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 _____	12/01/2011

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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to care plan interventions to ensure a urinary catheter bag and tubing was not touching the floor for 1 of 1 residents in a low bed (Resident # 28). Findings include: 1. Resident # 28 was admitted to the facility with diagnoses of urinary retention. A review of the annual Minimum Data Set (MDS) assessment of 10/20/11, Resident # 28 was dependent in care and incontinent of bowel. An indwelling catheter	F 279	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.	12/29/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Jenny Sproul, Administration 12/20/11

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 279	Continued From page 1 was present. On 11/30/11 at 10:15 AM, Resident # 28 was observed in bed. The bed was raised to the highest position so housekeeping staff could sweep under the bed. The bed was then lowered to the lowest position by Nurse # 1. On 11/30/11 10:23 AM, Resident # 28 was observed for a treatment change with Nurse # 1. Resident # 28's bed was in the lowest position as an intervention to prevent falls. Nurse # 1 completed the treatment and left the room. The catheter bag and tubing were noted lying on the floor. An observation made on 11/30/11 at 11:29 AM revealed the catheter bag and tubing remained on the floor. During an interview on 11/30/11 at 11:37 AM, Nursing Assistant (NA) # 2 stated, "The catheter bag and tubing is supposed to be off the floor. When I left (Resident # 28) this morning, the bag was not on the floor. I had clamped it to the end of the bed frame where it would not touch the floor. I don't know who moved it." During an interview on 11/30/11 at 11:53 AM, Nurse # 1 stated she had lowered Resident # 28's bed after housekeeping staff swept under the bed. Nurse # 1 stated she was not aware the catheter bag and tubing was on the floor after she lowered the bed or during the treatment change. Nurse # 1 stated she would never have left the catheter bag and tubing on the floor if she had seen it there.	F 279	Croatan Ridge Nursing and Rehabilitation Center'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 this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. F 279 Resident #28 had urinary catheter bag re-adjusted to ensure that the bag and tubing did not touch the floor by the DON on 11/30/11. This intervention was also Care	12/29/11

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F 279	Continued From page 2 A review of Resident # 28's urinary care plan of 8/1/11 revealed the care plan addressed the issues of risk for infection and urinary tract infections. Care plan interventions were: changing the catheter per physician order and protocol, emptying the bag at the end of each shift, monitoring / recording output, ensuring drainage tubing was secured with an anchoring device/strap, and monitoring for symptoms of a urinary tract infection. No interventions were in place to ensure the catheter bag and tubing were kept of the floor when the bed was in the lowest position. During an interview on 11/30/11 at 3:36 PM, the Director of Nursing (DON) stated it was her expectation that Resident # 28's catheter bag and tubing would be off the floor, and included on the care plan. "For (Resident # 28) the care plan would have to be specific because the bag should be below the bladder and he's on a low bed. It should be on the care plan."	F 279	Planned in the residents medical record by the DON/MDS nurse on 11/30/11. All other residents in the facility with urinary catheters were audited to ensure that urinary catheter bags and tubing were not touching the floor by the DON on 11/30/11. These residents Care Plans were also reviewed and an intervention was added to keep the urinary catheter bag and tubing from touching the floor by the DON/MDS nurse on 11/30/11.	12/29/11
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must 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. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		

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		F 279	100% in-servicing of all nursing staff to keep urinary catheter bags and tubing from touching the floor by the DON, completed on 12/21/11. Administrative nurses will monitor/audit all residents to include resident #28 with urinary catheters to ensure all bags and tubing are kept from touching the floor using a monitoring tool, daily X 1 week, then weekly X 4, then monthly X 3. Administrative nurse will follow up on any potential concerns upon identification. A review of all residents Care plans with urinary catheters to ensure that intervention to keep the catheter bag and tubing from touching floor in place by DON/MDS completed on 11/30/11. Care plans will be audited on an ongoing basis to ensure interventions for drainage bags and tubing not touching the floor are addressed	12/29/11

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		F 279	The executive QI committee will meet to review audits to identify and address concerns and/or trends and to follow up as necessary to determine the frequency and/or need for continued monitoring, weekly X 4, then monthly X 3 then quarterly.	12/29/11

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F 441	Continued From page 3 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to ensure a urinary catheter bag and tubing did not touch the floor for 1 of 1 residents (Resident # 28). Findings include: 1. On 11/30/11 at 10:15 AM, Resident # 28 was observed in bed. The bed was raised to the highest position so housekeeping staff could sweep under the bed. The bed was then lowered to the lowest position by Nurse # 1.	F 441	F 441 Resident #28 had urinary catheter bag re-adjusted to ensure that the bag and tubing did not touch the floor by the DON, completed on 11/30/11. All other residents in the facility with urinary catheters were audited to ensure that urinary catheter bags and tubing were not touching the floor by the DON completed on 11/30/11.	12/29/11

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F 441	Continued From page 4 On 11/30/11 10:23 AM, Resident # 28 was observed for a treatment change with Nurse # 1. Resident # 28's bed was in the lowest position. Nurse # 1 completed the treatment and left the room. The catheter bag and tubing were noted lying on the floor. An observation made on 11/30/11 at 11:29 AM revealed the catheter bag and tubing remained on the floor. During an interview on 11/30/11 at 11:37 AM, Nursing Assistant (NA) # 2 stated, "The catheter bag and tubing is supposed to be off the floor. When I left (Resident # 28) this morning, the bag was not on the floor. I had clamped it to the end of the bed frame where it would not touch the floor. I don't know who moved it." During an interview on 11/30/11 at 11:53 AM, Nurse # 1 stated she had lowered Resident # 28's bed after housekeeping staff swept under the bed. Nurse # 1 stated she was not aware the catheter bag and tubing was on the floor after she lowered the bed or during the treatment change. Nurse # 1 stated she would never have left the catheter bag and tubing on the floor if she had seen it there. During an interview on 11/30/11 at 3:36 PM, the Director of Nursing (DON) stated it was her expectation that Resident # 28's catheter bag and tubing would be off the floor. The DON stated even though a low bed was required for Resident # 28, the bed should be raised enough for the catheter bag and tubing to clear the floor.	F 441	100% in-servicing of all nursing staff to keep urinary catheter bags and tubing from touching the floor by the DON, completed on 12/21/11. Administrative nurses will monitor/audit all residents to include resident #28 with urinary catheters to ensure all bags and tubing are kept from touching the floor using a monitoring tool, daily X 1 week, then weekly X 4, then monthly X 3. Administrative nurse will follow up on any potential concerns upon identification. The executive QI committee will meet to review audits to identify and address concerns and/or trends and to follow up as necessary to determine the frequency and/or need for continued monitoring, weekly X 4, then monthly X 3 then quarterly.	12/29/11
F 464 SS=D	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS	F 464		

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F 464	Continued From page 5 The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview and record review, the facility failed to provide a table at an appropriate height for 1 of 1 residents (#14). The findings include: Resident #14 was admitted to the facility on 01/02/10 with cumulative diagnoses that included Intracerebral Hemorrhage, Hypertension, Reflux Disease, Osteoporosis, Glaucoma and Dysphagia. The resident was coded on the most recent MDS (minimum data set) dated 01/05/11 as having short and long term memory problems and as being impaired in the decision making process. In addition, the resident was coded as being independent in eating. The resident was observed on 11/29/11 at the lunch meal sitting at table with other residents. Resident #14 was sitting in her wheel chair. Her chin was observed to be at a level with the table top. Resident #14 was observed to put some green peas on her fork and as she lifted it to her mouth some of the peas fell off. A staff member sitting with another resident suggested that resident #14 use her spoon. When the resident	F 464	F 464 Resident #14 was provided with a table that was appropriate for residents height while in dining room at meal times by DON on 11/29/11. All residents were reviewed to ensure that table(s) was appropriate for all residents. No other issues/concerns were observed by DON/administrative staff on 11/29/11.	12/29/11

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F 464	Continued From page 6 used the spoon she had to raise the spoon up to get it away from the table and then bring it down to her mouth to eat the peas. Resident #14 was observed to reach for the glass with the tea in it and she had to lift the glass up with both hands and then bring it near to her lap (lower) before taking a sip of the tea. During an interview with nurse aide #1 on 11/29/11 at 12:50 PM it was revealed " she seems to be to short for the table. The table is too high for her. We used to have an over bed table in here (dining room). I don ' t know where it went. " During an interview with the resident on 11/29/11 at 4:53 PM it was revealed " it is uncomfortable for me to eat with the table so high. " During an interview with the Director of Nursing on 12/01/11 at 12:15 PM it was revealed " the table is too high for her, we used to have a lower table in there. " The facility failed to ensure that a dining room table was at an appropriate height for a resident. facilitly failed to ensure that a resident had a proper height table at mealtime.	F 464	Table was placed in dining room for resident(s) use to include resident #14 to ensure that resident has a table that is height appropriate for use during mealtimes. Placement of this table will remain in the dining rooms and appropriate table height for all residents to include resident #14 will be monitored by the DON/administrative staff daily utilizing a QI tool. The executive QI committee will meet to review audits to identify and address concerns and/or trends and to follow up as necessary to determine the frequency and/or need for continued monitoring, weekly X 4, then monthly X 3 and then quarterly.	12/29/11

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

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FORM APPROVED
OMB NO. 0938-0391

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 _____	CONSTRUC 12/15/2011

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K 012 SS=D	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: 42 CFR 483.70(a) By observation on 12/15/11 at approximately noon the following building construction type was non-compliant, specific findings include; there were penetrations around the ceiling attic access that does not meet the required fire resistance rating, near room 400.	K 012	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.	1/29/12
K 018 SS=D	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 1¾ 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.	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Penny Sproul Administrator 12-30-11

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 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 12/15/11 at approximately noon the following corridor door was non-compliant, specific findings include; door to clean utility room, near room 400, did not close and latch tightly in It's frame.	K 018	Croatan Ridge Nursing and Rehabilitation Center'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 this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	1/29/12
K 052 SS=F	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: 42 CFR 483.70(a) By observation on 12/15/11 at approximately noon, during the inspection and testing of the facility fire alarm system, that consisted of multiple components, the automatic dialer component, when placed in trouble from phone line failure, located in the mechanical room, did not send a trouble signal to the remote annunciator next to the main fire alarm control panel located at the nurses station. The	K 052	<u>K 012</u> On 12/15/2011 Maintenance Director caulked around identified ceiling attic accesses, #6 and #7 accesses that did not meet the required fire resistance rating, using fire retardant caulking (3M) fire barrier sealant with 4 hour rating.	

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K 052	Continued From page 2 mechanical room, where the automatic dialer component was located, gave an audible trouble signal, however, the remote annunciator next to the main fire alarm control panel, located at the nurses station, showed no power to the unit. There was not a visual and audible signal at the main communications area.	K 052	All other ceiling attic accesses in facility were checked by the maintenance director to assure the required fire resistance rating was met.	1/28/12
K 062 SS=F	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: 42 CFR 483.70(a) By observation and documentation on 12/15/11 at approximately noon the following sprinkler system was non-compliant, specific findings include; there was a gallon of sediment from 1/09, documentation from 10/10 indicated that the "system needs flush", documentation from 7/11 states "check to see if flushed". Records did not indicate that the system had been flushed. The system shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of water-based fire protection systems.	K 062	On 12/30/2011 Hillco, Inc. will inspect and make additional corrections, if necessary, to #6 and #7 ceiling attic access to assure compliance. All other ceiling attic accesses in facility will be inspected and corrections made, if necessary, to meet fire resistance rating. Maintenance Director will audit all ceiling attic accesses in facility utilizing a QI monitoring tool weekly x 4 weeks and then monthly x 3 months to assure ceiling attic accesses remain within the fire resistance rating.	
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067		

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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 067	Continued From page 3 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 12/15/11 at approximately noon the following heating, ventilating, and air conditioning (HVAC) system was non-compliant, specific findings include; unit #7 that feeds room 401 and the adjacent corridor was not functioning during the survey. It could also not be concluded if the unit was tied into the fire alarm for shut down upon fire alarm activation.	K 067	The executive QI committee will meet to review audits to identify and address concerns and/or trends and to determine the frequency and/or need for continued monitoring, weekly x 4 weeks, then monthly x 3 months. K 018 On 12/16/2011 maintenance director adjusted the door jam hinges and door latch of door found by surveyor that did not close and latch tightly in its frame, near room 400, to meet compliance. Maintenance Director then inspected and corrected all other doors in the facility to assure door jam hinges and door latches are functioning correctly and in compliance with Life Safety Code Standards.	12/16

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

PRINTED: 12/19/2011
FORM APPROVED
OMB NO. 0938-0391

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 _____	12/15/2011

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K 012 SS=D	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: 42 CFR 483.70(a) By observation on 12/15/11 at approximately noon the following building construction type was non-compliant, specific findings include; there were penetrations around the ceiling attic access that does not meet the required fire resistance rating, near room 400.	[redacted]	On 12/30/2011 Hillco, Inc. inspected and made additional corrections to door jam hinges and door latches found not to be in compliance with the Life Safety Code Standard. Maintenance Director will audit all door jam hinges and door latches utilizing a QI monitoring tool weekly x 4 weeks and then monthly x 3 months to assure door jam hinges and door latches are functioning correctly as per Life Safety Code Standard. The executive QI committee will meet to review audits to identity and address concerns and/or trends and to determine the frequency and/or need for continued monitoring, weekly x 4 weeks and then monthly x 3 months.	1/24/12
K 018 SS=D	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 1¾ 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.	[redacted]		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 12/15/11 at approximately noon the following corridor door was non-compliant, specific findings include; door to clean utility room, near room 400, did not close and latch tightly in it's frame.	[redacted]	K 052 On 12/15/2011 Hillco, Inc. was notified that during the Life Safety Inspection and testing of the facility fire alarm system that consisted of multiple components was not functioning as it should have. On 12/22/2011 Charles Taylor Electric replaced battery system and new annuccuator board to correct the malfunction of the fire alarm system. He then tested fire alarm system to assure it was functioning properly. Maintenance Director will check fire alarm system to assure functioning properly daily x 2 weeks, then weekly x 4 weeks and then monthly x 3 months to assure fire alarm system functioning properly to meet the Life Safety Code Standard.	1/20/12
K 052 SS=F	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: 42 CFR 483.70(a) By observation on 12/15/11 at approximately noon, during the inspection and testing of the facility fire alarm system, that consisted of multiple components, the automatic dialer component, when placed in trouble from phone line failure, located in the mechanical room, did not send a trouble signal to the remote annunciator next to the main fire alarm control panel located at the nurses station. The	[redacted]		

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K 052	Continued From page 2 mechanical room, where the automatic dialer component was located, gave an audible trouble signal, however, the remote annunciator next to the main fire alarm control panel, located at the nurses station, showed no power to the unit. There was not a visual and audible signal at the main communications area.	[redacted]	The executive QI committee will meet to review audits to identify and address concerns and/or trends and to follow up as necessary to determine the frequency and/or need for continued monitoring, weekly x 4 weeks and then monthly x 3 months. K 062 On 12/15/2011 Hillco Inc. was notified records did not indicate the automatic sprinkler system had been inspected and tested as required by Life Safety Code Standard. On 12/20/11 Sunland Fire Protection was here to inspect and test automatic sprinkler system. Report of inspection was obtained. Sunland Fire Protection, Inc. will be here week of 1/2/12 to correct findings. Corrections will be completed by 1/17/2011.	1/24/12
K 062 SS=F	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: 42 CFR 483.70(a) By observation and documentation on 12/15/11 at approximately noon the following sprinkler system was non-compliant, specific findings include; there was a gallon of sediment from 1/09, documentation from 10/10 indicated that the "system needs flush", documentation from 7/11 states "check to see if flushed". Records did not indicate that the system had been flushed. The system shall be properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of water-based fire protection systems.	[redacted]		
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	[redacted]		

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K 018 SS=D	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 1¾ 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.	[redacted]		

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