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
	345394	A. BUILDING _____ B. WING _____ MAR 28 2012	03/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOK STONE LIVING CENTER	8990 HWY 17 SOUTH POLLOCKSVILLE, NC 28573

(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 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure 1 of 1 residents (Resident #2) environment was free of odors. The findings include: On 2/28/12 at 1:45 pm resident #2 was observed in his room sitting in his wheelchair watching television. There was a strong odor of urine in the room,. A urine collection bag was observed at the head of the resident's bed. On 2/29/12 at 9:00 am, resident #2 bedroom was observed to have a strong odor of urine throughout the room. On 3/01/12 at 8:30 am, room of resident #2 was observed to have a strong odor of urine throughout the room; signage outside of resident #2's room stated that room was scheduled for deep cleaning. During an interview on 2/29/12 at 4:50 pm with nursing assistant (NA #1) revealed that Resident #2 will change the sheets and wipe down the mattress as they become soiled. NA #1 further revealed that the resident will normally change his	F 252	F 252 1 Resident #2's room was deep cleaned by Housekeeping to eliminate all odors and clean room on 3/1/12. 2. All rooms will be cleaned daily by Housekeeping & deep cleaned 2x a month to ensure environment is free of odors. 3. Housekeeping Supervisor, MDS Nurse, Floor Nurse, RN Supervisor, will monitor daily for 3 weeks and then Housekeeping Supervisor will check room(s) weekly to ensure environment is free of odors. 4. Monthly reviews will be discussed monthly during the QA meeting. The Housekeeping Supervisor, DON, and Administrator will ensure correction is achieved and maintained during the monthly QA meetings x 3 months.	3-28-12 3-28-12 3-28-12 3-28-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kevin Mallard — TITLE: Administrator — (X6) DATE: 3-28-12

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.

Revised

AG. 4

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BROOK STONE LIVING CENTER	8990 HWY 17 SOUTH POLLOCKSVILLE, NC 28573

(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 252	Continued From page 1 own sheets. NA#1 communicated he was aware of the scent of urine but does not smell the odor al the time. During an interview on 2/29/12 at 4:45 pm NA #2 indicated that no care is provided to Resident #2. NA #2 stated that resident #2 does empty his urine collection bag and that the resident is very independent. NA #2 is aware of the odor in the resident ' s room and further stated that odor was addressed in " morning meetings " . On 3/1/12 at 2:40 pm in an interview with the Director of Nursing (DON), she indicated an awareness of the strong smell of urine that is in the resident ' s room. The DON stated that the facility has hung socks with coal under the resident ' s bed to aid in absorbing the scent.	F 252	F311 1. Resident #2 has been evaluated and care planned for his ability to independently care for his supra pubic catheter. 2. Audit has been completed determining any Residents performing independent care are evaluated and care planned appropriately. (No other Resident(s) found to be performing independent care at this time) 3. MDS Nurse, Floor Nurse, DON, &/or RN Supervisor will assess all new Residents and existing residents for independent self care performance and evaluate their abilities. MDS Nurse will continue to assess Residents upon admission and quarterly during MDS assessment. 4. Monthly reviews will be discussed monthly during the QA meeting. The Administrator & MDS Nurse and DON will ensure correction is achieved and maintained during the monthly QA meetings x 3 months.	3-23-12 3-23-12 3-23-12 3-23-12
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to assess 1 of 1 resident ' s (resident #2) resident ' s ability to independently care for his supra pubic catheter. Findings include: Resident #2 was admitted to the facility on 10/3/11 with diagnosis of a spinal injury, hypertension, urinary tract infections due to	F 311		

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F 311	Continued From page 2	F 311		

supra-pubic catheter, and pressure ulcers. The 1/25/12 Minimum Data Set (MDS) coded the resident as being cognitively intact and independent for activities of daily living.

An observation on 2/28/12 at 1:45 pm revealed Resident #2 was seen sitting in his room in his wheelchair watching television. There was a strong odor of urine in the bedroom. A urine collection bag was observed at the head of the resident ' s bed.

Further record review revealed that two Care Plan Conference summaries dated 11/10/11 and 1/10/12 identified: self care-does most of own ADL care; changes own colostomy; and transfers self.

On 2/29/12 at 4:40 pm in an interview with NA #1 (nursing assistant) NA # 1 stated that Resident #2 did his own ADL ' s. The NA #1 stated that Resident #2 liked to be independent. The NA stated that the resident sometimes empties the urine collection bag. NA #1 indicated when the resident is in bed he connects the catheter tubing to the urine collection bag and when he gets out of bed he then connects the catheter tubing to a leg bag which collects the urine. NA#1 indicated he was unaware of any training or assessment the resident received regarding his personal care for the supra pubic catheter and has been doing his own catheter care as long as he has been in the facility.

NA #1 indicated that the resident is particular with his choice of nursing assistants that assist him with his care and prefers to do the care himself. NA #1 stated he will change the sheets and wipe

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F 311	Continued From page 3 down the mattress as they become soiled. NA #1 further revealed that the resident will normally change his own sheets. The NA #1 stated he was aware of the scent of urine but does not smell the odor all the time On 2/29/12 at 4:59 pm in an interview, NA #2 indicated that no care is provided to Resident #2. NA #2 stated that resident #2 does empty his urine collection bag and that the resident is very independent. NA #2 is unaware of any training that the resident may have had regarding the continence care. NA #2 is aware of the odor in the resident ' s room and further stated that odor was addressed in " morning meetings " . Resident interview on 3/1/12 at 1:40 pm regarding the facilities assessment of his ability to provide his own supra pubic catheter care showed that the resident has been providing his own care for 6 to 7 years. Resident indicated the facility changed and emptied his catheter initially when admitted. Resident stated the facility did watch him do his catheter care in the beginning. Resident relayed it has been about a year ago when an RN or an LPN has watched him do his catheter care. Resident uses hand sanitizer when he provides his own care and communicated that he is not monitored while performing his own continence care. Resident empties his own collection bag once the bag is full. Occasionally nursing assistants will dispose of it when Resident is not in the room. Resident did not choose to allow surveyors to watch his supra pubic care routine. On 3/1/2012 at 2:30 pm the MDS/Care Plan Coordinator indicated that resident #2 provides	F 311		

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F 311	Continued From page 4 his own supra pubic catheter care and it should be care planned. MDS coordinator stated that the responsibility of determining the resident ' s ability to provide self-care is the responsibility of the MDS coordinator. She further revealed that he had been providing his own incontinent care prior to her employment. His technique should be assessed, probably quarterly and she will monitor his ability to independently complete the task. On 3/1/12 at 2:40 pm in an Interview with the Director of Nursing (DON) indicated that the resident is competent enough do his own care. He does ask us to look at him occasionally. The DON further indicated the resident has been performing his own continenence care years prior to being admitted. A care plan should identify a resident that perform his own ostomy care. There is no documentation that any monitoring has taken place. There should be nursing notes that document care provided. The DON is unaware of any training provided to the resident in regards to self care. DON is aware of the strong smell of urine that is in the resident ' s room. The facility has hung socks with coal under the resident ' s bed to aid in absorbing the scent.	F 311		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		

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F 431	Continued From page 5 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to insure that there were no expired medications in one (1) of (2) (the T hall) medication storage rooms. Findings include: On 3/1/2012 at 4:00 PM an observation was made of the T-hall medication storage room. It revealed a plastic container with 34 individually wrapped, single dose heparin flushes. Sixteen of these had an expiration date of September, 2011.	F 431	F 431 1. Outdated heparin flushes were disposed of 3/2/2012.. 2. Audit of all medications was completed to ensure no other out dated items were in medication storage rooms (no other out dated medications were found). 3. Administrator, Floor Nurse, &/or DON will monitor for 3 months to ensure no out dated medications are in medication storage rooms. Administrator will continue to check for out dated medications weekly and the DON will continue to check for out dated medications 2x a month. 4. Monthly reviews will be discussed monthly during the QA meeting. The Administrator & DON will ensure correction is achieved and maintained during the monthly QA meetings x 3 months.	3-23-12 3-23-12 3-23-12 3-23-12

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F 431	Continued From page 6 In an interview with the Nurse Facilitator on 3/1/2012 at 4:45 PM, the Nurse Facilitator stated that the pharmacy consultant checks the stock on Tuesday of the week before the QA meeting, which is the third Wednesday of the month. This nurse facilitator stated that the DON (Director of Nursing) also checks the stock once per month, and that the Administrator checks the stock twice monthly when new stock arrives. On 3/5/2012 at 1:50 PM in an interview, the DON stated that she checks the stock for expiration dates once per month, usually the middle of the month, but she does not have a written schedule to do these checks. The DON said that she will go into the medication room to put things away and she checks things then for expiration. The DON also stated that there are no labels that state when the stock was checked. The DON was unable to provide a reason why there was expired medication found in the medication storage room.	F 431		
F 463 SS=D	483.10(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure that call lights in 2 of 18 shared bathrooms (rooms 104 and134 share a bathroom; rooms103 and101 share a bathroom) were operational. Observation on 2/28/12 at 2:15 pm revealed two	F 463	F 463 1. Call lights for shared rooms 104 and 134 bathroom; and rooms 103 and 101 bathroom were repaired immediately. 3-23-12 2. Audit has been completed determining all other call lights were working properly for all bathrooms and bedrooms (the bathroom light shared for rooms 133 and 135 needed repaired). 3-23-12 3. Maintenance Director will monitor 5x a week for 2 months to ensure call light system is working properly; then once a week thereafter. 3-23-12 4. Monthly reviews will be discussed monthly during the QA meeting. The Administrator, Maintenance Director, & DON will ensure correction is achieved and maintained during the monthly QA meetings x 3 months. 3-23-12	

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F 463	Continued From page 7	F 463		

call lights that were not operational in 2 of 18 shared bathrooms. When call lights were turned to the on position in shared bathrooms, call lights were found not to flash outside residents rooms 104,134,103, and101.

During an interview on 2/28/12 at 3:20 pm, maintenance staff stated that he is made aware of call light malfunctions by nursing staff. Malfunctioning call lights had not been bought to his attention.

Observation on 2/28/12 at 4:00 pm revealed maintenance making repairs to shared bathroom call lights 104,134,103, and 101.

Brook Stone Living Center
P.O. Box 429
Pollocksville, NC 28573
Phone: 252-224-0112 Fax: 252-224-1076

March 23, 2012

NC Department of Health and Human Services
Division of Facility Services
Nursing Home Licensure and Certification Section
2711 Mail Service Center
Raleigh, NC 27699-2711

Dear Ms. Goodson:

Enclosed you will find the revised plan of correction for the survey conducted in our facility from 02/27/12 to 03/02/12.

If you need further information, please contact me at the above number.

Sincerely,

Janice Mallard

Janice Mallard
Administrator

PRINTED: 03/23/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	345394	A. BUILDING 01 - MAIN BUILDING 01 B. WING APR 13 2012	03/22/2012

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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 III. The facility at the time of the inspection did not have 100% sprinkler coverage. The bedroom closets and the hall showers are not covered by sprinklers · On August 13, 2008, the Center for Medicare & Medicaid Services (CMS) published a final rule entitled " Medicare and Medicaid Programs; Fire Safety Requirements for Long Term Care Facilities, Automatic Sprinkler System. " · This regulation requires all long term Facilities to be equipped with a supervised automatic sprinkler system by August 13, 2013, installed in accordance with the 199 edition of the National Fire Protection Association ' s (NFPA) " Standard for the Installation of Sprinkler System " (NFPA13). · Facilities with existing sprinkler systems should review their sprinkler system to determine if they meet the requirements of the 1999 edition of NFPA 13. · Web Link - https://www.cms.gov/surveycertificationgeninfo/downloads/sciletter09-04.pdf The deficiencies determined during the survey are as follows:	K 000	**K 012** 1. Holes and/or penetrations in top layer of sheetrock located in the attic have been sealed in order to maintain the required rating of the area. 5-6-12 2. Maintenance Director has checked attic area to determine no other holes and/or penetrations exist. (None found) 5-6-12 3. Maintenance Director will monitor 1x weekly for one month and then once a month for 1 quarter to ensure no holes or penetrations are present in attic area. 5-6-12 4. Administrator and Maintenance Director will review monthly in QA meetings to ensure no holes or penetrations are present in attic area to maintain the required rating of the area. 5-6-12 **K 029** 1. a. Holes and/or penetrations in the ceiling in the soiled utility room located on the 300 Hall have been repaired. 5-6-12 b. The rope used to hold the door of the Janitors closet located on 200 Hall has been removed.	
K 012 SS=F	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,	K 012		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Debbie Mallard | TITLE: Administrator | (X5) DATE: 4-12-12

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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K 012	Continued From page 1 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation on Thursday 3/22/12 between at approximately 9:00 AM onward the following was noted: 1) The one hour rated ceiling in the T-Hall corridor was not maintain. Specific finding found holes in the top layer of sheetrock located in the attic has hole and/or penetrations that were not sealed in order to maintain the required rating of the area. 42 CFR 483.70(a)	K 012	c. The door to the storage room on 200 Hall has been repaired so it now closes, latches, and seals properly and is a ¾ hour fire resistance rating door. d. Holes and/or penetrations in the ceiling in the sprinkler riser/mechanical room have been sealed to meet the required rating of the area. 2. Maintenance Director has checked all utility rooms, mechanical rooms to ensure no holes / penetrations are present in ceilings in order to meet the required rating in all areas and that door(s) close, latch, & seal properly.	5-6-12
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Thursday 3/22/12 between at approximately 9:00 AM onward the following was noted:	K 029	Housekeeping / Laundry staff has been in-serviced to ensure ropes or no other materials / objects are used to prevent door(s) from closing. 3. Maintenance Director will monitor 1x weekly for one month and then once a month for 1 quarter to ensure no holes / penetrations exist in all utility rooms & mechanical rooms. Housekeeping Supervisor will monitor 5x a week and then 1x monthly to ensure door(s) to Janitors closets close properly with no preventive devise present.	5-6-12

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K 029	Continued From page 2 1) The soiled utility room located on 300 Hall has holes and/or penetrations in the ceiling that were not sealed in order to meet the required rating of the area. 2) The Janitors closet located on 200 Hall was held open with a rope to prevent the door from closing. 3) The storage room located on 200 used for kitchen storage did not close, latch and seal. The door will be required to be a 3/4 hour rated door and the room to meet the one hour fire resistance rating since the building is not 100% sprinkler coverage. 4) There are holes and/or penetrations in the ceiling in the sprinkler riser/ mechanical room that were not sealed in order to meet the required rating of the area. 42 CFR 483.70(a)	K 029	4. Administrator, Maintenance Director, and Housekeeping Supervisor will review monthly in QA meetings to ensure no holes in ceiling exist or have been repaired in all areas; doors close, latch, and seal properly, and no doors are prevented from closing properly.	5-6-12
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation on Thursday 3/22/12 between at approximately 9:00 AM onward the following was noted: 1) The exit door located on 300 hall across from the resident telephone room required more than 15 pounds of force to open. 42 CFR 483.70(a)	K 038	**K 038** 1. The exit door located on 300 Hall across fro the Resident telephone room will be replaced with a new door. 2. All exit doors have been checked to ensure exits are readily accessible at all times. (All work properly) 3. The Maintenance Director & Administrator will monitor 1x week for one month and then once a month for 1 quarter to ensure all exit doors are readily accessible at all times. 4. Administrator and Maintenance Director will review monthly in QA meetings to ensure all exit doors are readily accessible at all times.	5-6-12 5-6-12 5-6-12 5-6-12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345394	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKSTONE LIVING CENTER	8990 HWY 17 SOUTH POLLOCKSVILLE, NC 28573

(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 047 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation on Thursday 3/22/12 between at approximately 9:00 AM onward the following was noted: 1) There are several exit and directional signs in the facility that are not fully illuminated. One of the two bulbs in the light is not operational. 42 CFR 483.70(a)	K 047	**F 047** 1. Exit and directional signs in the facility that did not fully illuminate have been replace with exit and directional signs with LED lighting for complete illumination. 2. Maintenance Director checked all exit and directional signs to ensure they are fully illuminated. 3. The Maintenance director will monitor 1x weekly for one month and then once a month for 1 quarter to ensure all exit and directional signs are fully illuminated. 4. Administrator and Maintenance Director will review monthly in QA meetings to ensure all exit and directional signs are fully illuminated.	5-6-12 5-6-12 5-6-12 5-6-12
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation on Thursday 3/22/12 between at approximately 9:00 AM onward the following was noted: 1) The smoke duct detectors located in the HVAC unit was not maintained clean and in good operating condition. Location - HVAC unit in the attic area on T-Hall 42 CFR 483.70(a)	K 054	**K 054** 1. The smoke duct detectors located in the HVAC unit has been cleaned and is in good operating condition. 2. Maintenance Director checked all duct detectors and all are in good operating condition. 3. Maintenance Director & monitor 1x weekly for one month and then once a month for 1 quarter to ensure duct detectors located in the HVAC unit is clean and in good operation condition.	5-6-12 5-6-12 5-6-12
K 056	NFPA 101 LIFE SAFETY CODE STANDARD	K 056		

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K 056 SS=D	Continued From page 4 If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on Thursday 3/22/12 between at approximately 9:00 AM onward the following was noted: 1) The sprinkler heads in the kitchen were not clean and maintained in good condition. 42 CFR 483.70(a)	K 056	4. Administrator and Maintenance Director will review monthly in QA meetings to ensure duct detectors located in the HVAC unit is clean and in good operation condition. 5-6-12 K 056 1. The sprinkler heads in the kitchen has been cleaned and will be maintained in good condition. 5-6-12 2. Sprinklers will be cleaned by BFPE routinely as they perform yearly maintenance of sprinkler system. 5-6-12 3. Maintenance Director & Administrator will monitor 1x weekly for one month and then once a month for 1 quarter to ensure sprinkler heads are clean and maintained in good condition. 5-6-12 4. Administrator and Maintenance Director will review monthly in QA meetings to ensure all sprinkler heads are clan and maintained in good condition. 5-6-12	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation on Thursday 3/22/12 between at approximately 9:00 AM onward the following was noted: 1) The kitchen cooking equipment were not properly placed under the hood. The back of the	K 069	K 069 1. a. the kitchen cooking equipment has been properly placed under the hood to allow for proper protection. 5-6-12	

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K 069	Continued From page 5 equipment were placed to far back and not allowing for proper protection. 2).Based upon observation at the time of the survey the kitchen was experiencing a sever negative pressure. NFPA 96 (Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 1998 Edition) Section 5-3* Replacement Air. - " Replacement air quantity shall be adequate to prevent negative pressures in the commercial cooking area(s) from exceeding 0.02 in. water column (4.98 kPa). " 42 CFR 483.70(a)	K 069	b. Air pressure in the kitchen has been corrected to prevent the presents of negative pressure. 2. Maintenance Supervisor and Dietary Manager will monitor 1x weekly and then once a month for 1 quarter to ensure equipment is properly placed under the hood to allow for proper protection and ensure air pressure in kitchen is adequate to prevent negative pressures in the cooking area. 3. Administrator, Maintenance Director, and Dietary Manager will review monthly in QA meetings to ensure equipment is properly placed under the hood to allow for proper protection and ensure air pressure in kitchen is adequate to prevent negative pressures in the cooking area.	5-6-12 5-6-12
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation on Thursday 3/22/12 between at approximately 9:00 AM onward the following was noted: 1) The lights in the 300 hall dinning room and 100 hall dinning room hang lower than 6' 8". Means of egress shall be designed and maintained to provide headroom as provided in other section of the Code and shall be not less than 7 ft 6 in. (2.3 m) with projections from the	K 072	K 072 1 Lights in both the 300 Hall and 100 Hall Dinning room will be replaced with lights that do not hang lower than 6'8". 2 Lights were assessed and no other lights hang lower than 6'8" in building. 3 Maintenance Director & Administrator will monitor 1x weekly for one month and then once a month for 1 quarter to ensure dinning room lights do not hang lower than 6'8".	5-6-12 5-6-12 5-6-12

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K 072	Continued From page 6 ceiling not less than 6 ft 8 in. (2 m)nominal height above the finished floor. NFPA 101 7.1.5 (These light were not located above and dinning room table but in the general area) 42 CFR 483.70(a)	K 072	4. Administrator and Maintenance Director will review monthly in QA meetings to ensure dinning room lights do not hang lower than 6'8". 5-6-12	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation on Thursday 3/22/12 between at approximately 9:00 AM onward the following was noted: 1) Full and empty oxygen cylinders were stored together. If stored within the same enclosure, empty cylinders shall be segregated and designated (with signage) from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. [NFPA 99 4-3.5.2.2b(2)] (oxygen storage room near the nurses station) 42 CFR 483.70(a)	K 076	**K 076** 1. Full and empty oxygen cylinders have been segregated and appropriate signage is in place to determine full cylinders and empty cylinders to avoid confusion and delay when a full cylinder is needed hurriedly. 5-6-12 2. Staff has been in-serviced in the proper placement of full cylinder and proper placement of empty & full cylinders. 5-6-12 3. Maintenance Director and Administrator will monitor 1x weekly for one month and then once a month for 1 quarter to ensure proper placement for full and empty cylinders. 5-6-12 4. Administrator and Maintenance Director will review monthly in QA meetings to ensure proper placement of full and empty cylinders. 5-6-12 **K 104** 1. Equipment for the smoke dampers located in the smoke wall on T-Hall have been ordered for repairs to correct 5-6-12	

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K 104 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on observation on Thursday 3/22/12 between at approximately 9:00 AM onward the following was noted: 1) The smoke dampers located in the smoke wall on T- hall did not close upon activation of the fire alarm system. Location - HVAC unit in the attic area on T-Hall 42 CFR 483.70(a)	K 104	dampers so they close upon activation of the fire alarm system. 2. Smoke dampers will be inspected by BFPE annually to ensure they close upon activation of the fire alarm system. 5-6-12 3. The Maintenance Director will monitor 1x weekly for one month and then once a month for 1 quarter to ensure smoke dampers close upon activation of fire alarm system. 5-6-12 4. Administrator and Maintenance Director will review monthly in QA meetings to ensure smoke dampers close upon activation of fire alarm system. 5-6-12	
K 135 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Flammable and combustible liquids are used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals. Storage cabinets for flammable and combustible liquids are constructed in accordance with NFPA 30, Flammable and Combustible Liquids Code, NFPA 99. 4.3, 10.7.2.1. This STANDARD is not met as evidenced by: Based on observation on Thursday 3/22/12 between at approximately 9:00 AM onward the	K 135	K 135 1. Flammable fluid used for chaffing dishes has been placed in a fire proof cabinet. 5-6-12 2. Building was checked and no other flammable fluids were found. 5-6-12 3. The Maintenance Director will monitor 1x weekly for one month and then once a month for 1 quarter to ensure any flammable fluids in the building are stored properly. 5-6-12 4. Administrator and Maintenance Director will review monthly in QA meetings to ensure any flammable fluids in the building are stored properly. 5-6-12	

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	345384	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/22/2012

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BROOK STONE LIVING CENTER	8980 HWY 17 SOUTH POLLOCKSVILLE, NC 28573

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K 135	Continued From page 8 following was noted: 1) Flammable fluid used for chaffing dishes was not store in an approved fire proof cabinet. (One case was found on a shelf in the kitchen storage room on 200 hall) 42 CFR 483.70(a)	K 135	**K 144** 1. The remote generator annunciator panel is scheduled for repair for 4/18/12 to correct the showing of generator supplying power appropriately. 5-16-12 2. Generator contractor will check proper operation of annunciator panel is showing generator supplying power appropriately during annual servicing. 5-16-12 3. Maintenance Director & Administrator will monitor 1x weekly for one month and then once a month for 1 quarter to ensure remote generator annunciator panel is working properly by showing the generator supplying power when checked. 5-16-12 4. Administrator and Maintenance Director will review monthly in QA meetings to ensure remote generator annunciator panel is working properly by showing the generator supplying power when checked. 5-16-12	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation on Thursday 3/22/12 between at approximately 9:00 AM onward the following was noted: 1) The remote generator annunciator panel located at the nurse station did not show generator supplying power when checked. 42 CFR 483.70(a)	K 144		