

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

12/5/13
PRINTED: 11/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345011	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 10/24/2013
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NAME OF PROVIDER OR SUPPLIER BRIAN CENTER NURSING CARE/LEXI	STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292
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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
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews and record reviews the facility failed to provide water within reach for 1 of 35 sampled residents (Resident #1) and provide a call bell within reach for 2 of 35 sampled residents (Resident #52 and Resident #58)</p> <p>The findings included:</p> <p>1. Resident #1 was admitted on 7/5/1994 with diagnosis of Mental Retardation, Acute Renal Failure, Hypotension, Urinary Retention and Hypoglycemia, Diabetes Type 2.</p> <p>The most recent MDS (Minimum Data Set) dated 9/23/13 revealed Resident #1 needed supervision with eating and a urinary tract infection in the last 30 days. The Care Area Assessment triggered Dehydration/Fluid Maintenance.</p> <p>The care plan dated 10/13/13 revealed Resident #1 was at risk for fluid deficit related to medications and dysphagia and would have adequate hydration levels as evidenced by moist mucosa, adequate</p>	F 246	<p>The facility will continue to strive to provide services that are reasonable accommodations of the individual needs and preferences, except when the health and safety of the individual or other residents would be endangered.</p> <p>F246 Resident #1 was observed on 10/24/13 to have filled water pitcher at bedside with cups. Resident #1 care plan was reviewed by interdisciplinary team and care plan was updated to reflect behaviors related to pouring water pitcher out on floor.</p> <p>Resident #52 was re-evaluated by Occupational therapy to ensure that Resident had appropriate call light Devices. On 10/24 call light was Observed to be in reach of Resident #52 by Director of Nursing. Resident #52 care plan was reviewed and updated to include frequently monitoring for needs.</p> <p>Resident #58 was observed on 10/24/13 to have call light within reach</p> <p>The facility interdisciplinary team reviewed each facility resident to ensure that appropriate call light devices were in place, functioning and present at bedside on 10/25</p>	10/24/13 10/24/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Shonda Wingate* TITLE: *CNHA* (X6) DATE: *12-2-13*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their 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 246	<p>Continued From page 1</p> <p>urinary output and supple skin. The approaches included to provide liquids at consistency ordered by physician and Regular diet.</p> <p>The Nutritional Therapy Review dated 10/8/13 indicated that increased fluid was provided due to lasix use and increased (BUN) Blood urea Nitrogen. On 9/25/13 BUN value was 32 (normal range 6-23).</p> <p>Review of the Medication Administration Record for October 2013 revealed Resident #1 was a Dehydration Risk and required 8 ounces of fluids four times a day and med plus 2.0 three times a day.</p> <p>Observation of Resident #1 on 10/21/13 at 1:30 PM revealed Resident #1 in bed with no water at bedside.</p> <p>Observation on 10/22/13 at 9:15 AM revealed an empty water pitcher on over bed table at bedside. Resident #1 was in day room.</p> <p>Observation on 10/22/13 at 11:25 AM revealed Resident #1 was in room with no water at bedside.</p> <p>During an interview with Resident #1 on 10/22/13 at 11:45 AM, resident requested to lie down and requested water, the water pitcher was empty. Resident #1 lips and tongue were noted to be dry. Facility staff was notified of Resident #1's request and water was provided.</p> <p>Observations on 10/22/13 at 2:09 PM revealed Resident #1 in bed and ice</p>	F 246	<p>The facility interdisciplinary team reviewed each facility resident to ensure that residents requiring water pitchers had them available at bedside on 10/25.</p> <p>The facility direct care staff was provided re-education related to facility practice regarding providing fresh water at bedside each shift, to include cups and straws if indicated. The direct care staff was also provided re-education to ensure that each resident has appropriate call light devices and that it is within reach of the resident on 10/28 and completed on 11/4/13 by facility DON/Weekend Coordinator. Newly hired direct care staff will receive the education during orientation.</p> <p>The facility ambassador and Weekend Coordinator will complete facility rounds daily, at various times to ensure that call lights and fresh water are present at the resident bedside for the next 30 days.</p> <p>The facility ambassador will discuss findings with DON. The DON will report findings to facility Quality Improvement Performance Committee weekly times four and monthly thereafter. The findings will be reviewed for trends.</p>	12/18/13	12/18/13

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F 246	<p>Continued From page 2</p> <p>water provided at bedside. On 10/23/13 at 2:30 PM Resident #1 was in bed, water was out of reach and no cup available. On 10/24/13 at 8:25 AM, Resident #1 was in dining room eating breakfast independently with tomato juice, orange juice, coffee and milk provided for fluids.</p> <p>During an interview with NA #1 on 10/23/13 at 9:55 AM indicated that he was not aware of how often fresh water was provided to the residents, he indicated that he was new and would find out the information. NA #1 later revealed that fresh water is provided every shift and as needed.</p> <p>During an interview with the CMA #1 on 10/24/13 at 1 40 PM revealed that resident care needs and changes are communicated during report at shift change and on the RCS sheets (Resident Care Specialist Assignment Sheets). CMA #1 further indicated that extra fluids are provided to Resident #1 because he is a dehydration risk and it is noted on the MAR to provide 8 ounces of fluids four times a day with medications.</p> <p>The DON indicated during an interview on 10/24/13 at 2:00 PM that her expectations were that the residents should have fresh water provided and in reach every shift and as needed unless they have fluid restrictions or have thickened liquids. She further indicated that Resident #1 has a tendency to pour his water out in the floor.</p>	F 246		
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F 246	<p>Continued From page 3</p> <p>2. Resident #52 was admitted to the facility on 2/12/13 with the diagnosis including Pneumonia, Diabetes, Hypertension and Stroke.</p> <p>The MDS dated 8/8/13 assessed Resident #52 as requiring total assistance with ADL 's (Activity of Daily Living), incontinent of bowel and bladder and unable to walk. Resident had some impairment with recall of month and year, no problems with recall.</p> <p>Resident #52 's care plan dated 2/26/13 for problems of falls and transfers included an approach to keep call light in reach.</p> <p>During an observation on 10/22/13 at 10:57 AM the call bell was noted to be attached to right side rail and hanging down to floor. On 10/23/13 at 1:05 PM the call bell was draped over the top of the right side rail and extended below the bottom of the rail with the flat part of the call bell resting on the seat of a chair beside the bed. The resident was turned to the right, but the call bell was out of her reach. On 10/24/13 at 1:00 PM the call light was draped over bottom of the side rail and the call light was out of Resident #52 's reach.</p> <p>An interview with NA #2 on 10/24/13 at 1:41 PM revealed that she was not sure if Resident #52 could use her call light and that staff go in room and anticipate her needs, she has never known resident to use</p>	F 246		
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F 246	<p>Continued From page 4</p> <p>the call light and further indicated that she normally puts the call light beside her on the bed, but did not when she repositioned her at lunch.</p> <p>3. Resident #58 was admitted to the facility on 8/31/10 with diagnosis including Stroke, Hypertension, Chronic Kidney Disorder and Hemiplegia.</p> <p>The MDS dated 8/1/13 assessed the resident as requiring extensive assistance of one person for ADL ' s. Resident had some memory impairment with short and long term memory.</p> <p>The care plan dated 6/6/13 revealed a problem of falls and included an approach to " Place the call light within reach " A problem dated 6/6/13 for Potential for injury, impaired ability to self transfer related to: weakness, gait/balance, history of falls, mental status and status post cerebral vascular accident included an approach to place call light within reach, encourage resident to obtain assistance for transfers.</p> <p>During an observation on 10/21/13 at 1:45 PM revealed Resident #58 ' s call light to be hanging behind his bed and not in reach. On 10/22/13 at 9:19 AM the call light was out of reach and sitting on room mates bed side table. At 11:18 AM on 10/22/13 the call light was still out of reach and sitting on room mates bedside table, Resident #58 indicated during this time that he could not reach the</p>	F 246			

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F 246	Continued From page 5 call light and he would yell for help if needed. During an observation on 10/23/13 at 1:06 PM revealed the call light was on the left side of the mattress beside the resident. Interview with the visitor revealed she had asked staff to place the call light on the bed. The call light had been on the floor, out of residents reach. Interview with the visitor revealed this happens often when she visited and she visits a few times a week. Observation on 10/24/13 at 7:58 AM revealed Resident#58 had his call light hanging from the side rail and was out of reach. During an interview with NA #2 on 10/24/13 at 1:41 PM revealed that Resident #58 does use his call light when he wants water. He can reach it if it is kept on his bed or on the chair beside his bed. An interview with the DON on 10/24/13 at 3:30 PM revealed that her expectations were that call lights should be kept in reach for residents.	F 246		
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	F 371		

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F 371	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired single serving milk cartons from use in the walk in refrigerator, failed to date food when opened and failed to store opened food items to keep out air in the walk in refrigerator, walk in freezer and dry storage area. The findings included: Observations on 10/21/13 at 10:30 AM with the dietary manager revealed 31 of 33 single serving milk cartons had expired on 10/20/13. The milk cartons were stored in two milk crates ready for use in the walk in refrigerator. The dietary manager removed the expired milk with signage indicating staff was not to use the milk. Interview on 10/21/13 at 10:35 AM with the dietary manager revealed the milk should be checked each day and expired milk should be removed from use. Observations on 10/21/13 at 10:33 AM with the dietary manager revealed a zip lock bag of cheese had been opened, and was not wrapped, nor was the zip lock bag secured to prevent the food from being open to air. A box of processed cheese had been opened. The lid to the box was not secured and the cheese had not been wrapped to prevent the food from being open to air. Two zip lock bags of sandwiches and a cup of peaches were not dated.	F 371	F371 The facility will continue to strive to store, prepare, distribute and serve food under sanitary conditions. On 10/21/12, the Dietary Manager removed 31 cartons of milk from the walk in refrigerator On 10/21/13 the Dietary Manager removed and disposed of one zip lock bag of cheese, box of processed cheese, two zip lock bagged sandwiches, cup of peaches, zip lock bag of frozen French toast and three zip lock bags of opened cereal. On 10/21/13, the Dietary Manager cleaned the meat slicer. The facility dietary staff was provided re-educated regarding procedure for checking and removing items that are identified with expired dates. The staff were also provided re-education regarding labeling, dating and ensuring that items are placed in air tight sealed bag or containers when not in use. Education provided by Dietary Manager on 10/22/13. Newly hired dietary staff will be provided education during orientation. Dietary Manager or facility cook will complete kitchen inspection daily to ensure that products are being used prior to expiration date and expired items have been disposed of times thirty days.	12/18/13	

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F 371	Continued From page 7 Observations on 10/21/13 at 10:45 AM with the dietary manager revealed a zip lock bag of frozen French toast was open to air. Observations on 10/21/13 at 10:50 AM in the dry storage revealed 3 zip lock bags of opened cereal. The zip lock bag was not secured and the food was open to air. One of the three bags of cereal had not been dated when opened. Interview on 10/21/13 at 10:53 AM with the dietary manager revealed the food items should be kept sealed and dated when opened. Observations on 10/21/13 at 11:00 AM revealed the meat slicer had dried food debris at the base of the slicer. Observations on 10/24/13 at 7:45 AM with the dietary manager revealed the meat slicer had dried food debris at the base of the slicer. Interview on 10/24/13 at 7:48 AM with the dietary manager revealed kitchen equipment was on a cleaning scheduled. She was not aware it had not been cleaned. Interview on 10/24/13 at 4:00 PM with the corporate dietary consultant revealed the milk cartons should have been checked and removed. The items in the walk in refrigerator and freezer should be checked daily by the dietary manager to ensure the staff was following the manager ' s expectations.	F 371	Dietary Manager or facility cook will complete sanitation rounds to ensure that facility equipment is clean and stored appropriately times thirty days. The facility Dietary Manager will report findings of inspections to Quality Improvement Performance Committee weekly times four weeks, monthly thereafter. The findings will be reviewed for trends.	12/18/13 12/18/13	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441			

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F 441	<p>Continued From page 9</p> <p>interviews with staff, the facility failed to follow infection control practices to prevent cross contamination for 1 of 1 resident (Resident # 91) on contact precautions.</p> <p>Findings included:</p> <p>The Contact Precautions policy dated 2012 stated, "It is the intent of this facility to use contact precautions in addition to standard precautions for residents known or suspected to have serious illnesses easily transmitted by direct resident contact or by contact with items in the resident's environment." It further stated, "Gloves should be worn when entering the room and while providing care for the resident. Gloves should be removed before leaving the resident's room and hand hygiene should be performed immediately."</p> <p>The Clostridium difficile (c-diff colitis) fact sheet dated 2012 stated, "Wash hands with soap and water. Do not use an alcohol handrub."</p> <p>Resident #91 was admitted on 4/30/13. Her diagnoses included chronic obstructive pulmonary disease and clostridium difficile.</p> <p>The physician assessment dated 10/3/13 indicated the resident was noted with multiple loose stools on 10/2/13, had a history of clostridium difficile, and was placed on contact isolation.</p> <p>The lab report dated 10/3/13 indicated Resident #91 was positive for clostridium difficile and stated, "Initiate contact isolation if patient is in a healthcare setting."</p> <p>The physician assessment dated 10/22/13 stated</p>	F 441	<p>F 441</p> <p>The facility will continue to strive to establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection</p> <p>F441</p> <p>Resident #91 reviewed on 10/25/13 by attending physician and found no longer to require contact precautions.</p> <p>Nurse #1 was provided re-education on 10/25/13 by facility DON regarding equipment required to adhere to contact precautions and appropriate hand washing.</p> <p>The facility staff were provided re-education regarding procedure for adhering to contact precautions on 10/28/13 and completed on 11/4/13 by DON and Weekend Coordinator.</p> <p>The facility DON and Weekend Coordinator will complete 1-2 random observation of care being provided to residents identified with contact precautions times four weeks and bi-monthly times one.</p>	12/18/13
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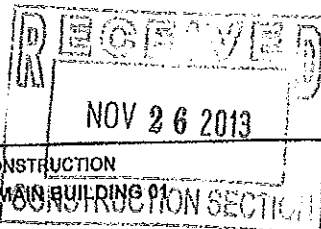
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F 441	<p>Continued From page 10</p> <p>Resident #91 was "currently on Vancomycin second to c-diff colitis" and should "continue Vancomycin and monitor."</p> <p>The nurse's note dated 10/22/13 stated Resident #91 "had some loose stool this am."</p> <p>On 10/23/13 at 11:22 am Nurse #1 was observed entering Resident #91's room. The resident was receiving a nebulizer treatment. A cart of personal protective equipment was in the hallway to the left of the door, and a contact precautions sign was on the door. The nurse went into the room, was not wearing gloves, took the nebulizer mask off the resident, rinsed out the medication reservoir, and stored the mask, reservoir and tubing. The nurse did not wash her hands or use hand sanitizer. Nurse #1 pushed the resident in her wheelchair out of the room and down the hallway while simultaneously pulling the medication cart behind her. She left the medication cart at the nurse's station and continued to push Resident #91 down the hallway to the main dining room.</p> <p>During an interview on 10/23/13 at 11:26 am Nurse #1 stated, "I should have worn gloves to take off and rinse her mask and should have washed my hands after disconnecting her [nebulizer]. I did not do that, but am going to do that now."</p> <p>During an interview on 10/23/13 at 11:32 am the Director of Nursing indicated she was the coordinator of the facility's infection control program, would expect staff to wear gloves when providing care for a resident on contact precautions, and expect staff to wash their hands with soap and water after providing care.</p>	F 441	<p>The facility DON will report findings on observation to Quality Improvement Committee weekly times four and bi monthly times one.</p>	12/18/13
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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: 345011	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING <i>CONSTRUCTION SECTION</i> B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2013
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NAME OF PROVIDER OR SUPPLIER BRIAN CENTER NURSING CARE/LEXI	STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292
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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
K 000	INITIAL COMMENTS 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 facility is Type V (111) protected construction utilizing North Carolina Special locking arrangements, and is equipped with a complete automatic sprinkler system.	K 000	K012 Correction for the alleged deficient practice noted as "hole behind the door to the 200 hallway unit manager office where door knob was hitting wall"- was immediate repair of the noted hole. A door stop was installed to prevent future occurrence. The Maintenance Director surveyed the remainder of the building to locate and repair any like instances with any negative findings reported immediately to the Administrator. The Maintenance Director will continue with this type survey monthly for the next three months with a summary of all these findings presented to and discussed during those corresponding monthly Safety Committee meetings. Reviews will then continue quarterly thereafter until next annual survey. Completion date of 11/15 2013	11-15-13
K 012 SS=D	CFR#: 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 11/14/2013 the following Life Safety Item was observed as noncompliant, specific findings include: There as a hole behind the door to the 200 hallway unit manager office where the door knob was hitting the wall.	K 012	K029 Correction for the alleged deficient practice noted as "unsealed penetration in the rated ceiling in the dry storage room around the second sprinkler head"- was to seal around affected head with an appropriate sealant to restore proper ceiling rating. The Maintenance Director will do a walk through of the remainder of the building to locate any other unsealed penetrations in rated ceilings and repair upon discovery. The Maintenance Director will do monthly checks for the next three months to maintain continued compliance and report all findings for discussion at those corresponding Safety Committee meetings. Reviews will then continue quarterly thereafter until next annual survey. Completion date of 11/15/2013	11-15-13
K 029 SS=D	CFR#: 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	K 029	K038 Correction for alleged deficient practice noted as "means of egress leading to the service hallway in both directions was reduced from 8 feet by plastic construction dust control barriers." - was immediate removal of barriers. The Maintenance Director will assess and determine appropriate dust control in future to maintain proper 8 feet of clearance for egress if need in any corridor. All determinations will be presented to the Safety Committee and facility's Div Dir of Facility Engineering for input and discussion before proceeding with barriers for dust control and maintaining proper egress. Correction date of 11/14/2013	11-14-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Shonda L. Wingate* TITLE *Administrator* (X6) DATE *11-20-13*

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345011	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/14/2013
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER NURSING CARE/LEXI			STREET ADDRESS, CITY, STATE, ZIP CODE 279 BRIAN CENTER DRIVE LEXINGTON, NC 27292	
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K 029	Continued From page 1 doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 11/14/2013 the following Life Safety item was observed as noncompliant, specific findings include: There were unsealed penetrations in the rated ceiling in the dry storage room around the second sprinkler head.	K 029		
K 038 SS=E	CFR#: 42 CFR 483.70 (a) 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: Based on the observations and staff interviews on 11/13/2013 the following Life Safety item was observed as noncompliant with the means of egress, specific findings include: The means of egress leading to the service hallway in both directions was reduced from eight (8) feet by plastic construction dust control barriers.	K 038		
	CFR#: 42 CFR 483.70 (a)			