

MAY 31 2013

PRINTED: 05/22/2013
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: 345318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/09/2013
NAME OF PROVIDER OR SUPPLIER BRUNSWICK COVE NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1478 RIVER ROAD WINNABOW, NC 28479	
(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 000	INITIAL COMMENTS	F 000	F - 000 Filing this Plan of Correction does not constitute an admission that the deficiencies alleged, did in fact, exist. This Plan of Correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality resident care.	6/4/2013
F 170 SS=C	<p>There was an amendment to tag 253 on 5/22/13. A corrected 2567 was sent to the facility.</p> <p>483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL</p> <p>The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, the facility failed to deliver mail to residents of the facility on Saturday. (Resident # 97).</p> <p>Findings included:</p> <p>Resident # 97 was originally admitted to the facility on 3/7/11. According to the most recent Minimum Data Set (MDS) dated 3/15/13, Resident # 97 cognition was intact.</p> <p>During an interview on 5/5/13 at 2:30 PM, Resident # 97 revealed the facility did not deliver mail on Saturday. He stated they (residents) received mail on Monday.</p> <p>During an interview on 5/8/13 at 4:50 PM, the Activity Director stated no one delivered mail on Saturday. She revealed she delivered mail on Monday. She said the facility had a post office box and the mailman also delivered mail at the front of the facility. The Activity Director explained that staff in the front office picked up the mail from the post office. She revealed one of the</p>	F 170	<p>1) The Weekend Manager of the Day (MOD) will assure delivery of mail received for Resident #97.</p> <p>2) The nature of the deficiency prohibits identification of affected residents.</p> <p>3) The Weekend Manager of the Day (MOD) will deliver mail to residents within 24 hours of postal delivery. The MOD will document delivery of the mail on the MOD checklist. The Administrator will in-service members of the management team on their responsibility to deliver mail when they serve as MOD.</p> <p>4) The administrator or his designee will monitor by way of review of the MOD checklist and resident interviews, monthly for three months, then at least quarterly, to assure mail is delivered per regulatory requirements. Monitors will be reviewed at scheduled QA Committee meetings. The Administrator will be responsible for overall compliance.</p>	

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



TITLE
Administrator

(X6) DATE

5/27/2013

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 170	Continued From page 1 office staff delivered mail and she also delivered mail to residents of the facility. During an interview on 5/8/13 at 4:55 PM, the Business Office Manager revealed the facility had a mail delivery box at the facility and she went to the post office once a week to pick up mail from the post office box. She revealed that she put the mail in the Activity Director's box to deliver mail to residents. She explained that they delivered mail daily. The Business Office Manager stated there was no mail delivery on Saturday, however, mail was delivered on Monday morning. She stated mail was retrieved for activities to deliver the mail. She revealed sometimes a nurse would get the mail and put it inside the box to be delivered. During an interview on 5/9/13 12:40 PM, the Administrator stated starting Saturday, 5/11/13 a manager would be responsible for ensuring mail delivery. He added this was something that had fallen through the cracks and he would ensure procedures were put in place to correct the problem.	F 170			
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by:	F 246	F246 1) On 5/9/13, the Assistant Maintenance Supervisor replaced the pull chain on the over bed lights to assure access for residents #95 and #49. 2) The Maintenance Supervisor, or his designee, will conduct a review of resident rooms to identify the need for over bed light pull chains. The Maintenance Supervisor will correct areas identified through this review. 3) The Maintenance Supervisor will perform random observation of resident rooms monthly to assure over bed light chains are in place and functioning. 4) The Maintenance Supervisor, or his designee, will monitor through observational	6/4/2013	

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F 246	<p>Continued From page 2</p> <p>Based on observations, record reviews, and interviews with residents and staff the facility failed to provide access to the over the bed light for 2 of 20 residents on the 200 hall. Residents #95 and #49.</p> <p>Findings include:</p> <p>1). Resident # 95 was admitted to the facility in 2008 and was readmitted in April of 2013. The latest Minimum Data Set (MDS) assessment completed for Resident #95 was his reentry in 4/2013. The resident was assessed to be alert and oriented but needed extensive assistance for bed mobility, transfers, dressing, toileting, and hygiene. He could not ambulate and required limited assistance with locomotion and set up for eating. The resident was dependent on staff for bathing.</p> <p>During the initial tour of the facility on 5/6/13 at 11:25 AM Resident # 95 was observed in his room. The resident was lying in his bed with the over the bed light on. The over the bed light pull string was observed to be absent. The only way to turn the light on or off was by a short metal chain approximately 6 inches long which extended from the light.</p> <p>During a second observation on 5/7/13 at 10:00 AM the over the bed light for Resident # 95 revealed no pull string. The resident was sitting up in his wheel chair on the opposite side of the bed from the 6 inch pull chain.</p> <p>A third observation on 5/8/13 at 1:12 PM revealed the resident in bed with the only the 6 inch metal chain attached to the over the bed light. The light</p>	F 246	<p>rounds of resident rooms monthly for three months, then at least quarterly, to assure an over bed light chain is in place. Monitors will be reviewed at scheduled QA Committee meetings. The Administrator will be responsible for overall compliance.</p>		

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F 246	<p>Continued From page 3 was off.</p> <p>A review of the medical record for Resident #95 revealed he had been assessed as a high risk for falls. His last falls assessment was completed 5/5/13.</p> <p>A review of the care plans updated on 5/7/13 for Resident #95 revealed goals and interventions for potential for falls related to weakness, chronic pain, and adverse effects from psychotropic medications. Interventions included, place items frequently used by resident within easy reach to avoid resident reaching for items and give verbal reminders not to ambulate or transfer without assistance.</p> <p>Resident #95 was interviewed during the initial tour of the facility. He stated he was not able to reach the pull cord on his over the bed light because the string had broken off from the short chain. The resident revealed he had to wait for someone to come by and catch their attention to turn the light on or off. The resident stated he had climbed up on the end of the bed and turned the light off or on himself. Resident #95 stated he was not steady on his feet and he should not stand up on the bed but he revealed he got tired of waiting for staff. The resident reported he had told two staff people about the light but no one had fixed it yet.</p> <p>An interview was conducted with Nursing Assistant (NA) #1 on 5/9/13 at 10:55 AM. She stated she knew Resident #95 use to have a long string on his over the bed light chain. She revealed at some point the long pull string just disappeared. NA#1 stated she had turned the</p>	F 246			

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F 246	<p>Continued From page 4</p> <p>light on for Resident #95 a few times but she indicated his light was usually on when she arrived for first shift. The NA revealed she knew how to report a needed repair to maintenance by placing a request slip in the black box at the nursing station.</p> <p>An interview was conducted with the Assistant Maintenance Supervisor on 5/9/13 at 11: 40 AM. He stated all staff employees and department heads were asked to fill out a repair requisition form when they saw a needed repair or a problem. He revealed the requisition forms were kept at each nursing station and staff were to place them in the black mail box when completed. The Assistant maintenance Supervisor stated he checked the mail boxes at each nursing station the first thing each morning and at least twice more during the day. He removed an over the bed light pull chain with string kit from his maintenance cart. He stated he kept them on his cart at all times so he could replace the pull string as soon as he was made aware one was broken. The Maintenance Supervisor stated a new pull kit came with a prescribed chain and a string of about 36 inches. He revealed when he had to replace the string he used a heavy cording and asked the resident how long they wanted their cord to be. He indicated Maintenance makes the replacement cord the length the resident requested. The Maintenance Assistant Supervisor stated many residents could not reach their light chain if the string was broken.</p> <p>During an interview with the Director of Nursing on 5/9/13 at 2:14 PM she stated it was her expectation nursing staff would make Maintenance immediately aware of any needed</p>	F 246			

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F 246	<p>Continued From page 5 repairs they observed.</p> <p>2) Resident # 49 was admitted to the facility in November 2012. The most recent quarterly Minimum Data Set (MDS) was completed on 4/20/13. Resident # 49 was assessed to be moderately impaired in daily decision making skills. He was independent with most activities of daily living and was not steady but could steady himself without human intervention.</p> <p>During the initial tour of the facility on 5/6/13 at 11:30 AM Resident # 49 was not in his room. The over the bed light pull string was observed to be absent. The only way to turn the light on or off was by a short metal chain approximately 6 inches long which extended from the light. The bed positioned so the left side of the bed was flush against the wall. The over the bed light chain was approximately 6 feet from the bed.</p> <p>During a second observation of 5/17/13 at 10:05 AM the over the bed light for Resident # 49 revealed no pull string. The resident was not in the room during the observation.</p> <p>A third observation was conducted on 5/9/13 at 11:30 AM. Resident #49 was observed sitting in his chair by the bed. There was no pull string attached to the 6 inch metal chain connected to his over the bed light.</p> <p>A review of the medical record for Resident # 49 revealed he had been assessed as a high risk for falls. Progress notes revealed the resident was getting weaker, loosing weight, and a steady decline in health was anticipated.</p> <p>A review of the care plans updated on 12/5/12</p>	F 246			

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F 246	<p>Continued From page 6</p> <p>listed goals and interventions for risk of falls due an unsteady gait. The resident was placed in the fall prevention program. Interventions listed included keep frequently used items with in easy reach of the resident to avoid resident reaching for them. The resident was to keep adequate lighting in room to decrease fall risk and the room should be free of safety hazards. The resident was care planned for impaired physical mobility related to weakness.</p> <p>An interview was conducted with Nursing Assistant (NA) #1 on 5/9/13 at 10:55 AM. NA #1 revealed she was assigned to Resident #49 on first shift. She stated she was very familiar with the resident and had been at the facility for two years. The NA revealed she knew how to report a needed repair to maintenance by placing a request slip in the black box at the nursing station.</p> <p>An interview was conducted with Resident #49 on 5/9/13 at 11:30 AM. The resident stated he could not reach the pull for the over the bed light from either his bed or his chair. The resident revealed he could certainly turn his light on and off better if he did not have to get up and walk over to the light to use the short chain. He stated it was a big effort sometimes just to get out of his chair. Resident #49 revealed he had told two people on staff his light string was gone. He could not remember who he had told.</p> <p>An interview was conducted with the Assistant Maintenance Supervisor on 5/9/13 at 11: 40 AM. He stated all staff employees and department heads were asked to fill out a repair requisition form when they saw a needed repair or a</p>	F 246			

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F 246	Continued From page 7 problem. He revealed the requisition forms were kept at each nursing station and staff were to place them in the black mail box when completed. The Assistant maintenance Supervisor stated he checked the mail boxes at each nursing station the first thing each morning and at least twice more during the day. He removed an over the bed light pull chain with string kit from his maintenance cart. He stated he kept them on his cart at all times so he could replace the pull string as soon as he was made aware one was broken. The Maintenance Supervisor stated a new pull kit came with a prescribed chain and a string of about 36 inches. He revealed when he had to replace the string he used a heavy cording and asked the resident how long they wanted their cord to be. He indicated Maintenance makes the replacement cord the length the resident requested. The Maintenance Assistant Supervisor stated many residents could not reach their light chain if the string was broken. During an interview with the director of Nursing on 5/9/13 at 2:14 PM she stated it was her expectation nursing staff would make Maintenance immediately aware of any needed repaired they observed.	F 246		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility	F 253	F253 -- 1) The Housekeeping Supervisor placed a new mattress on Resident #49's bed on 5/9/13. 2) The Housekeeping Supervisor will conduct a review of resident rooms to identify and replace mattresses showing cracks, tears, or excessive wear. 3) The Housekeeping Supervisor will in-service the Housekeeping staff on their responsibility to report mattresses in need of replacing. The Housekeeping Supervisor will perform random observations of mattresses at	6/4/2013

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F 253	<p>Continued From page 8</p> <p>failed to provide a mattress with an intact cover for 1 of 1 resident mattress observed. Resident # 49.</p> <p>Findings include:</p> <p>Resident # 49 was admitted to the facility in November 2012. The most recent quarterly Minimum Data Set (MDS) was completed on 4/20/13. Resident # 49 was assessed to be moderately impaired in daily decision making skills. He was independent with most activities of daily living and was not steady but could steady himself without human intervention.</p> <p>Resident #49 was observed on 5/9/13 at 11:30 AM sitting asleep in his chair by the bed. The resident stated he did not like the mattress on his bed. Resident #49 revealed the mattress on his bed was torn and had been "patched" with tape. He stated he could feel the torn tape when he lay on his bed.</p> <p>An observation was made of Resident #49's bed. The bed was observed to be positioned so the left side of the bed was flush to the wall. The resident pulled the bedding back and revealed the cover on the mattress was cracked in multiple places down the left side. An area approximately 8 inches long and the width of the mattress had been torn away and the inner foam of the mattress was exposed. No tape was observed on the mattress.</p> <p>Resident #49 stated he slept on his right side and he could feel the cracked mattress cover while in bed. The resident revealed he had told several staff members his mattress was torn but he had</p>	F 253	<p>least monthly to identify and replace mattresses as indicated.</p> <p>4) The Housekeeping Supervisor, or her designee, will monitor through observational rounds of resident rooms monthly for three months, then at least quarterly, to assure a sanitary, orderly, and comfortable interior. Monitors will be reviewed at scheduled QA Committee meetings. The Administrator will be responsible for overall compliance.</p>		

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F 253	<p>Continued From page 9</p> <p>not been able to get a new mattress. The resident stated staff changed his sheets and made his bed every day so he knew they had seen the exposed "stuffing" .</p> <p>An interview was conducted with Housekeeper #1 on 5/9/13 at 1:42 AM. She stated she sprayed down Resident #49's mattress each day when she cleaned his room if the sheets were off the bed. She revealed she did that for every bed on the hall during her daily cleaning. The Housekeeper stated once a month each room was deep cleaned. She revealed during the monthly deep cleaning the mattresses were taken off the bed frames, disinfected, and the bed was dusted. The Housekeeper stated she was not aware the mattress was torn and she revealed Resident #49 had never told her his mattress was damaged. The Housekeeper stated her department was in charge of changing out mattresses and cleaning them.</p> <p>During an interview with Nursing Assistant (NA) #1 on 5/9/13 at 2:35 PM she stated Resident #49 had never told her his mattress was torn on the left side. She revealed she changed the resident's sheets as needed and made his bed each day. The NA revealed she was routinely assigned to Resident #49 but she was not aware of any damage to his mattress. The NA stated when she was aware a mattress was damaged she reported it to Housekeeping so a new mattress could be exchanged out.</p> <p>An interview was conducted with the facility Housekeeping Supervisor on 5/9/13 at 3:45 PM. She stated it was her expectation Housekeeping Staff would replace any damaged mattresses</p>	F 253			

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F 253	Continued From page 10 they found while cleaning and that nursing staff would report any damaged mattresses they observed to Housekeeping Services. During an interview with the Director of Nursing on 5/9/13 at 2:14 PM she stated it was her expectation nursing staff would be aware of any damages to a resident's mattress as they provided morning care and changed out bed linens. She revealed nursing staff should report any observed damages to Housekeeping.	F 253		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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, staff interviews and record review the facility failed to maintain the hood vents and ansul rods free from grease and dust build up. The findings include: A review of the 2005 dated Policy and Procedure Manual titled, Cleaning Instructions, Cleaning Hoods and Filters reads as follows: "Policy: Stove hoods and filters will be cleaned according	F 371	F 371 – 1) Individual residents were not identified in the CMS-2567. The Dietary Manager assured the hood was cleaned on 5/14/13. 2) The nature of the deficiency prohibits identification of affected residents. 3) The Dietary Manager will develop a cleaning schedule for the hood system. The Dietary Manager will in-service the dietary staff on the hood system cleaning schedule. The Dietary Manager will conduct at least weekly observations to assure the hood system is clean. 4) The Dietary Manager will monitor through observation, monthly for three months, then at least quarterly, to assure the hood system is clean. Monitors will be reviewed at scheduled QA Committee meetings. The Administrator will be responsible for overall compliance.	6/4/2013

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345318	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/09/2013
NAME OF PROVIDER OR SUPPLIER BRUNSWICK COVE NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1478 RIVER ROAD WINNABOW, NC 28479	
(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 371	<p>Continued From page 11</p> <p>to cleaning schedule, or at least monthly.</p> <p>Procedure:</p> <ol style="list-style-type: none"> 1. Remove screens from hoods. 2. Place in soapy water in the sink. Scrub thoroughly. Rinse. (Or run through the dish machine if appropriate). 3. Remove and let screens air dry. 4. Replace screens over stove. 5. To clean interior and exterior of hood, use a clean cloth soaked in soapy detergent water. Rinse thoroughly and air dry. A more abrasive cleaning agent may be needed in some cases. A cleaning agent that can handle grease may be needed in some cases." <p>During the initial kitchen tour on 5/6/13 at 11:16 AM the hood vents and ansul rods located above the stove top, flat grill and deep fat fryer were observed with a golden film of grease and dust build up.</p> <p>During a second observation on 5/8/13 at 3:55 pm the hood vents and ansul rods were observed in the same condition. A third observation on 5/9/13 at 9:30 AM revealed the hood vents and ansul rods were in the same condition.</p> <p>An interview with the Dietary Manager on 5/9/13 at 9:35 AM, she stated we have a service that comes out regularly to clean the hood system. She indicated we do take the filters down and run through the dish machine.</p> <p>Review of the Daily Cleaning Schedule: Cook duties line 6 reads "Vent Hood, inside and out"</p> <p>Record review of the completed Daily Cleaning Schedule/ cook sheets dated 5/8/13 to 4/29/13</p> 	F 371		

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F 371	Continued From page 12 and 4/28/13 had check marks beside " Vent Hood, inside and out ". The Dietary Manager revealed the checkmarks indicate the hood vents were cleaned. Interview with the Dietary Manager on 5/9/13 at 9:45 AM she indicated Vent hood inside and out does mean the filters should be cleaned. It is the cook's responsibility to clean the filters daily. She indicated staff were taking the filters down and outside to clean immediately.	F 371			

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NAME OF PROVIDER OR SUPPLIER BRUNSWICK COVE NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1478 RIVER ROAD WINNABOW, NC 28479	DATE JUN 28 2013
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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 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.	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by:	K 018	K018 1) "resident room door 405" hinge was adjusted for proper closure 6/5/2013 "storage room door in kitchen" cam was replaced 6/5/2013 "pantry room door in kitchen" repaired 6/5/2013 "nurse station door on the 200 hall" repaired on 6/5/2013 2) Maintenance supervisor or designee will inspect doors for proper closure. 3) Administrator will monitor for compliance. 4) Monitoring will be reviewed at scheduled QAPI Committee meetings. 5) All repairs/replacements done on 6/5/2013	6/5/13

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CONSTRUCTION SECTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *6/20/13*

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 018	Continued From page 1 Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: doors that would not close and latch for smoke tight seal at time of survey are: 1. resident room door 405 2. storage room door in kitchen. 3. pantry room door in kitchen. 4. nurse station door on 200 hall.	K 018		
K 029 SS=E	42 CFR 483.70(a) 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: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: lounge room on 200 hall is being used as a storage room. Door is not self closing. 42 CFR 483.70(a)	K 029	K029 1) Self closure hinge was placed on door on 6/5/2013 2) Maintenance supervisor or designee will inspect doors for proper closure. 3) Administrator will monitor for compliance. 4) Monitoring will be reviewed at scheduled QAPI Committee meetings. 5) All repairs/replacements done on 6/5/2013	6/5/13

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K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: exit access was not a solid path (easily maintained in inclement weather) to a public way (exit from 500 wing).	K 038	K038 Request extension to September 3, 2013 to get competitive bids and for the paving to be completed.	
K 062 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: sprinkler heads in laundry room have excess lent on sprinkler bulb. 42 CFR 483.70(a)	K 062	K062 1) A cleaning schedule has been developed for the cleaning of the laundry room sprinkler heads. Laundry staff has been in serviced on the cleaning schedule and the importance of keeping sprinkler heads clean. 2) Maintenance supervisor or designee will inspect sprinkler heads for compliance 3) Laundry supervisor will monitor. 4) Monitoring will be reviewed at scheduled QAPI Committee meetings. 5) 6/6/2013	6/6/13

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K 069 SS=E	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: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: the deep fat fryer in kitchen area is without the required splash guard.	K 069	K069 1) Splash guard placed on deep fat fryer 2) Dietary manager or designee will monitor kitchen for other non compliance issues. 3) Dietary manger to monitor 4) Monitoring will be reviewed at scheduled QAPI Committee meetings. 5) 6/18/2013	6/18/13
K 076 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: empty oxygen cylinders were stored with	K 076	K076 1) In serviced all nursing staff on the proper handling/storage of O2 cylinders 2) Daily (per shift) audit tool will be in place for nurses to initial each shift that O2 cylinders are stored properly. 3) Administrative staff will round and monitor for compliance. 4) Monitoring will be reviewed at scheduled QAPI Committee meetings. 5) 7/1/2013	7/1/13

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K 076	Continued From page 4 full cylinders in oxygen storage room on 300 hall.	K 076		
K 147 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: objects being stored on light fixtures in rooms, 205 and 213. 42 CFR 483.70(a)	K 147	K147 1) Starting with rooms 205 and 213 all objects being stored on light fixtures were removed. 2) Administrator, DON, and Maintenance Supervisor will monitor for compliance. 3) Storage of items on light fixtures will be monitored by administrative staff 4) Monitoring will be reviewed at scheduled QAPI Committee meetings. 5) 6/6/2013	6/6/13