PRINTED: 01/18/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345514			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		B. WI	B. WING			C 0/2012	
	ROVIDER OR SUPPLIER			1:	EET ADDRESS, CITY, STATE, ZIP CODE 210 EASTERN AVENUE PO BOX 157 ASHVILLE, NC 27856		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 000	complaint investiga	re cited as a result of the tion survey of 12/20/12. Event	F	000			
	ID# MOEI11.						
		DEDISHIDDI IED BEDDESENTATIVE'S SIGN			TITIF		(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.

JAN 1 1 2013

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

PRINTED: 12/31/2012 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345514	B. WING		C 12/20/2012	
	OVIDER OR SUPPLIER		1	REET ADDRESS, CITY, STATE, ZIP CODE 1210 EASTERN AVENUE PO BOX 167 NASHVILLE, NC 27856	12012012	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 371 SS=E	authorities; and (2) Store, prepare, dis- under sanitary condition This REQUIREMENT by: Based on observation facility failed to keep a mayonnaise at or beloduring operation of the of kitchenware with alt to sanitize meal carts kitchen after returning resident care areas. If the sanitize meal carts kitchen after returning resident care areas. If the sanitize meal carts kitchen after returning resident care areas. If the sanitize meal carts kitchen after returning resident care areas. If the sanitize meal carts kitchen after returning resident care areas. If the sanitize meal carts kitchen after returning resident care areas. If the sanitize meal carts kitchen after returning resident care areas. If the sanitize meal carts with the s	sources approved or ry by Federal, State or local stribute and serve food ons is not met as evidenced in and staff interview the a cold salad made with ow 41 degrees Fahrenheit errayline, failed to dispose oraded surfaces, and failed which were emptied in the from dining rooms and Findings include: /18/12 the trayline was in were three trays in an open of Cole slaw were being ed on resident trays. /12 a calibrated do to check the temperature slaw, one form each of the as being stored. The do 58 degrees Fahrenheit in Fahrenheit in another, and the another. At this time a led she started preparing AM on 12/18/12, using	F 371	This plan of correction will ser- compliance with requirements of part 483, and Subpart B. Prepar submission of the plan of corre response to HCFA 2567 for the and does not constitute an agree admission by Autumn Care of truth of the facts alleged or the of the conclusions stated on the of deficiencies. This plan of co- prepared and submitted becaus requirements under state and fe Autumn Care of Nash contends in substantial compliance with requirements 42 CFR, Part 483 Subpart B throughout the time stated in the statement of defici- accordance with state and feder Autumn Care of Nash submits correction to address the statem deficiencies and to serve as its of compliance with the pertiner requirements as of the dates sta- plan of correction and as fully of all areas as of 12/28/2011.	of 42 CFR, ration and ction is in c survey ement or Nash of the correctness c statement orrection is c of the deral laws the , and period encies. In ral law, this plan of nent of allegation at ted in the	
BORATORY E	IRECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATURE		In what	1/3/12	

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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STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	B WING			C 12/20/2012		
MANE OF D	OMBED OF CURRIER	345514			12/2	0/2012
NAME OF PI	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE 210 EASTERN AVENUE PO BOX 157		
AUTUMN	CARE OF NASH		N	ASHVILLE, NC 27856		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 371	Continued From page chilled ingredients fro She reported the Cole cabbage, mayonnaise According to the emp preparation of the slar and placed the tray provided in the same day the into the walk-in refrige began operation just 12/18/12. At 10:20 AM on 12/20 (DM) presented the tray in the into the walk-in refrige began operation just 12/18/12. At 10:20 AM on 12/20 (DM) presented the tray in the into the tray in the into the walk-in refrige escalibrated thermometer registered 41 degrees calibrated thermometer temperature as the tray DM stated the Cole slawas prepared and sent However, she reported guidance on the preparation of the preparation of the preparation of the same day they we supposed to store the on ice. She comment to only bring a tray of walk-in refrigerator at	m the walk-in refrigerator. e slaw contained shredded e, salt, pepper, and sugar. loyee, she finished w at 9:00 AM on 12/18/12, an containing it in the chill. At 10:30 AM on ne Cole slaw was placed in bowls were transferred back erator until the trayline orior to 12:00 noon on 1/12 the dietary manager ayline temperature log for d the 12/18/12 Cole slaw s Fahrenheit when a er was used to check ayline began operation. The aw served during the survey rved on the same day. d she was going to revise aration of cold salads to yees to prepare these yonnaise the day before rrage in the cooler. She trained to keep these operation of the trayline. 1/12 a dietary employee en preparing colds salads are served, but they were m in the walk-in refrigerator ed the staff was instructed salad bowls out of the a time so the salads would	F 371	For the residents affected and residents having the potential affected: The coleslaw was removed fr tray line and cooled prior to e service on 12/18/12. Compromised small wares we disposed of on 12/18/12. Food carts were re-sanitized a quaternary solution unmixed cleaning solution on 12/18/12 Measures put in place: In-service provided to dietary employees by Certified Dieta Manager on 12/21/12 and 12/12 regarding preparation and ser cold foods, disposal of comprismall wares and proper use of quaternary solution. Monitoring: Certified Dietary Manager or will audit preparation and ser cold foods weekly x 3 weeks monthly x 3 months. Certified Dietary Manager or will audit for damaged/comprismall wares weekly x 3 week monthly x 3 months. Certified Dietary Manager will audit for damaged/comprismall wares weekly x 3 week monthly x 3 months. Certified Dietary Manager will monitor for appropriate use of quaternary and cleaning solutions.	om the continued ere using with 2. Ty 28/12 vice of comised f designee ving of and designee romised s and all f	12/28/12 12/28/12
	resident trays.	pefore being placed on		weekly x 3 weeks and then m 3 months.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I'''	(X2) MULTIPLE CONSTRUCTION A. BUILDING			VEY ED	
	345514 B. WING			C 12/20/2012			
	ROVIDER OR SUPPLIER			12	EET ADDRESS, CITY, STATE, ZIP CODE 210 EASTERN AVENUE PO BOX 167 ASHVILLE, NC 27856		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 371	at 10:25 AM on 12/14 soup/cereal bowls wi inside, 4 of 12 plastic abraded and rough it mugs were abraded At 10:20 AM on 12/14 (DM) stated the dieta dispose of compromishowing it to her. Strompromised kitcher were cracked or chip or finish was damage unappealing to reside At 10:55 AM on 12/1 stated the dietary stated the striped down returned from a red to 12/18/12 the dietary thought this red buck sanitizing solution. However, at 9:57 AM compatible with a quit was used to check the striped did not chansolution was present.	ion of kitchenware beginning 3/12 11 of 20 plastic ere abraded and rough a dessert bowls were enside, and 6 of 20 coffee and rough inside. 8/12 the dietary manager ary staff was trained to sed kitchenware after the reported that answer included items which ped, items where the glaze end, and items which looked ents and staff. 8/12 a dietary employee ff was responsible for pulling as chipped, cracked, tained. She reported this sented to the DM who	F	371	Any area of identified concerr will be addressed with retraini and will be brought to the Q. A Committee for any further need action.	ng A.	

PRINTED: 12/31/2012 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	A. BUILDING		C 12/20/2012				
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CC 1210 EASTERN AVENUE PO BOX 1 NASHVILLE, NC 27856	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 371	strength of the sanitized dietary employee who surveyors that the red dishwashing solution. At 10:20 AM on 12/18 (DM) stated meal carticare areas and dining down with quaternary were emptied in the k bucket was filled with the dispensing system sink system and kept meal carts. According member who filled the solution was supposed a strip before actually At 10:55 AM on 12/18 who made up the red 12/18/12 for wiping down usually mixed soapy wanitizing solution who explained with this mix cleaned and sanitized was important to kill the She commented a strip solution.	es of green based on the ing agent. At this time the made up the solution told bucket only contained 1/12 the dietary manager serturning from resident rooms were to be wiped sanitizing solution after they itchen. She reported a red quaternary solution from at the three-compartment available for wiping down go to the DM, the staff bucket with sanitizing doto check the strength with using it. 1/12 the dietary employee, bucket of solution used on own meal carts, stated she vater with quaternary en filling the bucket. She cture the carts were both. The employee reported it he germs on the meal carts. p, which changed different to be used to check the	F				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/18/2013 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES						. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		CONSTRUCTION 01 - MAIN BUILDING		(X3) DATE S COMPLI	
		345514	1 .				02/1	2/2013
	PROVIDER OR SUPPLIER			1210	TADDRESS, CITY, STATE, Z EASTERN AVENUE PO B HVILLE, NC 27856	OX 157	R 0 6 201	4
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOU THE APPR	JLD BE	(X5) COMPLETION DATE
K 000	This Life Safety Co conducted as per T at 42CFR 483.70(a Health Care section publications. This b construction, one st automatic sprinkler	de(LSC) survey was he Code of Federal Register); using the 2000 Existing of the LSC and its referenced uilding is Type (V 111) ory, with a complete	ΚO		This plan of correction will se allegation of compliance with 42CFR, Part 483, Subpart B for acilities. Preparation and subcorrection is in response to H6 survey conducted 02/12/2013 an agreement or admission by of the truth of the facts alleged he conclusions stated on the stelliciencies. This plan of conclubinited because of the required federal laws.	requirements or long term of mission of the CFA 2567 for and does not Autumn Car I or the correct tatement of rection is prepresent	s of care te plan of the constitute to of Nash ctness of	***
K 029 SS=D	One hour fire rated fire-rated doors) or extinguishing syster and/or 19.3.5.4 prot the approved automoption is used, the aother spaces by smdoors. Doors are sefield-applied protect	construction (with ¾ hour an approved automatic fire in accordance with 8.4.1 ects hazardous areas. When eatic fire extinguishing system areas are separated from oke resisting partitions and elf-closing and non-rated or live plates that do not exceed pottom of the door are	К 0	i de la constant de l	For the residents found to be a saving the potential to be affect equipment Room and both docere repaired on 2/26/12. All cepaired as needed for proper of the saures put in place: Staff in naintenance or administration to close/latch properly for im the things of the saures will perform audits to lose latching/closings weekly nonthly thereafter to ensure the properiately. Any problems will perform a saure the properiately. Any problems will be brought to Quality Assurance will any necessary further the saure and any necessary further the saure of the properior of the saure of the properior of the saure of the	eted: Doors of the control of the co	y Room d and dand dtching. alert which do ir. tor or his oper no operate sed ddits will	2/26/13 3/3/13 3/4/13
K 038 SS=D	A. Based on observed doors to the Equip. Is solled linen and the falled to close and is 42 CFR 483.70 (a) NFPA 101 LIFE SAFExit access is arrang accessible at all times.	not met as evidenced by: ration on 02/12/2013 the Room on the 400 hall, the clean linen side of the laundry atch. ETY CODE STANDARD ged so that exits are readily as in accordance with section	K 0:	38	TITLE		Λ	(X8) 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.

PRINTED: 02/18/2013 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OND NO.	0930-0391
STATEMENT	IDENTIFICATION NI IMBER		(X2) M A. BU		PLE CONSTRUCTION G 01 - MAIN BUILDING	(X3) DATE SURVEY COMPLETED	
	345514		B. WI	NG		02/12/2013	
	ROVIDER OR SUPPLIER			13	EET ADDRESS, CITY, STATE, ZIP CODE 210 EASTERN AVENUE PO BOX 157 ASHVILLE, NC 27856		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 038	A. Based on obser interviewed did not	· · · · · · · · · · · · · · · · · · ·		038	For the residents found to be affected and having the potential to be affected: Staff vinterviewed on 2/12/13 by Life Safety Surin-serviced regarding the master switches stations. Measures put in place: All staff in-service knowledge of master switches at nurses staindividual release switches at each door. Monitoring: Administrator or designee wiasking 4 persons each week about master of four weeks and then four persons montmonths to insure knowledge and complian will be brought to the Quality Assurance to	who were weyor were at nurses d to insure ations and Il audit by switches hly for 5 ce. Results	2/12/13 3/3/13 3/4/13
K 062 SS=D	Required automaticontinuously maint		K 06		For the residents found to be affected and having the potential to be affected: Five yobstruction tests were completed on 2/25/1 dry sprinkler systems. Facility's Env. Services Director will keep of needed inspections and follow up with a calendar/notebook.	ear 3 on both o records	2/25/13 3/4/13
	A. Based on obsert facility did not have	is not met as evidenced by: evation on 02/12/2013 the documentation of the five (5) st being done on the dry			Measures put in place: Calendar/notebook kept and monitored for required inspection Environmental Services Director monthly. will be taken to QA. Committee to confirm complete and that future needed testing is timely.	s by Book a testing	3/4/13

J MILINE	NT OF DEFICIENCIES NOF CORRECTION	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		O, 0938-0
		IDENTIFICATION NUMBER:			COM	SURVEY PLETED
		345514	B. WING	MAR 0 4 2013	1	
NAME OF	PROVIDER OR SUPPLIER		ler	(DECY ADDROG OF AND	02	/12/2013
AUTUA	IN CARE OF NASH	· ,		REET ADDRESS, CITY, STATE, ZIP CODE 1210 EASTERN AVENUE PO BOX 157 NASHVILLE, NC 27856		
(X4) ID PREFIX TAG	I (AVAID DELICIENC)	NTEMENT OF DEFICIENCIES Y MUSY BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	MINDE	COMPLE) DATE
K 000	INITIAL COMMENT	·s	K 000		·	
K 029	at 42CFR 483.70(a) Health Care section publications. This be construction, one ste automatic sprinkler section The deficiencies det are as follows:	ermined during the survey		This plan of convection will serve as the far allegation of compliance with requirement 42CFK, Part 483, Subpart B for long term facilities. Preparation and submission of a convection is in response to HCFA 2567 for survey conducted 02/12/2013 and does not an agreement of udmission by Amunn Cap of the truth of the facts affected or the correlation conclusions stated on the statement of deficiencies. This plan of correction is pressubmitted because of the requirements and and federal laws.	s of care he plan of r the constitute to of Nagh ciness of	**
SS=D	One hour fire rated of fire-rated doors) or a extinguishing system and/or 19.3.5.4 prote the approved automa option is used, the arother spaces by smoldoors. Doors are self-	onstruction (with 1/2 hour napproved automatic fire in accordance with 8.4.1 cts hazardous areas. When all of fire extinguishing system eas are separated from the resisting partitions and f-closing and non-rated or a plates that do not exceed all of the door are	K 029	For the residents found to be affected and it having the potential in he affected: Dones it Equipment Room and both doors to I aundred were repaired on 2/26/12. All doors checked repaired as needed for proper closing and la Mensures put in place: Staff in-serviced to a maintenance or administration of any divors not close/latch properly for immediate repaired monitoring: Environmental Services Direct designee will perform audits to check for product latching/closings weekly for 4 weeks at monthly thereafter to ensure they continue to impropriately. Any problems will be address immediately with repair. Results of these and he brought to Quality Assurance team quarter review and any necessary further action.	o y Room i and i and iching, leri which do or or his iper id then operate ed if it is not in the control of the control o	2/26/1: 3/3/13 3/4/13
038 N SS=D Ea	A. based on observate loors to the Equip. Ro colled linen and the cleated to close and late 2 CFR 483.70 (a) IFPA 101 LIFE SAFE wit access is arranged accessible at all times.	TY CODE STANDARD If so that exits are readily in accordance with section	K 038	n		
ATORY DI	HECTOR'S OR PROVIDER/S	UPPLIER REPRESENTATIVE'S SIGNATUL	RE C.	TIYLE	ال م	6) DAYE
	taldment ending with an as	Olympic Carlelland Committee		TIYLE	-11	DAYE .

hny 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

FORM CMS-2507(02-99) Provious Versions Obsoleto

Event ID: MOEI21

Facility ID: 970970

If continuation sheet Page 1 of 2

PRINTED: 02/18/2013 FORM APPROVED OMB NO. 0938-0301

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		OMB NO. 0938-03
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION MAK (X) DATE SURVEY DING 01 - MAIN BUILDING COMPLETED
		345514	B. WIN	
NAME OF I	PROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUM	N CARE OF NASH			1210 EASTERN AVENUE PO BOX 157
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		NASHVILLE, NC 27856
PREFIX TAG	COACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPUTED OF COMPUTED DAYS) CROSS-REFERENCED TO THE APPROPRIATE DAYS DEFICIENCY) (XS)
	7.1, 19.2.1 This STANDARD is A. Based on observa	not met as evidenced by:	Κo	interviewed on 2/12/13 by 1.1/e Sufery Surveyor were interviewed on 2/12/13 by 1.1/e Sufery Surveyor were in-serviced (egurding the master switches at nurses stations. Measures put in place: All staff in-serviced to insure knowledge of muster switches at nurses stations and individual release switches at each door. Monitoring: Administrator or designee will audit by asking 4 persons each work about master switches for four weeks and then four persons measure for so
	release switch at the 42 CFR 483,70 (a)	now about the master nurses station. ETY CODE STANDARD	K 06	months to insure knowledge and compitance, Results will be brought to the Quality Assurance team for review and any necessary further notion. 3/4/13
1 0 1	continuously maintair condition and are insi	prinkler systems are ned in reliable operating pocted and tested , 4.6.12, NFPA 13, NFPA 25,		For the residents found to be affected and for those having the potential to be affected. Five year obstitution tests were completed on 2/25/13 on both dry sprinkler systems. Facility's Fav. Services Director will keep records of needed inspections and follow up with contractor to ensure inspections are completed via a unlendar/notebook.
fa y s	4. Based on observate cility did not have do	of met as evidenced by; dion on 02/12/2013 the cumentation of the five (5) ding done on the dry		Measures put in place: Calendar/notebook will be kept and monitored for required inspections by Environmental Services Director monthly. Bunk will be taken to QA, Committee to confirm testing complete and that future needed testing as selveduled timely.
	7-99) Previous Versions Obse			