

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345309</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>04/14/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 CAROLINE AVENUE WELDON, NC 27890</b>	
(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 000	INITIAL COMMENTS  A Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. In the exit conference all deficiencies noted were discussed and acknowledged with administration.  Stories: 1 Construction Type: III (211) Constructed: 1989 Fully Sprinkled - Yes At time of survey the: Total Certified Bed Count = 55 Census = 43	K 000		
K 025 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by: NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observations, on Thursday 4/14/2016 at approximately 9:00 AM onward, the following deficiencies were noted: The smoke walls are was non-compliant, specific findings include:  1. The three smoke walls located on the front hall, one on administration hall and the hall to the right and the hall to the left have holes and/or	K 025	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction	5/29/16

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

TITLE

(X6) DATE

Electronically Signed

05/05/2016

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 025	<p>Continued From page 1</p> <p>penetrations that were not sealed in accordance with an approved fire rated assemble in order to maintain the fire resistance rating of the wall. There are multiple cable and conduit penetrations in the walls that are not sealed in accordance with an approved and listed fire stop assembly and/or fire stop assembly method.</p> <p>2000 NFPA 101 Section 5.7 Maintenance. Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance.</p> <p>2000 NFPA 101, 8.3.2* Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.</p> <p>2000 NFPA 101 Section 19.3.7.3, 8.3.6.1 NFPA 101, 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</p>	K 025	<p>constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Though there were no residents immediately affected in this case, there is a potential for all residents to be affected. Maintenance Director will have all penetrations on administration hall to the right, to the left of 100 hall and all conduit penetrations filled with approved fire rated assemble by 5/29/16.</p> <p>Maintenance Director will check all smoke walls and attic spaces for holes and/or penetrations that are not sealed in accordance with an approved fire rated assembly, which includes 5/8 sheet rock where applicable and also fire collars for PVC conduit penetrations. Maintenance Director will go behind any contractor to ensure there are no new penetrations. Maintenance Director will check for penetrations weekly for four months or until the issue is deemed resolved by the Facility Safety Committee and Quality Assurance Committee (QA) and quarterly thereafter.</p>	

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

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K 025	Continued From page 2 protected as follows: 1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. 2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. 3) Where designs take transmission of vibration into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose.  This deficiency affected four of five smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 025			
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with 0 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1	K 029		5/29/16	

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K 029	<p>Continued From page 3</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observations, on Thursday 4/14/2016 at approximately 9:00 AM onward, the following deficiencies were noted: The hazardous areas are non-compliant. Specific findings included.</p> <ol style="list-style-type: none"> <li>In the main electrical room in the back right corner there are pipes penetrating the ceiling that are not properly sealed in order to maintain the require resistance rating of the room.</li> <li>The corridor door to the central supply room is not self-closing and the door is no longer rate due to the sheeting on the intior side of the door broken and stripped away from the doon were the closure was mounted.</li> <li>The oxygen storage room on 100 hall was not equipped with a self-closing device.</li> <li>The storage roon located in the front center hall was not equipped with a self-closing device.</li> </ol> <p>NFPA 101, 19.3.2.1 Doors are self-closing. NFPA 101, 8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows: (1) The space between the penetrating item and the smoke partition shall meet one of the following conditions:</p>	K 029	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.</p> <p>Though there were no residents immediately affected in this case, there is a potential for all residents to be affected.</p> <ol style="list-style-type: none"> <li>Maintenance Director filled holes in main electrical room in back right corner with 3m fire barrier sealant CP 25WBT on 4/25/16. Maintenance Director will check all electrical rooms for penetrations and go behind any contractor to ensure there are no new penetrations. Maintenance Director will check for penetrations weekly for four months or until the issue is deemed resolved by the Facility Safety Committee and Quality Assurance Committee (QA) and checked quarterly thereafter.</li> <li>Maintenance Director ordered a 45</li> </ol>	

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K 029	<p>Continued From page 4</p> <p>a. It shall be filled with a material that is capable of limiting the transfer of smoke.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the smoke partition, the sleeve shall be solidly set in the smoke partition, and the space between the item and the sleeve shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of limiting the transfer of smoke.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(3) Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions:</p> <p>a. It shall be made on either side of the smoke partitions.</p> <p>b. It shall be made by an approved device that is designed for the specific purpose.</p> <p>2000 NFPA 101 Section 5.7 Maintenance. Whenever or wherever any device, equipment, system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance.</p>	K 029	<p>minute fire rated door for central supply room on 4/28/16. Facility will be in compliance by 5/29/16. Door closure was ordered on 4/27/16 to be in compliance by 5/29/16. Maintenance Director will check all fire rated doors to ensure there are no defected doors and do a facility audit to add door closures throughout the facility on doors where required. Maintenance Director check all doors that require a door closure and all fire rated doors for defects weekly for four months or until the issue is deemed resolved by the Facility Safety Committee and Quality Assurance Committee (QA) and checked quarterly thereafter.</p> <p>3. Oxygen storage room closure was ordered on 4/28/16. Maintenance Director will do a facility audit to add door closures throughout the facility on doors where required. Maintenance Director will check all doors that require a door closure weekly for four months or until the issue is deemed resolved by the Facility Safety Committee and Quality Assurance Committee (QA) and checked quarterly thereafter.</p> <p>4. Hazardous storage door closure for was ordered on 4/25/16. Maintenance Director will do a facility audit to add door closures throughout the facility on doors where required. Maintenance Director will check all doors that require a door closure weekly for four months or until the issue is deemed resolved by the Facility Safety Committee and Quality Assurance Committee (QA) and checked quarterly thereafter.</p>		

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K 045 K 045 SS=D	Continued From page 5 NFPA 101 LIFE SAFETY CODE STANDARD  Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8 This STANDARD is not met as evidenced by: Based on observations, on Thursday 4/14/2016 at approximately 9:00 AM onward, the following deficiencies were noted: The egress illumination was observed as noncompliant: specific findings include.  1. The Rehab and Therapy room located on the front hall did not have a light on emergency power.  NFPA 101, 19.2.8, 7.9 Emergency Lighting,  This deficiency affected one of five smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to loss of power.	K 045 K 045	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Though there were no residents immediately affected in this case, there is a potential for all residents to be affected. On 4/28/16, Maintenance Director, installed emergency lighting in the rehab gym. Maintenance Director will perform an audit of all emergency lighting and add emergency lighting fixtures where required. A test of emergency lighting system will be conducted monthly for four months by the Maintenance Director or until the issue is deemed resolved by the Facility Safety Committee and Quality Assurance Committee (QA) and checked quarterly thereafter.	5/29/16	
K 061 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 061		4/21/16	

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K 061	<p>Continued From page 6</p> <p>Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72</p> <p>This STANDARD is not met as evidenced by: Based on observations, on Thursday 4/14/2016 at approximately 9:00 AM onward, the following deficiencies were noted: The automatic sprinkler system was non-compliant, specific findings include:</p> <p>1. The sprinkler tamper supervisory signal could be silenced permanently. Supervisory signals shall not be silenced permanently except by reopening/restoration of the valve.</p> <p>Reference NFPA 101, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>NFPA 13 "...distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system."</p> <p>NFPA 9.7.2.1 "...supervisory attachments shall be installed and monitored for integrity in accordance with NFPA 72 AND a distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system...Supervisory signals shall sound AND shall be displayed either at a location within the protected building that is constantly attended by qualified personnel or at an approved, remotely located receiving facility.</p> <p>This deficiency affected all smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury</p>	K 061	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Though there were no residents immediately affected in this case, there is a potential for all residents to be affected. BFPE arrived on 4/21/16 and added a relay so panel cannot be permanently silenced except for restoration of main shut off valve to sprinkler system. Maintenance Director will check sprinkler tamper weekly for four months or until the issue is deemed resolved by the Facility Safety Committee and Quality Assurance Committee (QA).</p>		

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K 061	Continued From page 7 due to fire and/or smoke.	K 061		
K 062 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observations, on Thursday 4/14/2016 at approximately 9:00 AM onward, the following deficiencies were noted: The sprinkler system was non-compliant. Specific findings included:</p> <ol style="list-style-type: none"> <li>1: The control valves for the backflow preventor for the sprinkler system could not be tested due to corrosion on the stems. The valves were not not maintained in good operating condition.</li> <li>2. Base upon document review of the sprinkler inspections report the gauges for the sprinkler system need to be replace and/or recalibrated.</li> <li>3. In the sprinkler riser room a sprinkler heads rated for Intermediate Temperature Classification, Glass Bulb Color of Green (200°F) is being used in place of Ordinary Temperature Classification, Glass Bulb Color of Red (155°F).</li> </ol> <p>Ref: 2000 NFPA 101 19.7.6, 4.6.12, 1999 NFPA 13, NFPA 25, 9.7.5 Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems.</p> <p>This deficiency affected all smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.</p>	K 062	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Though there were no residents immediately affected in this case, there is a potential for all residents to be affected.</p> <ol style="list-style-type: none"> <li>1. BFPE has ordered necessary parts for existing backflow preventer valve for the sprinkler system. After consulting with surveyor, facility was granted a 28 day extension to be compliance by 6/26/16. Maintenance Director will conduct a test of tamper valve backflow preventer monthly for four months or until the issue is deemed resolved by the Facility Safety Committee and Quality Assurance Committee (QA) and quarterly thereafter. Maintenance Director will also check behind BFPE after every inspection.</li> <li>2. BFPE will replace water pressure</li> </ol>	6/26/16



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K 062	Continued From page 8	K 062	gauge on sprinkler system by 6/26/16. Maintenance Director will check to ensure water pressure gauge on sprinkler system is working properly weekly for four months or until the issue is deemed resolved by the Facility Safety Committee and Quality Assurance Committee (QA) and quarterly thereafter. Maintenance Director will also check behind BFPE after every inspection. 3. BFPE replaced 200 degree head with 155 degree head on 6/26/16. Maintenance Director will check in the sprinkler riser room sprinkler head to ensure head is intact weekly for four months or until the issue is deemed resolved by the Facility Safety Committee and Quality Assurance Committee (QA) and quarterly thereafter. Maintenance Director will also check behind BFPE after every inspection.		
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 observations, on Thursday 4/14/2016 at approximately 9:00 AM onward, the following deficiencies were noted: The smoke duct detector was non-compliant, specific findings include:  1. The smoke duct detector located in the HVAC unit in the attic on the front hall was not properly installed. The air sample tube was not oriented in	K 067	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facilities allegation of	5/29/16	

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K 067	Continued From page 9 the correct direction and a short air sampling tube was used for an exhaust tube. NFPA 90A, 4-4.4.1  This deficiency affected two of five smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 067	compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Though there were no residents immediately affected in this case, there is a potential for all residents to be affected. On 4/21/16, BFPE reinstalled the air sample tube in the correct direction pulling from return air. The exhaust tube was also replaced on the opposite side. Maintenance Director will check all air sample tubes to ensure that tubes are in correct direction pulling from return air. Maintenance Director will conduct a monthly check of exhaust tubes for four months or until the issue is deemed resolved by the Facility Safety Committee and Quality Assurance Committee (QA) and checked quarterly thereafter. Maintenance Director will check behind any contractor that goes into the attic space. After the reinstallation of the sample and exhaust tubes, BFPE tested the smoke duct detector on 4/21/16 and it functioned properly. Maintenance Director will test all smoke duct detectors to ensure they function properly. Maintenance Director will conduct a monthly test for four months, using a fog machine for simulated smoke, or until the issue is deemed resolved by the Facility Safety Committee and Quality Assurance Committee (QA) and quarterly thereafter.		
K 104 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are	K 104		5/29/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345309</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/14/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>101 CAROLINE AVENUE WELDON, NC 27890</b>		
(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 104	<p>Continued From page 10</p> <p>not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 &amp; NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observations, on Thursday 4/14/2016 at approximately 9:00 AM onward, the following deficiencies were noted: The smoke dampers are was non-compliant, specific findings include:</p> <p>1. The two smoke dampers located in the administration hall smoke wall did not close upon activation of the fire alarm when tested.</p> <p>NFPA 90A; Section 4-4.4.2 In addition to the requirements of 4-4.3, where an approved fire alarm system is installed in a building, the smoke detectors required by the provisions of Section 4-4 shall be connected to the fire alarm system in accordance with the requirements of NFPA 72, National Fire Alarm Code.</p> <p>NFPA 101: 8.2.4.4.3</p> <p>This deficiency affected two of five smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.</p>	K 104	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Though there were no residents immediately affected in this case, there is a potential for all residents to be affected. BFPE added a relay to both supply and return duct to engage upon installation of fire drill or actual fire on 4/27/16. Maintenance Director will check all smoke dampers to ensure that they close upon activation. Maintenance Director will test smoke dampers by activating the fire pull station to ensure the smoke dampers function properly monthly for four months or until the issue is deemed resolved by the Facility Safety Committee and Quality Assurance Committee (QA) and quarterly thereafter.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345309</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/14/2016</b>
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K 130 K 130 SS=D	Continued From page 11 NFPA 101 MISCELLANEOUS  OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observations, on Thursday 4/14/2016 at approximately 9:00 AM onward, the following deficiencies were noted:  Staff in the kitchen when questioned were not familiar on how to operate the Ansul System in case of an emergency. NFPA 96: 8-1.4 "Instructions for manually operating the fire-extinguishing system shall be posted conspicuously in the kitchen and shall be reviewed periodically with employees by the management."	K 130 K 130	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facilities allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. Though there were no residents immediately affected in this case, there is a potential for all residents to be affected. On 4/14/16, Maintenance Director in-serviced dietary employees on ansul system by instructing them to pull pin on silver canister by side exit door, walk out door and do not return to kitchen until cleared by Maintenance Director, Administrator or fire department. Procedure on how to activate ansul system will be posted conspicuously in kitchen. Maintenance Director will review with staff on monthly fire drills and until the issue is deemed resolved by the Facility Safety Committee and Quality Assurance Committee (QA).	4/14/16	