STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345211	A. BUILDING _____ B. WING _____	02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERPOINT CREST NURSING AND REHABILITATION CENTER	2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to treat a resident in a dignified manner by administering eye drops to 1 of 1 residents (# 12) while the resident was seated at a table with 3 other residents during breakfast. The findings include: Resident #12 was admitted to the facility on 05/25/10 with cumulative diagnoses that included Alzheimer's disease and Hypertension. The resident was coded on the most recent MDS (minimum data set) dated 01/24/12 as having short and long term memory problems and as being moderately impaired in the decision making process. The resident was observed on 02/02/12 at 8:25AM on the secured unit, sitting in the dining room at a table with 3 other residents. Resident #12 had finished eating, but her table mates were still eating their breakfast. There were 5 other tables in the dining room with residents at each table eating their breakfast. Nurse #1 was observed to bring the medication cart into the dining room and prepared medications for resident #12. Included in the medications for this resident was Refresh eye drops. When Nurse #1 administered all the pills to the resident, she	F 241	Riverpoint Crest 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. Riverpoint Crest 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, Riverpoint Crest 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.	

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

S.W m.l. J.T.E

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345211	A. BUILDING _____ B. WING _____	02/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERPOINT CREST NURSING AND REHABILITATION CENTER	2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563

(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 241	Continued From page 1 brought the eye drops over to the resident. Nurse#1 had to encourage the resident to keep her eyes open for the administration and after some difficulty was able to administer the eye drops. During an interview with nurse #1 on 02/02/12 at 08:48 AM it was revealed "I am not aware of any policy about giving medications to residents while in the dining room. This is what I always do." During an interview with the Director of Nursing (DON) on 02/02/12 at 10:00 AM it was revealed "we do not have a policy about giving medications in the dining room , but it is not ok to give eye drops in the dining room. We should only be giving by mouth medications while residents are in the dining room."	F 241	F 241 All licensed nurses and medication aides will be inserviced on dignity, to include providing privacy to residents when administering eye drops, by Feb. 23, 2012. On Feb. 3, 2012 resident #12 was reviewed by the Director of Nursing for dignity to include dignity during the administration of eye drops. No issues were identified. All residents were observed by administrative nurses on Feb. 20, 2012 for dignity to include during the administration of eye drops. All residents receiving eye drops, including resident # 12, will be monitored to ensure dignity/privacy is maintained during the administration of eye drops.	2/23/201

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 monitoring.

COMPLETE IN-SERVICE TRAINING REPORT WITH PERSONNEL ATTENDING

Facility: Riverpoint Crest Department: Nursing.

Date: 2-16-12 thru 2/21/12 Time: varied. To:

Meeting area: 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: Katie L Ramey Melissa Parker RN/DON

Title: RN/SDC

Signature: Katie L Ramey Title: RN/SDC

Riverpoint Crest Nursing and Rehab Center

Employee list of Nurses and Med Aides

Christine Casen, LPN

Lydria Collins, LPN

Jennifer Corona, RN

Carolyn Cribb, RN

Nancy Davidson, RN

Arika Dawson, LPN

Belinda Dillahunt, LPN

Billie Ellis, LPN

Monica Frazier, LPN

Reba Gay, RN

Sharon Gillyourd, Med Aid

Tracey Hardy, Med Aid

Vanessa Joyner, LPN

Kari Linthicum, RN

Diane Maiden, LPN

Dana McCarthy, LPN

Patricia Morris, LPN

Melissa Norman, RN

Melissa Parker, RN

Katie Ramey, RN

Kimberly Sadler, LPN

Stephanie Walker, LPN

Jennifer White, LPN

Eye Drop Administration

Date_____ Time_____

Nurse/med aide observed_____

Resident(s) observed_____

Privacy provided when administering eye drops?_____

If no, retraining provided?_____

Nurse retrained signature_____

Signature of nurse completing audit_____

Eye Drop Administration

Date 2-20-12 Time 0740

Nurse/med aide observed Kari Linthicum

Resident(s) observed Seiko Sugiyama · Susie Dupre

Cecil Toler

Privacy provided when administering eye drops? Yes

If no, retraining provided? _____

Nurse retrained signature _____

Signature of nurse completing audit [signature]

Eye Drop Administration

Date 02/20 Time 1200

Nurse/med aide observed Christine Cesen

Resident(s) observed O. Rogers

Privacy provided when administering eye drops? yes

If no, retraining provided? _____

Nurse retrained signature _____

Signature of nurse completing audit [signature]

Eye Drop Administration

Date 2-20-12 Time 0913

Nurse/med aide observed Belinda Dillehunt

Resident(s) observed Ruby Daniels · Anna Ingram ·

Mary Levy · Gethe Lewis · Rayford Godley

Privacy provided when administering eye drops? Yes

If no, retraining provided? _____

Nurse retrained signature _____

Signature of nurse completing audit [signature] RN

Eye Drop Administration

Date 2/20/12. Time 0815.

Nurse/med aide observed Kari Linthicum

Resident(s) observed B. Campbell, M. Finke, L. Jones

M. Johnson, L. Dunn,

Privacy provided when administering eye drops? Yes.

If no, retraining provided?_____

Nurse retrained signature_____

Signature of nurse completing audit Jennifer LeMaster

Eye Drop Administration

Date 2/20/12 Time 0800

Nurse/med aide observed Kim Sadler

Resident(s) observed Bryan, M. Williams, B White, Booth, Davis Hankey, Cooper

Privacy provided when administering eye drops? yes

If no, retraining provided? _____

Nurse retrained signature _____

Signature of nurse completing audit Dana McCarthy

Eye Drop Administration

Date 2·20·12. Time 0800

Nurse/med aide observed Christine Casen.

Resident(s) observed Wilson Justice, Octavious Rogers;

Claude Hall.

Privacy provided when administering eye drops? yes.

If no, retraining provided? n/a.

Nurse retrained signature n/a.

Signature of nurse completing audit [signature] RN

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: 13
Including cover

THANK YOU,

Melissa Parker RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345211	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERPOINT CREST NURSING AND REHABILITATION CENTER	2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type V protected construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Riverpoint Crest 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. Riverpoint Crest 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, Riverpoint Crest 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.	
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 3/1/12 at approximately noon the following exit discharge illumination was observed as noncompliant: specific findings include a single bulb fixture at the 500 exit and it's path to the public way. Lighting must be arranged to provide light from the exit discharge leading to the public way (parking lot). The walking surfaces within the exit discharge shall be illuminated to values of at least 1 ft-candle measured at the floor. Failure of any single 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 045		
K 069	NFPA 101 LIFE SAFETY CODE STANDARD	K 069		4/15/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Paul [signature] — TITLE: Administrator — (X6) DATE: 3/14/12

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ner 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.

DRW

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345211	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERPOINT CREST NURSING AND REHABILITATION CENTER	2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563

(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 069 SS=D	Continued From page 1 Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 3/1/12 at approximately noon. the facility's cooking system was not protected in accordance with NFPA 96 - Ventilation Control and Fire Protection of Commercial Cooking Operations. Specific findings include; the deep fryer was located next to a gas cook top stove without the required splash guard in the dietary kitchen.	K 069	K069 Stainless steel splash guard was installed between the deep fryer and the gas cook top. Maintenance staff will inspect entire kitchen to identify any other areas where water has the potential to splash into deep fryer. If any other areas are identifed, a splash guard will be installed. Maintenance staff will inspect kitchen weekly to insure that no other issues of water potentially splashing into deep fryer exist. 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.	4/15/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345211	A. BUILDING 02 - BUILDING 02 B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERPOINT CREST NURSING AND REHABILITATION CENTER	2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type V protected construction, one story, with a complete automatic sprinkler system. There were no Life Safety Code Deficiencies noted at time of survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paul [illegible]	Administrator	3/14/12

ıy 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 llowing 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 ıys 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.

DRW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345211	A. BUILDING 03 - BUILDING 03 B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVERPOINT CREST NURSING AND REHABILITATION CENTER	2600 OLD CHERRY POINT ROAD NEW BERN, NC 28563

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type V protected construction, one story, with a complete automatic sprinkler system. There were no Life Safety Code Deficiencies noted at time of survey.	K 000		

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

Paul [signature] Administrator 3/14/12

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 llowing 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 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 'ogram participation.

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

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
345211	Riverpoint Crest Nursing & Rehab (Britthaven)	3/1/12
K1		* K4

K6 DATE OF PLAN APPROVAL: 2/4/98

K3 MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS: 3

NUMBER OF THIS BUILDING: 0303

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786R	2000 EXISTING
13	2786R	2000 NEW

ASC Form		
14	2786U	2000 EXISTING
15	2786U	2000 NEW

ICF/MR Form		
16	2786V, W, X	2000 EXISTING
17	2786V, W, X	2000 NEW

*K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/MR IS SURV

SMALL (16 BEDS OR LESS)

K8: [ ]

1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]

4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]

7 PROMPT
8 SLOW
9 IMPRACTICAL

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X and Y.)

K29: [ ] K56: [ ]

ENTER E – SCORE HERE)

K5: [ ] e.g. 2.5

*K9: FACILITY MEETS LSC BASED ON *(Check all that apply)*

A1. [X] (COMP. WITH ALL PROVISIONS)
A2. [ ] (ACCEPTABLE POC)
A3. [ ] (WAIVERS)
A4. [ ] (FSES)
A5. [ ] (PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. [ ]

K0180

A. [X] FULLY SPRINKLERED (All required areas are sprinklered)
B. [ ] PARTIALLY SPRINKLERED (Not all required areas are sprinklered)
C. [ ] NONE (No sprinkler system)

* MANDATORY

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

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
345211 K1	Riverpoint Crest Nursing & Rehab (Britthaven)	3/1/12 * K4

K6 DATE OF PLAN APPROVAL: 1/1/85

K3 MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS: 3

NUMBER OF THIS BUILDING: 0103

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786R	2000 EXISTING
13	2786R	2000 NEW

ASC Form		
14	2786U	2000 EXISTING
15	2786U	2000 NEW

ICF/MR Form		
16	2786V, W, X	2000 EXISTING
17	2786V, W, X	2000 NEW

*K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/MR IS SURV

SMALL (16 BEDS OR LESS)

K8: [ ]

1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]

4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]

7 PROMPT
8 SLOW
9 IMPRACTICAL

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X and Y.)

K29: ☐ K56: ☐

ENTER E – SCORE HERE)

K5: [ ] e.g. 2.5

*K9: FACILITY MEETS LSC BASED ON *(Check all that apply)*

A1. ☐ (COMP. WITH ALL PROVISIONS)
A2. ☒ (ACCEPTABLE POC)
A3. ☐ (WAIVERS)
A4. ☐ (FSES)
A5. ☐ (PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. ☐

K0180

A. ☒ FULLY SPRINKLERED (All required areas are sprinklered)
B. ☐ PARTIALLY SPRINKLERED (Not all required areas are sprinklered)
C. ☐ NONE (No sprinkler system)

* MANDATORY