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

FEB 21 2012

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345391 | A. BUILDING _____ B. WING _____ | 01/27/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H | 1131 NORTH CHURCH STREET GREENSBORO, NC 27401 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | F 441 | The facility will 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<br><br>**For the resident cited:**<br>The blood glucose machine was cleaned and sanitized for resident number 37 prior to his next blood glucose test.<br>**For all residents:**<br><br>Nurses and CNA's on duty at the time of the survey were immediately inserviced regarding the correct procedure for the cleaning and disinfection glucometer per the manufacturer's instructions.<br><br>Facility will inservice all nurses and CNA's regarding the appropriate procedure for cleaning and disinfecting glucometer per the manufacturers instructions.<br><br>**System Changes:**<br>All newly hired nurses and CNA's will receive training specifically in the procedure for cleaning and disinfection of glucometers per the manufacturer's instructions as part of the facility's mandatory orientation for new hires. The facility will also address the cleaning and disinfecting of glucometer in a biannual infection control inservice for nurses and CNA's. | 1/25/2012<br>1/26/2012<br><br>2/24/2012<br><br>2/24/2012 |

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

Administrator | 2-17-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 441 | Continued From page 1<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and staff interviews the facility failed to clean and disinfect a glucometer for 1 of 2 sampled resident (residents # 37 and #176 ) observed receiving blood glucose monitoring.<br><br>Findings include:<br><br>The Center for Disease Control (CDC) and Prevention Guidelines for Glucose Monitoring read in part: "Any time blood glucose monitoring equipment is shared between individuals there is a risk of transmitting viral hepatitis and other blood borne pathogens. Decontaminate environmental surfaces such as glucometers regularly and any time contamination with blood or body fluids occurs or is suspected. Glucose test meters approved for use with more than one person must be cleaned and disinfected following disinfection guidelines." Accu-check or fingerstick blood sugar (FSBS) tests involve sticking a resident's finger for a blood sample, which is then placed on a strip. The strip goes into a glucose meter that reads the blood sugar level.<br><br>The facility's policy titled Infection Control-Standard Precautions dated 9/2005 read in part under the heading Resident-Care Equipment "Ensure that reusable equipment is not used for the care of another resident until it has been appropriately cleaned."<br><br>The Manufacturer's recommendation titled "Recommended (brand name glucometer) | F 441 | **Monitors:**<br>Administrative nursing staff will observe blood glucose checks five times a week for four weeks, then weekly ongoing. A skills checklist will be utilized. Education will be provided at the time the checklist is completed if needed. Results of skills checklists and will be reviewed in the facility's monthly Quality Improvement Meetings. | 2/24/2012 |

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| F 441 | Continued From page 2<br>Cleaning and Disinfecting Guidelines" read in part "Cleaning and disinfecting can be completed by using a commercially available EPA-registered (Environmental Protection Agency) disinfectant detergent or germicide wipe. To use a wipe remove from container and follow the product label instructions to disinfect the meter." The product instructions for an acceptable EPA registered germicidal wipe used by the facility read in part "Some organisms are removed from the surface by thoroughly wiping the surface with the wipe. Most remaining organisms are killed within two (2) minutes by exposure to the liquid wipe."<br><br>Resident #37 was admitted to the facility on 10/13/2011 with diagnoses that included diabetes mellitus (DM). Review of Resident #37's medical record found orders dated 10/13/2011 that included blood sugar checks before meals and at bedtime.<br><br>In an observation on 1/25/2012 at 11:35 am Nurse #1 prepared to obtain a finger stick blood sugar for Resident #37 by removing the glucometer from its case and removing a test strip from its bottle. She cleaned her hands with hand sanitizer and put on gloves. She inserted the test strip into the glucometer, wiped Resident #37's finger with an alcohol pad, obtained a blood sample using a disposable lancet, and applied a drop of blood to the test strip. After reading the test results, Nurse #1 disposed of the used test strip, alcohol pad, and the lancet. She then placed the glucometer on the medication cart, removed her gloves and washed her hands. After recording the blood sugar, Nurse #1 started to put the glucometer back into its case. When asked | F 441 | | |

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how often the glucometer was cleaned she responded that it was cleaned each night when calibrated. Asked if that was the only time it was cleaned, Nurse #1 stated that if there was any visible blood on the glucometer it was cleaned right away with a sanitizer wipe. Nurse #1 also stated that the Nursing Assistants (NA) and Nursing Technicians (NT) usually took the blood sugars so they regularly cleaned the glucometers. She indicated that she was only taking Resident #37's blood sugar because the resident said she felt like it was low.

During an interview on 1/25/12 at 12:35 pm Nurse #2 when asked who cleaned the glucometers responded that anyone who used it cleaned it after each used with an alcohol swab. Per manufacturer's recommendations, alcohol is not considered an acceptable disinfectant.

At 12:40 pm on 1/25/2012 NA #1 and NT #1 were interviewed together. In the interview they stated they cleaned the glucometers with sanitizer wipes which were usually in the basket attached to the rolling blood pressure machine. There were none present at the time so they obtained the wipes from the dispenser on the wall in front of the nurses' station. NA#1 stated she cleaned the glucometer after each use. NT#1 stated that she cleaned the glucometer before and after each use.

On 1/25/2012 at 12:50 pm NA #2 stated in an interview that the glucometer was always cleaned with a germicide wipe after each use before storing. She indicated the wipes are located next to the glucometer storage. The germicidal wipes were observed in a container on the wall by the

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| F 441 | Continued From page 4 | F 441 | | |

glucometer storage box. They were the EPA registered germicidal wipes recommended by the manufacturer.

In an interview on 1/25/2012 at 12:55 pm NA #3 indicated that the glucometer was cleaned before and after each use with a sanitizing wipe. She stated that it was wiped down and allowed to dry for two minutes. She pointed out the sanitizer wipe container on the wall next to the glucometer storage.

During an interview at 1:00 pm NA #4 stated that he cleaned the glucometer after every use, but used alcohol preps instead of sanitizer wipes.

Resident #176 was admitted to the facility on 1/17/12 with diagnoses that included DM. Review of physician's orders dated 1/17/12 found an order to check blood sugars before each meal and at bedtime.

On 1/25/2011 at 4 pm NT # 1 checked the blood sugar on Resident # 176. She washed her hands and used gloves to take the blood sugar. She disposed of the lancet and alcohol wipes. Then NT #1 took the glucometer out of room and cleaned it with disinfectant wipes. NT #1 stated that she cleaned the glucometer after every use. She indicated the wipes were usually in the basket attached to the wheeled blood pressure machine. They were not in the basket at that time so NT#1 obtained the wipes from the dispenser on the wall in front of the nurses ' station. She disposed of her gloves and washed her hands.

At 4:15 pm on 1/25/2012 NT #2 demonstrated the method for use of and disinfection of the

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| F 441 | Continued From page 5<br>glucometer. Hands were cleaned with hand sanitizer and gloves put on. The glucometer was cleaned with a sanitizer wipe located on the wall by the glucometer storage. The test strip and alcohol wipes were gathered along with the glucometer to take to a resident's room. After use the wipes would be disposed of in the trash. The test strip and lancet would be disposed of in a sharps safe container. The glucometer was taken back to the storage area, cleaned with another sanitizer wipe and placed in its open storage bag to air dry. The gloves were removed and hands washed. When asked how often the glucometer should be cleaned NT #2 stated at least after every use before putting it away. She indicated that she had received this training during an in-service when hired.<br><br>The Administrator stated in an interview on 1/25/2012 at 5:30 pm that the NAs and NTs were assigned to take blood sugars and had been in-serviced in September 2011 about cleaning glucometers. The facility started using a new glucometer in 9/2011 and the manufacturer's representative gave an in-service at the facility on the use and care of the glucometers. The Administrator indicated that it was possible that not all the nurses received that training.<br><br>On 1/26/2012 at 12:00 noon the Administrator provided a copy of the manufacturer's handout for the 9/13/2011 in-service on the care and cleaning of the glucometers. The handout included the use of an EPA registered disinfectant or germicide that was approved for healthcare settings. The Sanitizer wipes used by the facility were noted in the handout to act as both a cleaner and disinfectant and were registered with the EPA. | F 441 | | |

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| F 441 | Continued From page 6<br>The sign off sheet for this in-service was also provided. Nurse #1, NA #1, NA #2, and NT #5's names were not on the list. Nurse #2, NT #1, NA #2, NA #3, and NA#4's names were on the list.<br><br>In a joint interview on 1/27/2012 the Director of Nurses and the Administrator indicated they expected all staff to follow the proper procedures for cleaning and disinfecting glucometers before and after each use. | F 441 | | |

PRINTED: 03/05/2012
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OMB NO. 0938-0391

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| | 345391 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 02/29/2012 |

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| K 000 | INITIAL COMMENTS<br><br>Surveyor: 27871<br>This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III(211) construction, one story, with a complete automatic sprinkler system.<br><br>The deficiencies determined during the survey are as follows: | K 000 | 1. Immediate Response - Penetration was filled with fire rated sealant.<br><br>2. Corrective Action - Inspection was made of all mechanical rooms to ensure other possible penetrations were sealed.<br><br>3. Systemic Changes - A contractor "Statement of Responsibility" was established to ensure sealing of penetration after work is completed and will be monitored by the maintenance department.<br><br>4. Monitoring - The inspection of all mechanical rooms for penetrations was included on the daily rounds report. | |
| K 012 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27871<br>Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: mechanical room #3 has un-sealed penetrations that are not seal to maintain the 1 hour construction rating of the facility.<br><br>42 CFR 483.70(a) | K 012 | | 4-14-12 |
| K 018 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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 | K 018 | | 4-14-12 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 3/16/12

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| K 018 | Continued From page 1<br>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<br><br>Roller latches are prohibited by CMS regulations in all health care facilities.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27871<br>Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: doors to Physical Therapy and Asst. Director of Nursing were being held open with rubber wedge.<br><br>42 CFR 483.70(a) | K 018 | Immediate Response - All rubber wedges were removed from doors being held open.<br><br>Corrective Action - In-service of staff was conducted regarding the prohibited use of items that impeded the closure of doors.<br><br>Systemic Changes - Fire protection contractor was contacted to install mag locks on designated doors (i.e. physical therapy) that would release by fire alarm system.<br><br>Monitoring - Inspection of doors being impeded from closing was included on the daily rounds. Immediate correction would be made during rounds when observed and reported at the safety committee meetings. | 4-14-12 |
| K 051<br>SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided | K 051 | | 4-14-12 |

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| K 051 | Continued From page 2<br>that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27871<br>Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include; there was not a visual/audible trouble signal at the Fire Alarm Control Panel (FACP) with loss of telephone line connection and loss of battery and AC power. | K 051 | Immediate Action - Fire protection contractor was contacted to make appropriate repairs/commodation to FACP to provide a visual/audible trouble signal at panel.<br><br>Corrective Action - Repairs were made to FACP by T&S Fire Protection contractor.<br><br>Systemic Changes/Monitoring - Annually the fire protection contractor will ensure that all FACP's provide a working visual/audible trouble signal. This will be monitored by the director of facilities during the inspection process to ensure compliance. | 4-14-12 |
| K 147 SS=E | 42 CFR 483.70(a)<br>NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 | K 147 | | 4-14-12 |

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| K 147 | Continued From page 3<br>This STANDARD is not met as evidenced by:<br>Surveyor: 27871<br>Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: 1.facility has exposed light tubes with out protect covers at nurse station on South Hall, 2. residents bedroom #126 is using multi plug outlet for permanent power source for TV, 3. GFCI at South Courtyard(out side) is missing cover, 4. staff could not locate breaker for Fire Alarm Control Panel for loss of AC power test.<br><br>42 CR 483.70(a) | K 147 | Immediate Response -<br>1. Protected covers were installed on identified exposed light tubes.<br>2. Multi-plug outlets were removed from identified resident rooms.<br>3.GFCI cover was installed on identied outlet.<br>4. Fire protection contractor was contacted and facility staff located breaker for FACP and tested for loss of AC power.<br><br>Corrective Action -<br>1. Inspection was made on all exposed light tubes and protective covers were installed.<br>2. Inspection of all resident rooms were made to ensure that other multi-plug outlets were not in use or removed.<br>3. Inspection of other outside GFCI outlets was made for missing plate covers.<br>4. See above response.<br><br>Systemic Changes -<br>1. Inspection of exposed light tubes was added to the weekly light inspection form. | 4-14-12 |



2. Notification was sent to resident family members about prohibited use of multi-plug outlets in resident rooms. 3. Inspection of GFCI outlets for missing covers/repairs was included in daily rounds form. 4. Fire protection contractor was informed to include testing of power loss and visual/audible trouble signal on FACP.
Monitoring - 1&3. Daily rounds will be monitored by director of facilities for compliance. 2. Monitoring of use of multi-plug outlets will be included in resident room PM inspection and reported on in safety committee meeting. 4. Director of Facilities will monitor fire protection contractor for compliance.

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PRINTED: 03/05/2012
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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 | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345391 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 02/29/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| HEARTLAND LIVING & REHAB AT THE MOSES H CONE MEM H | 1131 NORTH CHURCH STREET GREENSBORO, NC 27401 |

| (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<br><br>Surveyor: 27871<br>This Life Safety Code(LSC) survey was conducted as per The Code of Federal Reg at 42CFR 483.70(a); using the Existing Hea Care section of the LSC and its referenced publications. This building is Type III(211) construction, one story, with a complete automatic sprinkler system.<br><br>The deficiencies determined during the survey are as follows: | K 000 | Copy<br>late Response - on was filled with fire lant.<br><br>ive Action - was made of all al rooms to ensure ible penetrations were sealed.<br><br>3. Systemic Changes - A contractor "Statement of Responsibility" was established to ensure sealing of penetration after work is completed and will be monitored by the maintenance department.<br><br>4. Monitoring - The inspection of all mechanical rooms for penetrations was included on the daily rounds report. | |
| K 012 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27871<br>Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: mechanical room #3 has un-sealed penetrations that are not seal to maintain the 1 hour construction rating of the facility.<br><br>42 CFR 483.70(a) | K 012 | | |
| K 018 SS=E | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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 | K 018 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sharon Logan-Bass
TITLE: Administrator
(X6) DATE: 3/16/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| | 345301 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 02/29/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| K 018 | Continued From page 1<br>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<br><br>Roller latches are prohibited by CMS regulations in all health care facilities.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27871<br>Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include; doors to Physical Therapy and Asst. Director of Nursing were being held open with rubber wedge. | K 018 | Immediate Response - All rubber wedges were removed from doors being held open.<br><br>Corrective Action - In-service of staff was conducted regarding the prohibited use of items that impeded the closure of doors.<br><br>Systemic Changes - Fire protection contractor was contacted to install mag locks on designated doors (i.e. physical therapy) that would release by fire alarm system.<br><br>Monitoring - Inspection of doors being impeded from closing was included on the daily rounds. Immediate correction would be made during rounds when observed and reported at the safety committee meetings. | |
| K 051<br>SS=E | 42 CFR 483.70(a)<br>NFPA 101 LIFE SAFETY CODE STANDARD<br><br>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided | K 051 | | |

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| K 051 | Continued From page 2<br>that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 27871<br>Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: there was not a visual/audible trouble signal at the Fire Alarm Control Panel (FACP) with loss of telephone line connection and loss of battery and AC power. | K 051 | Immediate Action - Fire protection contractor was contacted to make appropriate repairs/commodation to FACP to provide a visual/audible trouble signal at panel.<br><br>Corrective Action - Repairs were made to FACP by T&S Fire Protection contractor.<br><br>Systemic Changes/Monitoring - Annually the fire protection contractor will ensure that all FACP's provide a working visual/audible trouble signal. This will be monitored by the director of facilities during the inspection process to ensure compliance. | |
| K 147 SS=E | 42 CFR 483.70(a)<br>NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 | K 147 | | |

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2. Notification was sent to resident family members about prohibited use of multi-plug outlets in resident rooms. 3. Inspection of GFCI outlets for missing covers/repairs was included in daily rounds form. 4. Fire protection contractor was informed to include testing of power loss and visual/audible trouble signal on FACP.

Monitoring - 1&3. Daily rounds will be monitored by director of facilities for compliance. 2. Monitoring of use of multi-plug outlets will be included in resident room PM inspection and reported on in safety committee meeting. 4. Director of Facilities will monitor fire protection contractor for compliance.