STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345491	A. BUILDING _____ B. WING _____	11/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROATAN RIDGE NURSING AND REHABILITATION CENTER	210 FOXHALL ROAD NEWPORT, NC 28570

(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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to notify a resident ' s physician and the resident's responsible party for	F 157	Croatan Ridge Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Croatan Ridge's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Croatan Ridge Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on	11/29/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Penny Sproul — TITLE: Administrator — (X6) DATE: 11-22-60

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.

AG

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F 157	Continued From page 1 a change in mental status for 1 of 1 sampled residents (resident #54) who made verbal statements regarding wanting to die. Findings included: Review of the clinical record of resident #54 indicated the resident was admitted into the facility on 2/11/2013. The resident's admission diagnoses included Depressive Disorder. Review of the admission Minimum Data Set (MDS) dated 2/18/2013 indicated the resident had mild cognitive impairment. Record review of a nursing note dated 7/30/2013 at 12:23 AM the following: "resident refused PM meds this shift, resident stated, "I don't want to take them because I just want to die." This nurse sat and talked to resident for a few minutes and informed resident on importance of taking meds. Resident stated, "I don't care, I'm not taking them." Resident told this nurse that he said he wanted to die because he wanted to go home, and his wife won't let him. This nurse made sure resident was safe and had no suicidal thoughts. Left room in low position and bed alarm in place. Call bell in reach." The note was signed by staff nurse #2. Upon review of nursing notes, the next note documented in the record was on 7/30/2013 at 6:27 AM and indicated: Resident refused AM meds due to reasons discussed in previous note. Continue to monitor." In an interview on 10/31/2013 at 3:45 PM with staff nurse #2 who documented the incident on 7/31/2013, the nurse indicated the resident told	F 157	this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F157 483.10(b)(11)Notify of Changes (Injury/Decline/Room, etc) Resident #54 has adjusted to facility and there have been no other episodes of resident stating "wanting to die" or refusals of treatment. 100%of residents currently in the facility have been reviewed and/or interviewed for statements and/or behaviors, such as refusals for treatment. Any issues were addressed at that time using a QI tool by DON and QI Nurse completed on November 27, 2013.	12/28/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345491	A. BUILDING _____ B. WING _____	11/01/2013

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CROATAN RIDGE NURSING AND REHABILITATION CENTER	210 FOXHALL ROAD NEWPORT, NC 28570

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F 157	Continued From page 2 her twice during the incident that he wanted to die. The nurse further reported she remained in the resident's room until he had more positive thoughts. She reported she left the resident's call bell in reach before she exited his room. She also stated did not notify anyone at that time, as she felt the resident was safe when she left his room. She indicated she reported the incident to the oncoming day staff, staff nurse #3, at change of shift. The nurse also indicated the information was relayed to the Social Worker via other nurses. In an interview with the Social Worker (SW) on 10/31/2013 at 3:45 PM, the SW indicated he had no knowledge of the incident until today's date. In an interview with the Director of Nursing (DON) on 10/31/2013 at 4:00 PM, the DON indicated she had no knowledge of the event until 10/31/2013. The DON reported the expectation based on review of the nursing note was the nurse should have reported it via phone to the DON immediately. In an interview on 11/01/2013 at 10:30 AM, staff nurse #3 was interviewed. The nurse reported she was the day shift nurse on duty the morning of 7/30/2013 and got report from staff nurse #2. The nurse stated that she was never told by staff nurse #2 that resident #54 made statements during the night that he wanted to die and was unaware of the event until today ' s date. In an interview with the facility administrator on 11/01/2013 at 11:00 AM, the administrator stated based on the documentation on 7/30/2013, the nurse on duty should have called the administrator immediately when resident #54	F 157	100% in-servicing of all nursing staff on immediately reporting to appropriate person(s) of statements regarding "wanting to die", refusal of treatment, change in condition, etc. This was done by QI Nurse and completed 11/27/2013 on. Monitor 24 hour reports daily for documentation of refusals of treatment, inappropriate statements and change in condition by the DON/Administrator/MDS Nurse. The Executive QI committee will meet monthly X3 to review trends and/or issues and to determine the continued need and frequency of monitoring.	

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F 157	Continued From page 3 made statements that he wanted to die.	F 157		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to act on a verbal grievance for 1 of 1 sampled residents (resident #54). Findings included: Record review of the facility grievance policy dated 1/24/2012 indicated "The Administrator is responsible to ensure that their facility has established and maintains open lines of communication to our customers. It is imperative that concerns and grievances from residents and/or family members are expressed freely, referred to the appropriate staff members, investigated timely and corrective measures instituted as appropriate." The following guidelines should be established and implemented: 1. Any staff member can receive a resident concern from a resident or family member. The staff member will complete a resident concern form at the time the concern is expressed, immediately inform their supervisor or department head, i.e. DON, SW, etc. When the concern or incident has occurred during the visitation time or during the shift reported, the	F 166	F166 483.10(f)(2)Right to Prompt Efforts to Resolve Grievances Resident #54 has been interviewed and states there have been no other issues that have not been addressed to resident's satisfaction at this time. 100% of all residents/responsible parties have been interviewed to insure all concerns have been addressed. Any issues were taken care of at that time. This was done by the Social Worker and completed on 11/27/2013 100% in-servicing of staff on the correct policy and procedure for resident concerns by QI Nurse and completed on 11/27/2013. Documentation of current residents will be	11/29/13

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F 166	Continued From page 4 supervisor should investigate and strive to resolve the concern promptly. Review of the resident's clinical record indicated the resident was admitted into the facility on 2/11/2013. Review of the admission Minimum Data Set (MDS) dated 2/18/2013 indicated the resident had mild cognitive impairment. Review of nursing notes from 2/11/2013 through 8/82013 indicated the resdient was able to make his needs known. Review of a nursing note dated 8/8/2013 revealed the following " I was in resident ' s room when he sat up in bed and became angry that the floor was being polished at 2130 (9:30PM). He said he was going out there to stop it. I followed him into the hallway, and he began calling another employee an a***(expletive) and telling him to stop. He stated that it was stupid to be polishing the floor at this time of night. Employee stated the administrator told him to get it done, but he had just finished the kitchen and was now going to do it. The resident then raised his hand and made a fist and began to make threatening remarks like he was going to hit the employee. At this point a CAN came to the areas, and we both talked the resident into going back to his room. He was medicated for anxiety. " The note was signed by staff nurse #1. Review of an of an incident report of the 8/8/2013 event focused on the resident ' s behavior and included the nursing note.	F 166	reviewed to assure all concerns have been addressed using the correct procedure and the appropriate person(s) are aware of concerns and they are being addressed with the correct procedure DON/Administrator/MDS Nurse using a QI tool 3X's per week X4, then weekly X4, then monthly X3. The Executive QI committee will meet monthly X3 to review trends and/or issues and to determine the continued need and frequency of monitoring.	

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F 166	Continued From page 5 Review of the facility grievance log for the month of August 2013 indicated no grievance filed for the incident. Review of the admission Minimum Data Set (MDS) dated 8/13/2013 indicated the resident had no cognitive impairment. In an interview with resident #54 on 10/31/2013 at 10:00 AM , the resident stated "I was sleeping that night, and I heard the machine running outside my door, and it sounded like it was hitting up against my door. I admit I was angry, and I told him to stop and that he had no business polishing the floor at night when we were all trying to sleep. He paid me no mind and kept polishing it. I admit I used threatening words with him, but I have never hit anybody in my life. I was just mad. I really would not have punched him, but it ticked me off. I was always my own boss when I was working, and I admit it bothers me that I have no control. My main issue is I don ' t want to be here, but I know I have to be. The nurse took me back in my room and gave me a pill. I did not feel like that solved the problem. I know I should not have acted like that, but they should not have made staff use that loud machine at night when we were trying to sleep. I feel like he should have stopped when I asked him to stop." An interview with staff nurse #1 was not conducted during the survey, as the nurse was no longer employed at the facility. In an interview with the facility administrator on 11/01/2013 at 11:00 AM, the administrator stated when the resident asked the staff member on 8/8/2013 at 9:30 PM to stop polishing the floor, he should have stopped. The administrator further	F 166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 166	Continued From page 6 reported no staff was told to polish resident hallways on second shift, nor would it have been permitted. The administrator also indicated the expectation was the grievance by the resident should have been investigated and was not.	F 166		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to provide a resident with food likes/dislikes for 1 of 1 sampled residents (resident #54) by providing the resident a meal tray which contained one of the resident ' s dislikes, white meat. Findings included: Review of the resident's clinical record indicated resident #54 was admitted into the facility on 2/11/2013. Review of the admission Minimum Data Set (MDS) dated 2/18/2013 indicated the resident had mild cognitive impairment. Review of the admission Minimum Data Set (MDS) dated 8/13/2013 indicated the resident	F 242	F242 483.15(b) Self-Determination-Right to Make Choices Resident #54, likes and dislikes for meals, has been reviewed and is correct at this time. 100% of all current residents have been reviewed for likes and dislikes for meals and is correct on the tray cards by the dietary manager, completed on 11/27/2013. 100% of dietary and nursing staff have been in-serviced on looking at the tray cards to insure likes and dislikes have been honored was done by Dietary Manager	11/29/13

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F 242	Continued From page 7 had no cognitive impairment. In an interview with resident #54 on 10/29/2013 at 11:09 AM, the resident stated "When I was admitted into the facility, I told staff I did not like or want white chicken, and I am tired of telling them not to bring me white meat. I cannot even tell you how many times they bring my tray with white meat on it, and I am tired of telling them. I am tired of fussing about it, so now I just don't say anything." In an interview with the facility dietary supervisor on 10/31/2013 at 10:45 AM, the dietary supervisor indicated it was her responsibility to assess the food likes and dislikes of the residents at the time of admission. She reported a file was kept in the kitchen which contained the food likes/dislikes of every resident in the facility. Review of the kitchen folder which contained all of the facility residents' dietary information on 10/31/2013 at 11:00 AM indicated resident #54 disliked white meat. Observation of the meal tray delivered to resident #54 in his room on 10/31/2013 at 1:20 PM revealed a fried chicken breast on his plate. A meal card was observed on the meal tray with the likes/dislikes noted on the card and included a dislike of white meat. In an interview with the dietary supervisor on 10/31/2013 at 3:15 PM, the dietary supervisor indicated the expectation was dietary staff should read the dislikes on each resident's meal card before placing food on their meal tray, and dietary staff should not place a dislike on a resident ' s tray.	F 242	and completed on 11/27/2013. Random resident tray cards and meals will be reviewed during meal time for the appropriated likes and dislikes by Dietary Manager using a QI tool daily X4 weeks, then weekly X4, then monthly X3. The Executive QI committee will meet monthly X3 to review trends and/or issues and to determine the continued need and frequency of monitoring.	

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STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
FOR SNFs AND NFs	345491	A. BUILDING: _____ B. WING _____	11/1/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROATAN RIDGE NURSING AND REHABILITATIOI	210 FOXHALL ROAD NEWPORT, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 431	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.

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.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interviews, the facility failed to ensure that there were no expired medications in one of two medication storage rooms (300,400,and 500 hall) checked.

On 11/1/13 at 10:40 AM, an inspection of the medication storage room on the 300, 400, and 500 hall (main nursing station), was conducted. Two unopened single dose vials of Engerix Hepatitis B vaccine were refrigerated. Each of the vials had an expiration date of 9/23/13.

On 11/1/13 at 10:55 AM, in an interview, Nurse #1 stated that she thinks that the nurse who is responsible for the check for expired medications, is the MDS nurse. Nurse #1 stated that she would ask the Director of Nursing (DON).

On 1/11/13 at 11:00 AM in an interview, the DON stated that the nurses rotate the stock as they use it, and are expected to check expiration dates. The DON stated that she tried to check the refrigerators in the medication storage room maybe once a month, but there was no schedule for it to be done. The DON stated that she could create a schedule for that.

A review of the facility Immunization Report for Hepatitis B revealed that no Hepatitis B vaccine had been given from September to November 1, 2013.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM ~~FOR SNFs AND NFs~~	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345491	A. BUILDING: _____ B. WING _____	11/1/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROATAN RIDGE NURSING AND REHABILITATIO!	210 FOXHALL ROAD NEWPORT, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 520	Continued From Page 1
F 520	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS

A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.

The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.

A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to maintain a quality assessment and assurance committee that consisted of the director of nursing, a physician designated by the facility, and at least three other staff members.

A review of materials in a binder given by the administrator, revealed a list of the QA committee as consisting of: the administrator, the director of nursing, and the facility medical director.

On 11/1/13 at 11:30 AM, in an interview, the facility administrator stated that the QA committee consisted of herself, the facility medical director, the director of nursing, and the staff development coordinator.

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	345491	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/04/2013

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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(111) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Croatan Ridge Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Croatan Ridge's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Croatan Ridge Nursing and	
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 1:00 pm onward, the following items were noncompliance, specific findings include: when fire alarm system was silenced strobes on horn;/strobe device's on 100, 200 and 400 stopped flashing.	K 052		

RECEIVED
DEC 30 2013
CONSTRUCTION SECTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ronnie Sorrell	Administrator	12-20-13

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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CROATAN RIDGE NURSING AND REHABILITATION CENTER	210 FOXHALL ROAD NEWPORT, NC 28570

(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 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(111) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Croatan Ridge Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Croatan Ridge's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Croatan Ridge Nursing and	
K 052 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 1:00 pm onward, the following items were noncompliance, specific findings include: when fire alarm system was silenced strobes on horn;/strobe device's on 100, 200 and 400 stopped flashing.	K 052		12/27/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ronnie Lanier	Administrator	12-20-13

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.

CW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345491	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 052	Continued From page 1 42 CFR 483.70(a)	K 052	Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	
K 066 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 1:00 pm onward, the following items were noncompliance, specific findings include: area under front canopy is being used for smoking when it rain's for residents and staff. Area does not have the required ash trays nor	K 066	**K 052** **A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4** 12/27/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 066	Continued From page 2 self closing container. 42 CFR 483.70(a)	K 066	Hillco, Inc. was contacted on 12/04/2013 and notified by Maintenance Director of the above citation given to the facility during the Life Safe Survey. He was later notified that Charles Taylor Electric would be at the facility on 12/06/2013 to assess and fix the findings of the survey. On 12/06/2013 CTE (Charles Taylor Electric) came to the facility assessed the specific findings and corrected them to meet the Life Safety Standard Code K 052. The Maintanence Director tested fire alarm system	