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

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PRINTED: 02/14/20 FORM APPROVE OMB NO. 0938-03

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION 2 2 2012	(X3) DATE SURVEY COMPLETED	-
		345211	B. WNG		02/02/2012	
	ROVIDER OR SUPPLIER INT CREST NURSING AM	ID REHABILITATION CENTER	26	EET ADDRESS, CITY, STATE, ZIP CODE 600 OLD CHERRY POINT ROAD IEW BERN, NC 28563		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLE	:11
	manner and in an envenhances each reside full recognition of his of the recognition of acility failed to treat a manner by administer residents (# 12) while a table with 3 other rethe findings include:  Resident #12 was admos/25/10 with cumulat Alzheimer's disease a resident was coded or (minimum data set) dashort and long term mobeing moderately improcess.  The resident was obsessed and the resident was obsessed to the resident was obsessed to bring their breakfulles in the dining root table eating their breakfulles in the dining root table eating their breakfulles in the dining root table eating their breakfulles in the dining root and preparesident #12. Included resident was Refresh et #1 administered all the	note care for residents in a circonment that maintains or ent's dignity and respect in or her individuality.  is not met as evidenced an and staff interview, the resident in a dignified ing eye drops to 1 of 1 the resident was seated at sidents during breakfast.  Interest to the facility on live diagnoses that included and Hypertension. The in the most recent MDS atted 01/24/12 as having emory problems and as aired in the decision making the residents. Resident go, but her table mates were ast. There were 5 other on with residents at each of state of the medications for the medications for this eye drops. When Nurse pills to the resident, she	F 241	Riverpoint Crest Nursing bilitation Center acknowledge of the Statement cies and proposes this rection to the extent of factually correct and in maintain compliance while rules and provision care of residents. The rection is submitted as allegation of compliance Riverpoint Crest Nursing bilitation Center's respondence agreement with ment of Deficiency denote agreement with ment of Deficiencies not constitute an admission deficiency is accurate. Riverpoint Crest Nursing bilitation Center reserve to refute any of the deficiency in the deficiency is accurated to refute any of the deficiency in the deficiency in the deficiency in the deficiency is accurated to refute any of the deficiency in the deficiency is accurated to refute any of the deficiency in the deficiency is accurated to refute any of the deficiency in the deficiency is accurated to refute any of the deficiency in the deficiency is accurated to refute any of the deficiency in the deficiency is accurated to refute any of the deficiency in the deficiency is accurated to refute any of the deficiency in the deficiency is accurated to refute any of the deficiency in the deficiency is accurated to refute any of the deficiency in the deficiency is accurated to refute any of the deficiency in the deficiency is accurated to refute any of the deficiency in the deficiency is accurated to refute any of the deficiency in the defi	owledges re- of Deficien- plan of cor- f findings is order to vith applica- s of quality of plan of cor- a written ce.  If and Reha- onse to this les does not in the State- or does it in that any Further, if and Reha- es the right iciencies on encies te Resolu- cedure ilstrative or	
ABORATORY D	DIRECTOR'S OR PROVIDERUS	PPLIER REPRESENTATIVE'S SIGNATURE		Administrator	2/21/12	

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

PRINTED: 02/14/20 FORM APPROVE OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	TIFICATION NUMBER:		P) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345211	B. WIN	3		02	/02/2012	
RIVERPO (X4) ID	SUMMARY	AND REHABILITATION CENTER STATEMENT OF DEFICIENCIES	ID	2600 ( NEW	ADDRESS, CITY, STATE, ZIP CODE OLD CHERRY POINT ROAD BERN, NC 28563 PROVIDER'S PLAN OF CO		(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI) TAG		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETION DATE	
F 241	Nurse#1 had to encher eyes open for the some difficulty was drops.  During an interview 08:48 AM it was respolicy about giving in the dining room.  During an interview (DON) on 02/02/12 "we do not have a pin the dining room, drops in the dining room,	ops over to the resident. courage the resident to keep he administration and after able to administer the eye with nurse #1 on 02/02/12 at yealed "I am not aware of any medications to residents while This is what I always do." with the Director of Nursing at 10:00 AM it was revealed policy about giving medications but it is not ok to give eye room. We should only be edications while residents are	F	241	All licensed nurses and aides will be inserviced to include providing presidents when admindrops, by Feb. 23, 2013  On Feb. 3, 2012 reside reviewed by the Directing for dignity to include during the administrate drops. No issues were All residents were observed administrative nurses administrative nurses administrative nurses administrative nurses administration of each of the each of the administration of each of the each of th	d on dignity, rivacy to istering eye 2. Int #12 was tor of Nursde dignity tion of eye identified. In erved by on Feb. 20, lude during	2/23/201	
					All residents receiving including resident # 12 monitored to ensure d ty/privacy is maintaine the administration of e	2, will be ligni- ed during		

#### F241 Continued from page 2

Administrative nurses will monitor eye drop administration for compliance and record results on an audit tool. Residents receiving eye drops will be randomly monitored 3 times per week for 4 weeks, then 2 times per week for 2 weeks, then weekly for 4 weeks. If any issues are identified the administrative nurse will provide retraining for the involved staff member.

Results of the audit will be reviewed weekly by the Administrator, Director of Nursing and the Administrative Nurses, with follow up taken as indicated for any potential identified concern. Results will be included in the monthly Quality Improvement committee meeting for 3 months, to identify any potential issues with training as indicated, and to determine the need for and/or the frequency of continued monitorings.

# COMPLETE IN-SERVICE TRAINING REPORT WITH PERSONNEL ATTENDING Department: \(\sin\cap(\Sin\cap())\) 2 Time: Varied. Employee group(s) present: RN, LPN, med aide. Total number of employees in group(s): Number present: Number not present: Dignity The facility must promote care for residents in manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his her individuality. Dignity includes providing privacy when administering eye drops to residents.

Conducted by: Kotie L. Rame y	Molissa Parker RNIDON
Title: RN SOC	
Signature: CMCHU SARQUUY	Title: RN 60c_

BN 1030 Rev. 3/95

#### Riverpoint Crest Nursing and Rehab Center

#### Employee list of Nurses and Med Aides

	,
Christine Casen, LPN Christine Cerm LPN	Kimberly Sadler, LPN humberly Sadler
Lydria Collins, LPN Pydlua Calluns LPN	Stephanie Walker, LPN Stephenie Walker
Jennifer Corona, RN GN COMNORN	Jennifer White, LPN Dornifer White Con
Carolyn Cribb, RN Weller	
Nancy Davidson, RN Composition	
Arika Dawson, LPN Aula Jawson Wor	
Belinda Dillahunt, LPN Bedinde Millah.	ut, epi
Billie Ellis, LPN Billia Chi	,
Monica Frazier, LPN Manuel Constitution	•
Reba Gay, RN Rela Gay, RN 1	r N
Sharon Gillyourd, Med Aid Slaved Aulysu	rol-
Tracey Hardy, Med Aid Laney Handy	
Vanessa Joyner, LPN Vanena H. Joepen U	) <b>0</b>
Kari Linthicum, RN Kau Kur	
Diane Maiden, LPM Come Moud SAN	
Dana McCarthy, LPN Dana McCarthylon	
Patricia Morris, LPN 9. Mounte	•
Melissa Norman, RN milion and market	
Melissa Parker, RN Melissa Perter P	
Katie Ramey, RN MOWLANDOWN RV	

Date	Time
Nurse/med aide observed_	
Resident(s) observed	
Privacy provided when adm drops?	inistering eye
If no, retraining provided?	· .
Nurse retrained signature	
Signature of nurse completi	ng

Date <u> </u>	Time	0740
Nurse/med aide observed	Kari Li	Hueum
Resident(s) observed Seiko	Sugry ama.	susie Dupre
Cecil Toler		
Privacy provided when admini drops? 식인 If no, retraining provided?		
Nurse retrained signature		· · · · · · · · · · · · · · · · · · ·
Signature of nurse completing audit(\mathbb{M}) (\mathbb{L}) (\mathbb{L}) (\mathbb{L})		

	•	
Date 02 20	Time 1200	<del></del>
Nurse/med aide observed	Christia Cesen	
Resident(s) observed	0. logers	
	•	
Privacy provided when admidrops?	inistering eye	
If no, retraining provided?		
Nurse retrained signature		
	<b>x</b>	
Signature of nurse completing	ng	
audit . MADA 0		

Date 2-20-12	Time 0915
Nurse/med aide observed	Belinda Dillahunt
Resident(s) observed Ruby D	anvels. Anna Ingram.
May Levy Gettre being	· Rayford Godley
<b>\</b>	
Privacy provided when admir	nistering eye
drops? Yes	
If no, retraining provided?	
Nurse retrained signature	
Signature of nurse completing	σ

Date 2/20/13.	Time Obis.
Nurse/med aide observed Koni	Linthicen
Resident(s) observed B. Complett,	M. Finke, L. Jones
M. Johnson, L. Dunn,	
Privacy provided when administe	ring eye
drops?	
If no, retraining provided?	
Nurse retrained signature	
Signature of nurse completing	

Date 2/20/12	Time	0800
Nurse/med aide observed Kim	n Sadle	<u> </u>
Resident(s) observed from, M. Will Harkey, Cooper	iamo, BW	hita, Booth, Davis
Privacy provided when administe drops?  If no, retraining provided?	ring eye	
Nurse retrained signature		· · · · · · · · · · · · · · · · · · ·
Signature of nurse completing	\	

Date 2 · 20 · 12.	Time_0800
Nurse/med aide observed	hristine Casen.
Resident(s) observed Wilson F	ustice, Octavious Rogers;
Claude Hall.	
Privacy provided when admir drops? \( \psi \D \cdot \)	nistering eye
If no, retraining provided?	Na.
Nurse retrained signature	<u> </u>
Signature of nurse completin	g .

#### FROM THE DESK OF MELISSA PARKER, RN DON RIVERPOINT CREST NURSING AND REHAB FAX: (252)637-0289

(252)637-4730

PLEASE DELIVER TO: Dianne Underwood, Facility Survey

Consultant

DATE/TIME: February 21, 2012

RE: Plan of Correction

Dianne-

I am faxing the Plan of Correction for our survey on January 30, 2012 through February 2, 2012.

The Plan of Correction will also be mailed to you today.

If any further information is needed, please call me.

NUMBER OF PAGES: \( \square\)
Including cover

THANK YOU,

pelisa Parker Ro

notice: Unauthorized interception of his telephonic communication could be a violation of federal and stat law(s). The documents attached to this transmittal contain confidential information. They belong to the sender and are legally privileged. The information contained herein is intended for use only by the authorized receiver named above. It cannot be re-disclosed for use by any other party. If you are not the authorized receiver your are hereby notified that any disclosure, copying, distribution, or taking any action in reliance on the information contained herein is prohibited. If you have received these documents in error, notify the sender immediately by telephone to arrange for the return of the original documents to said sender or to receive instructions for their destruction.

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION 1 9 2012 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING 01 - MAIN BUILDING 01 B. WING 03/01/2012 345211 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2600 OLD CHERRY POINT ROAD RIVERPOINT CREST NURSING AND REHABILITATION CENTER NEW BERN, NC 28563 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE ID (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Riverpoint Crest Nursing and Reha-K 000 K 000 INITIAL COMMENTS bilitation Center acknowledges re-This Life Safety Code(LSC) survey was celpt of the Statement of Deficienconducted as per The Code of Federal Register cles and proposes this plan of corat 42CFR 483.70(a); using the Existing Health rection to the extent of findings is Care section of the LSC and its referenced publications. This building is Type V protected factually correct and in order to construction, one story, with a complete maintain compliance with applicaautomatic sprinkler system. ble rules and provisions of quality of The deficiencies determined during the survey care of residents. The plan of corare as follows: rection is submitted as a written NFPA 101 LIFE SAFETY CODE STANDARD K 045 K 045 allegation of compliance. SS=D Illumination of means of egress, including exit discharge, is arranged so that failure of any single Riverpoint Crest Nursing and Rehalighting fixture (bulb) will not leave the area in bilitation Center's response to this darkness. (This does not refer to emergency lighting in accordance with section 7.8.) Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does It constitute an admission that any This STANDARD is not met as evidenced by: deficiency is accurate. Further, 42 CFR 483.70(a) Riverpoint Crest Nursing and Reha-By observation on 3/1/12 at approximately noon the following exit discharge Illumination was bilitation Center reserves the right observed as noncompliant: specific findings to refute any of the deficiencles on include a single bulb fixture at the 500 exit and it's path to the public way. Lighting must be arranged this Statement of Deficiencies to provide light from the exit discharge leading to through Informal Dispute Resoluthe public way (parking lot). The walking tion, formal appeal procedure surfaces within the exit discharge shall be and/or any other administrative or illuminated to values of at least 1 ft-candle measured at the floor. Failure of any single legal proceeding. lighting unit does not result in an illumination level of less than 0.2 ft-candles in any designated area. NFPA 101 7.8.1.1, 7.8.1.3, and 7.8.1.4. K 069 K 069 NFPA 101 LIFE SAFETY CODE STANDARD

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

Administrator

(X6) DATE

PRINTED: U3/U6/2012

y deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

Facility ID: 923028

#### K 045

Single bulb fixture will be replaced with a double bulb fixture.

Maintenance staff will inspect exit lighting throughout the facility to ensure that at least double bulb fixtures are present. If single bulb fixtures are identified, they will be replaced with double buld fixtures.

Maintenance will inspect exit lighting weekly to insure that all fixtures are working properly. Lighting will be replaced as needed.

Results of inspections will be reviewed monthly in the Quality Improvement meetings for 3 months, then quaterly for 2 quarters and then on an as needed basis.

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

FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) A A. BU		PLE CONSTRUCTION  G 01 - MAIN BUILDING 01	(X3) DATE S COMPL	
		345211	B. WI	NG _		03/0	01/2012
	PROVIDER OR SUPPLIER OINT CREST NURSIN	G AND REHABILITATION CENTE	ΞR	2	REET ADDRESS, CITY, STATE, ZIP CODE 600 OLD CHERRY POINT ROAD IEW BERN, NC 28563		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X6) COMPLETION DATE
	Cooking facilities ar with 9.2.3. 19.3.2  This STANDARD is 42 CFR 483.70(a) By observation on 3 the facility's cooking accordance with NF and Fire Protection of Operations.  Specific findings inclocated next to a gas	e protected in accordance	K	069	Stainless steel splash guard winstalled between the deep frand the gas cook top.  Maintenance staff will inspective kitchen to identify any ot areas where water has the poto splash into deep fryer. If a other areas are identifed, a siguard will be installed.  Maintenance staff will inspect kitchen weekly to insure that other issues of water potential splashing into deep fryer exist. Results of inspections will be reviewed monthly in the Quality provement meetings for 3 mothen quaterly for 2 quarters at then on an as needed basis.	t en- her otential ny olash t no ally :	4/15/12
i		:		:		1	1

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

PRINTED: 03/06/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  O 2 - BUILDING 02	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		345211	B. WING		004	03/01/2012	
	PROVIDER OR SUPPLIER DINT CREST NURSIN	G AND REHABILITATION CENTE	=R 26	EET ADDRESS, CITY, STATE, ZIP COI 00 OLD CHERRY POINT ROAD EW BERN, NC 28563		01/2012	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	STEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX YAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-RÉFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 000	INITIAL COMMENT	ΓŜ	K 000		**************************************		
	conducted as per T at 42 CFR 483,70(a Care section of the	de(LSC) survey was he Code of Federal Register a); using the Existing Health LSC and its referenced	-				
1	construction, one stautomatic sprinkler	uilding is Type V protected ory, with a complete system.	The second secon				
	There were no Life to noted at time of surv	Safety Code Deficiencies /ey.	-	•		ALL THE PROPERTY OF THE PROPER	
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		distance of the second					
			- And the second				
RATORY D	RECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE		(6) DATE	

by deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days flowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

PRM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NFL221

Facility ID: 923028

If continuation sheet Page 1 of 1

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

PRINTED: 03/06/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA   IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			- 1	VO EGILENING VS		
		345211	B. WING		03/	01/2012
		NG AND REHABILITATION CENTI	ER	FREET ADDRESS, CITY, STATE, ZIP COU 2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD RE	(X5) COMPLET DATE
K 000	INITIAL COMMEN  This Life Safety Conducted as per 1	TS ode(LSC) survey was The Code of Federal Register	K 000			
	at 42 CFR 483.70(a Care section of the publications. This b	a); using the Existing Health LSC and its referenced puilding is Type V protected tory, with a complete			·	
	There were no Life noted at time of sur	Safety Code Deficiencies vey.				
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7	1 to	ALLEMANTE OF SIGNAL	ONE	TITLE	(Xe	DATE

ny deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

DRM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NFL221

Facility ID: 923028

If continuation sheet Page 1 of 1

#### FIRE SAFETY SURVEY REPORT CRUCIAL DATA EXTRACT (TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUM	BER F	FACILITY NAME					SURVEY DATE		
345211 Riverpoint Cr				rsing & Rehak	* K4	3/1/12			
K6 DATE OF PLA APPROVAL  2/4/98  LSC FORM INDIC	CATOR	MULTIPLE ( TOTAL NUMBER NUMBER OF THIS	OF BUILD	DINGS <u>3</u> ING <u>0303</u> COMPLETE IF I SMALL (16 BED			IG MENT UNIT		
13	2786R	2000 NEW		K8:	2 SLOW	PTICAL			
	2786U 2786U 	2000 NEW BER OF FORM U	NG .	3 IMPRACTICAL  LARGE  4 PROMPT  5 SLOW  6 IMPRACTICAL  APARTMENT HOUSE  K8: 7 PROMPT  8 SLOW  9 IMPRACTICAL					
(Check if K29 or K in the 2786 M, R, 1 K29:	T, U, V, W, X a	and Y.)		ENTER E – SCC K5:	e.g. 2.5				
A1. X (COMP. WIT ALL PROVISIO	A2 H (ACC NS)	CEPTABLE POC)	A:		A4. [] (FSES)		A5. [] (PERFORMANCE BASED DESIGN)		
B				A. 🔲 Y SPRINKLERED d areas are sprinklered)	B, PARTIALLY SPF		C. NONE (No sprinkler system)		
* MANDATORY	#TT-orbor do A > ma	· · · · · · · · · · · · · · · · · · ·				AMARA ATT ANTI- T			

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Form CMS-2786R

#### FIRE SAFETY SURVEY REPORT CRUCIAL DATA EXTRACT (TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER		FACILITY NAME					SURVEY DATE					
<u>K1</u>	345211 Riverpoint Crest					Nursing & Rehab (Britthaven) 3/1/r						
K6 DATE OF PLAN APPROVAL 1/1/85			K3 MULTIPLE CONSTRUCTION  TOTAL NUMBER OF BUILDINGS 3  NUMBER OF THIS BUILDING 0103			A	A BUILDI B WING C FLOOR					
LSC FO	RM INDI	CATOR	**************************************		COMPL	ETEIF	ICF/MR IS SURV	D APART	MENT UNIT			
	Health C	2786R 2786R	2000 EXISTI 2000 NEW	NG	SMALL	(16 BEC	OS OR LESS)  1 PROMPT 2 SLOW 3 IMPRACTION	CAL				
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[	16 2786V, W, X 2000 EXISTING					5 SLOW 6 IMPRACTICAL						
17 2786V, W, X 2000 NEW  SELECT NUMBER OF FORM USED FROM ABOVE					APARTMENT HOUSE  7 PROMPT 8 SLOW 9 IMPRACTICAL							
in the 27	86 M, R, 1	<i>T, U, V, W, )</i> ] къ			K5;	E – SCO	PRE HERE)					
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* MANDA	TORY					~		* · · · · · · · · · · · · · · · · · · ·				

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Form CMS-2786R