

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

PRINTED: 09/12/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345506	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ <i>SEP 24 2012</i>	(X3) DATE SURVEY COMPLETED 08/23/2012
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NAME OF PROVIDER OR SUPPLIER WHITESTONE A MASONIC AND EASTERN STAR COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 700 SOUTH HOLDEN ROAD GREENSBORO, NC 27407
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(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
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F 176 SS=D	<p>483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE</p> <p>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews the facility failed to adequately assess one of ten sampled residents (Resident #136) for self administration of physician ordered eye drops.</p> <p>The facility form Request for Self-Administration of Medication was reviewed. It contained 17 questions related to knowledge of the medication, infection control, and safe keeping of medication in the room. The form had to be signed by the nurse, the supervisor RN, placed on the chart behind the Consents tab, and forwarded to the MDS/Care Plan Coordinator to document assessment of the resident for self-administration of medications.</p> <p>Resident #136 was admitted to the facility 8/10/2012 with diagnoses that included Glaucoma and Hypertension.</p> <p>The Admission Minimum Data Set (MDS) dated 8/17/2012 indicated that resident #136 was cognitively intact. The MDS also noted the diagnosis of Glaucoma.</p> <p>Review of the Admission Care Plan found no documentation to show resident #136 had been</p>	F 176	<p><i>This plan of correction is submitted as required by State and Federal law. The provider maintains that the alleged deficiencies do not individually or collectively jeopardize the health and safety of the residents, nor are they of such character so as to limit the providers' capacity to render adequate care.</i></p> <p>Tag F 176 483.10(n)</p> <ol style="list-style-type: none"> The resident identified within the deficiency was approached about self-administration of medications and chose to continue to allow staff to administer. Directed inservice training on self-administration of medications and our policies and procedures was done by our Staff Development Coordinator with the licensed nurses. The nurse identified as leaving the eye drops in the resident's room was counseled and re-educated on the policies and procedures for self-administration of medications by the Staff Development Coordinator. Medication pass observations will be done with a random licensed nurse weekly by our Staff Development Coordinator or Nursing Supervisor for 3 months and at least monthly going forward as part of our ongoing Quality assurance program to ensure all self-administration of medications procedures are followed. 	9/20/2012
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Giane A. [Signature]</i>	TITLE Administrator	(X6) DATE 9/19/12
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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 176	<p>Continued From page 1</p> <p>assessed for self-administration of medication.</p> <p>On 8/20/2012 the facility indicated Resident #136 was alert, oriented, and interviewable.</p> <p>Review of the medical chart for Resident #136 for 8/1-8/31/2012 found an order by the physician on admission for Combigan 0.2% one drop in both eyes two times a day. Wait three to five minutes between eye medications. The review did not reveal an order for resident #136 to self-administer the eye drops. The Consent section did not contain a Request for Self-Administration of Medication form.</p> <p>On 8/23/2012 at 8:45 am during a medication administration observation Nurse #1 stated that she would give resident #136 the oral medications and then take out the eye drops for administration. When we entered the room a medication container with a pharmacy label was noted on resident #136' bedside table. Nurse #1 picked it up and asked the resident where she got it. Resident #136 stated that the nurse left it there after she put in the eye drops the night before. Nurse #1 said the medication was resident #136's scheduled medicated eye drops. The label indicated the medication was Combigan 0.2% for drops in both eyes two times a day. The resident stated she had already put the drops into her eyes that morning. Asked if she was allowed to do that Nurse #1 put the container down and said she would have to check on it. The oral medications were given and Nurse #1 initialed the Medication Administration Record indicating that the ordered eye drops had been given, stating the resident said she had put the drops in herself.</p>	F 176	<p>4. Room inspections of 10 random rooms will be done weekly by either the Administrator, Director of Nursing or Staff Development Coordinator for 3 months and then monthly in conjunction with our Quality Assurance program to ensure no medications are left at the bedside.</p> <p>Completion date: September 20; 2012</p>	

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F 176	<p>Continued From page 2</p> <p>At 12:00 noon on 8/23/2012, the container with the eye drops was observed sitting on the bedside table in resident #136' room.</p> <p>In an interview on 8/23/2012 at 12:22 pm Nurse #2 was asked if an alert and oriented resident was allowed to administer their own medications, specifically eye drops. Nurse #2 stated that if a resident wanted to administer their own medications, there were assessments that had to be done, forms to fill out, education of the resident had to be completed, and the medication had to be kept in a locked box in the resident's room.</p> <p>At 12:43 pm on 8/23/2012, the container with the eye drops was observed in resident #136's room. Resident #136 was asked if the eye drops were always left in her room. She replied no they were usually put back into the cart. Asked if she usually put the drops into her own eyes, she said sometimes she did and sometimes the nurse did. She indicated that when she was admitted she was asked if she wanted to put the drops in herself and she said it didn't matter to her. Asked if she signed any forms or consent for putting the drops into her eyes, she said no she didn't.</p> <p>At 12:46 pm Nurse #1 was asked if she had found out if resident #136 was allowed to self-administer medications, she said she hadn't had time yet.</p> <p>Nurse Supervisor #1 stated in an interview at 2:40 pm on 8/23/2012 that they discouraged residents from self-administering medications because it was hard for resident's to comply with the medication orders. However, if a resident wanted</p>	F 176			

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F 176	Continued From page 3 to self-administer medications a Request for Self-Administration of Medication form had to be filled out with the resident answering all the questions indicating understanding of the medication, side effects, method and timing of administration. Then the nurse signed the form, the supervisor signed the form, the physician was notified to write an order for self-administration, and the medication was put into a lock box in the resident's room. Nurse Supervisor #1 accompanied me to resident #136's room and observed the container with the eye drops on the bedside table. Nurse Supervisor #1 took the eye drops to put back in the medication cart and said she would talk to resident #136 about the requirements for self-administration. On 8/23/2012 at 3:08 pm the Director of Nurses (DON) stated that if a resident met the criteria by assessment and answering the questions on the Request for Self-Administration of Medication they were checked each month to make sure they still met the criteria. Asked what needed to be done for a resident who met the criteria and wanted to self-administer medications. The DON indicated consent would be signed, the physician would be notified to write the order and both would be placed on the chart. The self-administration would need to be care planned and a lock box provided in the room for the safe keeping of the medication. Asked if it was acceptable for a nurse to leave eye drops in the resident's room and allow the resident to put their own eye drops in without an assessment or order, she said " no, it was not."	F 176			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371	Tag F 371 483.35(i) 1. Items identified during recertification inspection were corrected immediately by the Kitchen Manager and Director of Dietary Services.	9/20/2012	

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F 371	Continued From page 4 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to maintain sanitary conditions in the kitchen by not ensuring opened food items were sealed, dated and labeled; by not ensuring food service staff wore clean uniforms and the service repairman was wearing a hairnet; by not ensuring pans, meal tray covers, and utensils were stored/stacked clean and dry; and, by not ensuring food service equipment were maintained clean and free from debris. Findings included: 1. During the meal preparation and service in the kitchen on 8/22/12 at 11:15a, the Head Cook was observed wearing a stained, soiled white t-shirt while preparing and serving food on the meal tray line. Also observed was a Service Repairman repairing the stove in the food preparation area without a hairnet, throughout the meal tray line service for lunch. 2. During a kitchen observation on 8/22/12 at	F 371	2. A new sanitation checklist was developed by the Director of Dietary Services and a full inspection done to ensure entire kitchen meets sanitation requirements. 3. Directed inservice training on proper uniform, sanitation, cleaning schedules, and also proper drying and storing of equipment has been conducted by the Director of Dietary Services with all Dietary employees. 4. A detailed sanitation inspection will be completed weekly for 3 months and at least monthly going forward as part of our ongoing Quality Assurance program by either the Director of Dietary Services or the Kitchen Manager. Completion date: September 20, 2012	

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F 371	<p>Continued From page 5</p> <p>11:20a, 2 of 2 utensil drawers contained the following soiled and/or wet items: 2-stained slotted spoons; 1-brown, stained slotted 3oz (ounce) ladle; 1-brown, stained solid 4oz ladle; 1-#8 scoop with spotted yellow stains; 1-#16 wet scoop; 1-black plastic ladle with brown particles; 2-#8 scoops with brown debris; 2-small stainless steel measuring cups with brown stains; and, 1-6oz ladle with sticky white debris on the handle. The Knife Rack contained 1-boning knife with white debris on the blade, near the handle. There were 14 wet meal tray covers stacked at the meal tray serving line during the lunchtime service. The following stainless steel pans were stacked dirty and/or wet on the storage rack: 1-2"(Inch) deep ½ sized pan with dried brown debris; 1-6" deep ½ sized pan with debris; 6-2"deep hotel pans with debris and/or wet; and, 5-4" deep ¼ sized pans were stacked wet.</p> <p>3. During the kitchen observation on 8/22/12 at 11:30a, there were crumbs on the base of the meatslicer and in the area near the slicer ' s blade. The Kitchen Manager revealed the meatslicer, which was covered, was last used within the prior 24 hours. The inside of the microwave was stained with yellow/brown debris. The Storage Rack for the bins (sugar, thickener, rice, flour) had sticky white debris on the racks. The inside and outside of 7 of 7 heated delivery carts, which were being stacked with the prepared meal trays from the meal tray line, were dirty with stained, dried sticky brown debris, including the door handles. The inside of the lowerator/plate warmer used on the meal tray line contained dried food debris. The Kitchen Manager indicated the plate warmer was routinely</p>	F 371			

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F 371	Continued From page 6 cleaned on a weekly basis. The vent located on the right side of the ice machine had a build-up of thick gray lint. The Kitchen Manager stated the ice machine was to be cleaned daily.	F 371		
F 372 SS=E	4. During the kitchen observation on 8/22/12 at 12:32p, there were food items stored in the dry storage room that were not dated and labeled or left open: 1-resealed bag of refried beans; 2-bags of cake mixes; 1-bag of yellow cake mix; 1-bag of brown sugar; 1-bag of confectionary sugar; 1-bag of brownie mix; 3-bags of gravy mix; 3-bags of waffle mix; 1-bag of french onions; 1-bag of sweet potato mix; 6-bags of noodles and 1-unsealed bag of coco mix. Also, there was an unsealed 1/2 cooked ham and 1-resealed bag of shrimp that were not dated or labeled in the walk-in freezer. 483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on 2 of 2 observations, the facility failed to dispose of garbage and refuse by not ensuring 1of 3 garbage dumpsters properly concealed the waste within; and by not ensuring the area surrounding the dumpsters were free from refuse and debris. Findings included:	F 372	Tag F 372 483.35(i)(3) 1. Items identified during recertification inspection were corrected immediately by the Kitchen Manager and Director of Dietary Services. 2. Directed inservice training on proper disposal of garbage and dumpster maintenance was done with the kitchen staff as well as the housekeeping staff by the Director of Dining Services and the Director of Housekeeping Services. 4. An inspection of the dumpster/garbage disposal area will be completed weekly for 3 months and at least monthly going forward as part of our ongoing Quality Assurance program by either the Director of Dietary Services or the Kitchen Manager.	9/20/2012

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F 372	Continued From page 7 During the initial tour of the facility on 8/20/12 at 10:30am, food particles were observed on the ground next to the 3 garbage dumpsters behind the facility. During a second observation of the dumpster area on 8/23/12 at 1:25pm accompanied by the Kitchen Manager, the top lid and one of the side doors were open on 1 of the 3 garbage dumpsters. There were large white bags of garbage protruding from the opened areas of the dumpster. There was an unpleasant odor surrounding the area and several flying bees were observed landing on the trashbags.	F 372		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	Tag F 431 483.60(b), (d), (e) 1. Nurse who left the eye drops at the resident's bedside has been counseled and re-educated on proper procedures for medication storage. 2. Directed inservice training on proper medication storage will be done with licensed nursing staff by our Staff Development Coordinator. 3. Medication pass observations will be done with a random licensed nurse weekly by our Staff Development Coordinator or Nursing Supervisor for 3 months and at least monthly going forward as part of our ongoing Quality assurance program to ensure all medications are stored properly.	9/20/2012

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F 431	<p>Continued From page 8</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interviews the facility failed to store physician ordered medications in a locked compartment and limit access to the medication to authorized personnel for one of ten sample residents (Resident #136).</p> <p>Resident #136 was admitted to the facility 8/10/2012 with diagnoses that included Glaucoma and Hypertension.</p> <p>The Admission Minimum Data Set (MDS) dated 8/17/2012 indicated that resident #136 was cognitively intact. The MDS also noted the diagnosis of Glaucoma.</p> <p>On 8/23/2012 at 8:45 am during a medication administration observation Nurse #1 stated that she would give resident #136 the oral medications and then take out the eye drops for administration. When we entered the room a medication container with a pharmacy label was noted on resident #136's bedside table. Nurse #1</p>	F 431	<p>4. Room inspections of 10 random rooms will be done weekly by either the Administrator, Director of Nursing or Staff Development Coordinator for 3 months and then monthly in conjunction with our Quality Assurance program to ensure no medications are left at the bedside.</p>		

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F 431	<p>Continued From page 9</p> <p>picked it up and asked the resident where she got it. Resident #136 stated that the nurse left it there after she put in the eye drops the night before. Nurse #1 said the medication was resident #136's scheduled medicated eye drops. The label indicated the medication was Combigan 0.2% for drops in both eyes two times a day. The resident stated she had already put the drops into her eyes that morning. Asked if she was allowed to do that Nurse #1 put the container down and said she would have to check on it</p> <p>At 12:00 noon on 8/23/2012, the container with the eye drops was observed sitting on the bedside table in resident #136's room.</p> <p>In an interview on 8/23/2012 at 12:22 pm Nurse #2 was asked if an alert and oriented resident was allowed to keep their own medications, specifically eye drops in their room. Nurse #2 stated that if a resident wanted to administer their own medications, there were assessments that had to be done, forms to fill out, education of the resident had to be completed, and the medication had to be kept in a locked box in the resident's room.</p> <p>At 12:43 pm on 8/23/2012, the container with the eye drops was observed in resident #136's room. Resident #136 was asked if the eye drops were always left in her room. She replied no they were usually put back into the cart. Asked if she signed any forms or consent for keeping the eye drops in her room, she said no she didn't.</p> <p>Nurse Supervisor #1 stated in an interview at 2:40 pm on 8/23/2012 that if a resident wanted to self-administer medications a Request for</p>	F 431			

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F 431	<p>Continued From page 10</p> <p>Self-Administration of Medication form had to be filled out with the resident answering all the questions indicating understanding of the medication, side effects, method and timing of administration. Then the nurse then signed the form, the supervisor signed the form, the physician was notified to write an order for self-administration, and the medication was put into a lock box in the resident's room. Nurse Supervisor #1 accompanied me to resident #136's room and observed the container with the eye drops on the bedside table. Nurse Supervisor #1 took the eye drops to put back in the medication cart.</p> <p>On 8/23/2012 at 3:08 pm the Director of Nurses (DON) stated that if a resident met the criteria by assessment and answering the questions on the Request for Self-Administration of Medication they were checked each month to make sure they still met the criteria. Asked what needed to be done for a resident who met the criteria and wanted to self-administer medications. The DON indicated a consent would be signed, the physician would be notified to write the order and both would be placed on the chart. The self-administration would need to be care planned and a lock box provided in the room. Asked if it was acceptable for a nurse to leave eye drops in the resident's room and allow the resident to put their own eye drops in without an assessment or order, she said no it was not.</p>	F 431			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345506	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED OCT 05 2012 09/20/2012
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NAME OF PROVIDER OR SUPPLIER WHITESTONE A MASONIC AND EASTERN STAR COMMUNITY	STREET ADDRESS, CITY, STATE, ZIP CODE 700 SOUTH HOLDEN ROAD GREENSBORO, NC 27407
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K 000 INITIAL COMMENTS

K 000

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 V construction, one story, with a complete automatic sprinkler system.

The deficiencies determined during the survey are as follows;

K 012 NFPA 101 LIFE SAFETY CODE STANDARD SS=D

K 012

Tag K 012

Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1

The penetrations along the soffit of the loading dock and in the ceiling of the mechanical room will be repaired by 10/15/12.

10/15/12

This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 9/20/12 at approximately noon the following building construction items were observed as non-compliant, specific findings include:

The lead mechanic will check the soffit around the nursing center and the ceiling throughout the nursing center to ensure no other areas need repair by 10/15/12.

A. Penetrations along the soffit of the loading dock.
B. Penetrations around a sprinkler head and other piping in the ceiling of the mechanical room.

The Lead mechanic will monitor the condition of the soffit and ceiling monthly and report on it quarterly thru our Quality Assurance program to ensure there are no penetrations.

Tag K 029

K 029 NFPA 101 LIFE SAFETY CODE STANDARD SS=D

K 029

The kitchen storage room door will be repaired by 10/15/12.

10/15/12

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

The lead mechanic will check the doors throughout the nursing center to ensure no other doors need repair by 10/15/12.

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

TITLE

(X8) DATE

Cicanne Sims King

Administrator

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.

DRS

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

PRINTED: 09/21/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345506	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	OCT 0 30 55 (X3) DATE SURVEY COMPLETED 09/20/2012
NAME OF PROVIDER OR SUPPLIER WHITESTONE A MASONIC AND EASTERN STAR COMMUNITY		STREET ADDRESS, CITY, STATE, ZIP CODE 700 SOUTH HOLDEN ROAD GREENSBORO, NC 27407	
(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)
K 029	Continued From page 1 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: 42 CFR 483.70(a) By observation on 9/20/12 at approximately noon the following hazardous area was observed as non-compliant, specific findings include; the kitchen storage room door did not close tightly in it's frame.	K 029	The Lead mechanic will monitor door closures throughout the nursing center monthly and report on it quarterly thru our Quality Assurance program.
(X5) COMPLETION DATE			