.	
K 069 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation on Tuesday 10/2/12 at	K 069		

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K 069	Continued From page 2 approximately 9:00 AM onward the following was noted: 1) Based upon observation at the time of the survey the kitchen was experiencing a sever negative pressure. NFPA 96 (Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 1998 Edition) Section 5-3* Replacement Air. - " Replacement air quantity shall be adequate to prevent negative pressures in the commercial cooking area(s) from exceeding 0.02 in. water column (4.98 kPa). " 42 CFR 483.70(a)	K 069	Negative pressure in the kitchen to be balanced to meet Life Safety Code standards. Maintenance Director and Administrator to tour the facility and check air balance in all areas of the building. Any issues will be addressed as appropriate. Re-trained Maintenance Director regarding replacement air quality/negative pressure on 10/12/12. Maintenance Director will do a monthly audit and QI to monitor replacement air/negative pressure throughout the facility. Any issues will be addressed to Administrator and appropriate action taken.QI committee will review results of the audit monthly.	
K 076 SS=D	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 This STANDARD is not met as evidenced by: Based on observation on Tuesday 10/2/12 at approximately 9:00 AM onward the following was	K 076		

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 076	Continued From page 3 noted: 1) In resident room 713 an unsecured oxygen cylinder was found in the facility. 42 CFR 483.70(a)	K 076	The oxygen cylinder found in room 713 was removed by Bobby Doby and secured according to the standard on 10/2/12. Maintenance Director and Administrator toured total facility checking for unsecured oxygen cylinders. Any issues were corrected at that time on 10/2/12. Re-training/inservice initiated for 100% of staff regarding oxygen safety and standards. Training added to new hire orientation packet. 10/2/12. Administrative staff will conduct daily audits during QI rounds to assure that all cylinders are secured according to Life Safety Code Standards. Any issues to be reported to the Administrator for appropriate action. The QI Committee will review results of the audits monthly.	