STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345377	A. BUILDING _____ B. WING _____	01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD PLACE	2575 W 5TH ST GREENVILLE, NC 27834

(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 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide proper incontinent care and failed to apply barrier cream as ordered for 1 (Resident # 42) of 3 dependant residents whose personal care was observed. Findings include: Review of the facility policy entitled PERINEAL CARE/INCONTINENT CARE (female) revised 11/10/99; under Procedure #9 read: "Separate labia with one hand and wash with the other. Use gentle downward strokes from the front to the back of the perineum to prevent intestinal organisms from contaminating the urethra or vagina. Use a clean section of the wash cloth for each downward stroke." #14 of the policy read: "Apply cream or ointment as ordered." Resident # 42 was admitted to the facility on 07/29/11 with diagnoses of hypertension, congestive heart failure, osteoarthritis, and dementia. A quarterly Minimum Data Set (MDS) completed on 11/30/12 documented Resident #42 as having short term and long term memory problems and severe cognitive impairments. Resident #42 was	F 312	F312 1. Nursing Assistant #1 (assigned to Resident #42) was counseled and an individual inservice was conducted on 1-11-13 regarding the importance of following the policy and procedure for proper incontinent care and correctly applying barrier cream when ordered. A skills validation was completed on 1-11-13 to assure compliance with proper incontinent care and application of barrier cream if ordered.	2-6-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sean Lowe CMHA | TITLE: Administrator | (X6) DATE: 1-23-2013

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 312	Continued From page 1 identified as being dependant on staff for all activities of daily living and incontinent of bowel and bladder. Review of Resident #42's 01/13 Physician Order Sheet showed on 01/10/12 an order for [brand name] cream to be applied to peri(perineum)/buttocks area after incontinent episodes. An observation was made on 01/09/13 at 9:25 AM of personal care rendered by Nurse Aide (NA) #1 on Resident #42. NA #1 had 2 basins of water on the over bed table. NA #1 unfastened both sides of Resident #42's soiled brief and rolled the brief down between Resident #42's legs. NA #1 took 3 disposable wipes and wiped down Resident #42's perineal area and rolled the resident on her right side and took another 3 disposable wipes and wiped the rectal area, removed the soiled brief and rolled Resident #42 on her back. NA #1 then took a washcloth, wet it in one basin and added soap to the washcloth and washed Resident #42's perineal area with a circular motion and then 3 downward strokes without opening the labia and placed the washcloth back in the same basin. NA #1 then rolled Resident #42 onto her right side and washed the rectal area and discarded the washcloth. NA #1 rolled Resident #42 onto her back and used the second basin and washcloth and rinsed Resident #42 in the same manner. NA #1 then used another washcloth and the same water and proceeded to wash Resident #42's back and lower extremities and placed a clean brief on Resident #42. NA # 1 did not apply any cream to Resident #42's prior to the brief placement.	F 312	**F312** 2. Skills validations will be conducted by Nursing Administration on all nursing assistants from 1-16-13 to 2-6-13 to assure compliance with the Incontinent Care Policy and to assure compliance with proper incontinent care and application of barrier cream if ordered. The nursing assistants will be inserviced on 1-16-13 thru 2-6-13 regarding the importance of proper incontinent care and application of barrier cream if ordered. 3. Skills validations will be completed on a minimum of 6 Nursing Assistants on completing proper incontinent care and application of barrier cream if ordered weekly x 4 weeks then monthly x 4 months by Nursing Administration to assure compliance with proper incontinent care.	2-6-13 2-6-13

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F 312	Continued From page 2 In an interview with NA #1 on 01/09/13 at 12:00 PM, NA #1 said she was supposed to open the resident's labia and clean from front to back and then change the water after. NA #1 said she did not do that when she provided care to Resident #42. NA #1 said she forgot to apply the barrier cream to Resident #42's buttocks. During an interview with Nurse #1 on 01/10/13 at 10:05 AM, she said it was her expectation that the nurse aides provided incontinent care by opening a females labia and cleaning from front to back with a clean section of the cloth with each wipe to prevent infection. Nurse #1 said she expected the water to be changed after perineal care was given and barrier cream was to be applied after. In an interview with the Director of Nurses (DON) on 01/10/13 at 2:55 PM, she said it was her expectation that staff followed the facility's procedure and separate the labia and clean a female resident's perineal area using downward strokes with a clean section of the cloth and discard the dirty water prior to completion of a bath.	F 312	**F312** 4. The skills validations on proper incontinent care and any deficiencies found will be taken to the facility QA&A committee. The QA&A committee will make recommendations based on the finding of the skills validations.	2-6-13
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to sustain dish machine final rinse temperatures in the range recommended by the company which serviced the machine, failed to dispose of sandwiches at the end of the day per the expectations of dietary management, and failed to rewash or dispose of compromised kitchenware. Findings include: 1. During initial tour of the kitchen on 01/07/13, beginning at 10:10 AM, a hypochlorite-based sanitizing solution was observed feeding into the dish machine. A sign posted at the dish machine documented strips used to check the strength of the sanitizing solution should register at least 50 parts per million (PPM) of hypochlorite, and the final rinse temperature should range between 120 and 140 degrees Fahrenheit. A dietary employee confirmed that the facility utilized a low-temperature dish machine. Observation of the dish machine operation began at 9:14 AM on 01/09/13. A strip used to check the strength of the sanitizing solution feeding into the dish machine registered 75 PPM hypochlorite at that time. During six cycles from 9:32 AM through 9:54 AM on 01/09/13 the dish machine final rinse temperature was below 120 degrees Fahrenheit. When two racks of kitchenware were run through the dish machine at 9:32 AM on 01/09/13 the final rinse temperature registered 112 degrees Fahrenheit on the gauge, when two racks were run through at 9:37 AM the	F 371	**F371** 1. Dietary staff were informed of the proper temperature range that the final rinse of the dish machine should operate between. Should the temperature fall outside of the range the dietary staff was informed that the dishes should be considered dirty and run them again once the proper temperature was achieved. Should the dietary staff be unable to achieve the proper temperature range they were informed to call the Maintenance department to inform them and until the problem was fixed to use Styrofoam to serve meals on. All sandwiches that were made before 1-9-13 were immediately disposed of and fresh sandwiches were made. The dietary staff were informed that sandwiches were to be made in the morning and disposed of in the evening.	2-6-13

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F 371	Continued From page 4 temperature registered 112 degrees again, when two racks were run though at 9:42 AM the temperature registered 100 degrees, when two racks were run through at 9:47 AM the temperature registered 98 degrees, when two racks were run through at 9:50 AM the temperature registered 98 degrees again, and when two racks were run through at 9:54 AM the temperature registered only 94 degrees. None of this kitchenware was rewashed, and some of it was utilized at the 01/09/13 lunch meal. At 9:56 AM on 01/09/13 the dish machine process was haulted until the Maintenance Manager (MM) could investigate the problem of insufficient hot water. The MM reported the facility did not have an operational booster system, but two water heaters supplied hot water to the kitchen. He asked the dietary staff to delay washing the one and a half carts of kitchenware which remained until the hot water supply could be replenished. At 11:00 AM on 01/09/13 the dietary staff ran a test rack of kitchenware through the dish machine, and the final rinse temperature registered 122 degrees Fahrenheit. However, at 11:46 AM when two racks of kitchenware were run though the dish machine the final rinse temperature only registered 110 degrees Fahrenheit. The final rinse temperature only reached 110 degrees again when two more racks of kitchenware were run through the dish machine at 11:50 AM. None of this kitchenware was rewashed, and some of it was utilized at the 01/09/13 lunch meal. At 3:04 PM on 01/09/13 a plumber stated there	F 371	F371 The dishes in the dietary department that had chips, cracks or abrasions were disposed of. New dishes were ordered to replace the dishes that were disposed of. The dishes that had food particles on them were placed with the dirty dishes and rewashed to make sure all food particles were removed before being placed with the clean dishes.	2-6-13

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F 371	Continued From page 5 was a defective valve in the hot water system furnishing water to the kitchen, preventing the mixing of hot water from both water heaters. At 3:48 PM on 01/09/13 the dietary supervisor stated all three dietary employees working at the dish machine were supposed to watch the dish machine gauge everytime kitchenware was run through. She reported the wash and rinse temperatures were supposed to register 120 degrees Fahrenheit. If they did not, she explained the dietary staff was supposed to notify the MM. If the MM could not fix the problem, the supervisor commented paper/Styrofoam kitchenware was utilized or kitchenware could be washed and sanitized by a quaternary solution in the three-compartment sink system. At 4:10 PM on 01/09/13 the facility's registered dietitian (RD), with oversite over the kitchen, stated the two dietary employees working on the "dirty" side of the dish machine were supposed to watch the dish machine gauge continuously. If the final rinse temperature was not between 120 and 140 degrees Fahrenheit she reported the racks of kitchenware were to be run through again, and if the desired temperature range was not met this time, the MM was to be notified. If the problem could not be fixed, the RD commented the staff used paper/Styrofoam kitchenware to serve meals on. At 11:31 AM on 01/10/13, during a telephone conversation, the dish machine service representative stated the service company recommended a temperature of 120 degrees Fahrenheit for the final rinse on low temperature dish machines. He explained that even though	F 371	**F371** 2. All dietary staff will be inserviced by 2-6-13 on the correct temperature range in which the final rinse on the dish machine needs to be maintained at per the recommendation by the company that services the machine, the procedure for making sandwiches daily – storing of those sandwiches and disposing of sandwiches at end of final shift of the day, the disposal and replacement of any dishes/cup that are compromised (chips, cracks, abrasions, etc), the inspection of all dishes that come out of the dishwasher to make sure that no food particles are still present, and the proper way to stack clean items (no wet items or items with food particles left on them).	2-6-13

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENFIELD PLACE	2675 W 5TH ST GREENVILLE, NC 27834

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F 371	Continued From page 6 these machines had a hypochlorite-based sanitizing solution feeding into them, when the final rinse water was below 120 degrees Fahrenheit or above 140 degrees Fahrenheit the solution was not functioning at its optimal capacity, affecting its ability to sanitize. 2. During initial tour of the kitchen on 01/07/13, beginning at 10:10 AM, sandwiches labeled CS (chicken salad), BC (bologna/cheese), and PB (peanut butter) and dated 01/07/13 were found on a tray in the reach-in refrigerator. At 9:07 AM on 01/09/13 there were four sandwiches still dated 01/07/13 (two PB, one CS, and one BC) in the reach-in refrigerator. The ends/edges of the sandwich bread was tough. At 11:55 AM on 01/09/13 a tray with sandwiches was sitting beside the steam table, including the four sandwiches dated 01/07/13. The cook stated these sandwiches were brought out of refrigeration during operation of the lunch and supper traylines. He explained these sandwiches could be given out as snacks or could be used as alternate/substitute items at meals. The cook reported trayline operation usually took 45 minutes to a hour each meal. At 3:48 PM on 01/09/13 the dietary supervisor stated sandwiches were prepared twice daily. She reported these sandwiches were placed on snack carts or given out at meals. However, she explained if the sandwiches were not used by the end of the day, they were to be disposed of. At 4:10 PM on 01/09/13 the facility's registered dietitian (RD), with oversite over the kitchen,	F 371	F371 3. Audits will be performed by either the Registered Dietitian or the Kitchen Supervisor weekly x 4 weeks then monthly x 4 months to assure that the proper temperature on the final rinse on the dish machine is within the recommended range, that sandwiches are being made daily and disposed of each evening, that dishes are in good condition, that washed dishes have no remaining food particles on them and that stacked dishes are not wet. 4. The audits on final rinse temperature on the dish machine, sandwiches, condition of dishes and clean dishes and any deficiencies found will be taken to the facility QA&A committee. The QA&A committee will make recommendations based on the finding of the audits.	2-6-13 2-6-13

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F 371	Continued From page 7 stated sandwiches were supposed to be made up daily with any sandwiches leftover at the end of the day to be disposed of. She reported if the staff was placing sandwiches containing meat, cheese, and/or mayonnaise at the trayline during meals for 45 minutes to a hour per meal, keeping these sandwiches more than a day would pose a risk of spoilage or bacterial formation. 3. During initial tour of the kitchen on 01/07/13, beginning at 10:10 AM, 1 of 4 tray pans and 2 of 4 baking pans, which were stacked on top of one another in storage, were still wet. During an inspection of kitchenware, beginning at 11:52 AM on 01/09/13, 39 of 156 pieces or 25% of kitchenware was compromised with moisture, food particles/residue, or chips/abrasions. 1 of 20 plates was chipped, 5 of 16 sectional plates had dividing walls which were chipped, 3 of 16 sectional plates had yellow food particles on them, 3 of 21 plastic dessert bowls had tan/yellow food particles in them, 3 of 21 plastic dessert bowls were abraded inside, 4 of 29 plastic cereal/soup bowls had tan/brown food particles on them, 5 of 29 plastic cereal/soup bowls were abraded inside, 1 of 12 8-ounce cups had white particles inside, 1 of 12 8-ounce cups was abraded inside, 1 of 4 coffee mugs had white particles inside, 3 of 4 coffee mugs had brown residue inside, 2 of 18 side plates had black particles on them, 1 of 18 side plates had white particles on them, 1 of 13 tray pans had white/tan food particles inside, 2 of 7 metal bowls were wet and stacked inside one another, and 3 of 7 metal bowls had tan/brown particles inside of them. At 3:48 PM on 01/09/13 the dietary supervisor	F 371		

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F 371	Continued From page 8 stated she, the cooks, and the employee at the "sanitized" end of the dish machine were responsible for checking to make sure kitchenware was free of food particles before being placed in storage. She reported kitchenware found with food particles or residue was rewashed, and had to be clean and dry before being placed in storage. According to the supervisor, dietary staff was supposed to throw away kitchenware which was cracked, chipped, and abraded. At 4:10 PM on 01/09/13 the facility's registered dietitian (RD), with oversite over the kitchen, stated all kitchenware found with food particles on it was to be rewashed so that it could be clean and dry when placed in storage. She explained kitchenware was supposed to be completely air dried before stacking it on top of one another. The RD commented sometimes kitchenware had to be destained in order to remove residue, especially with coffee mugs. According to the RD, when kitchenware was found with cracks, chips, and abraded inner surfaces the dietary staff was supposed to pull it and present it to herself, the Administrator, or the dietary supervisor. She explained this way it could be determined which kitchenware needed to be reordered.	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345377	A. BUILDING 01 - MAIN BUILDING 01 B. WING FEB 19 2013	01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 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. The deficiencies determined during the survey are as follows:	K 000	**K018** 1. The Maintenance Department was informed of the 2 resident room doors not closing and latching properly with they immediately repaired the doors so that they would close and latch properly 2. All resident doors within the facility were checked to ensure that they all closed and latched properly. 3. All resident room doors will be checked weekly x 4 weeks to ensure that they close and latch properly. Following 1st 4 weeks the doors will be checked monthly ongoing. 4. The results of these audits will be brought to the facility Quality Assurance & Assessment Committee (QA&A) to ensure that resident room doors are closing and latching properly.	**3-6-13**
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by:	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2-15-2013

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

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K 018	Continued From page 1 Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: residents room doors 229 and 422 would not close and latch for smoke tight seal. 42 CFR 483.70(a)	K 018	**K025** 1. The Maintenance Department was informed of the unsealed openings in the smoke barrier wall on the 300 hall and they sealed the openings to ensure that the passage of smoke would be stopped. 2. All smoke barrier walls in the facility were checked to ensure that there were no unsealed openings that would not stop the passage of smoke. 3. All smoke barrier wall will be checked weekly x 4 weeks to ensure that they close and latch properly. Following 1st 4 weeks the doors will be checked monthly ongoing. 4. The results of these audits will be brought to the facility Quality Assurance & Assessment Committee (QA&A) to ensure that there are no unsealed openings in the smoke barrier walls.	**3-6-13**
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: smoke barrier wall on 300 hall has unsealed openings that would not stop the passage of smoke. 42 CFR 483.70(a)	K 025		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 029		

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K 029	Continued From page 2 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: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: Medical Records door is not self closing.	K 029	**K029** 1. The door to the Medical Records office was fixed so that it would be self closing. 2. All doors in facility that are supposed to be self closing were checked to ensure that they were functioning properly. 3. All doors will be check weekly x 4 weeks to ensure they are self closing properly. Following 1st 4 weeks the doors will be checked monthly ongoing. 4. The results of these audits will be brought to the facility Quality Assurance & Assessment Committee (QA&A) to ensure that self closing doors are operating properly.	**3-6-13**
K 062 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: facility could not provide proper	K 062		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345377	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 062	Continued From page 3 documentation that a 5 year obstruction investigation has been performed on sprinkler system. 42 CFR 483.70(a)	K 062	**K062** 1. The Maintenance Department was informed of the need to have the 5 year obstruction investigation on the sprinkler system and Williams Fire & Sprinklers Company were contacted to schedule the test 2. Williams Fire & Sprinklers Company came to the facility on February 14, 2013 to perform the obstruction investigation on the sprinkler system. 3. The facility will ensure that a 5 year obstruction investigation is scheduled with Williams Fire & Sprinkler Company every 5 years. 4. The results of the obstruction investigation will be brought to the facility Quality Assurance & Assessment Committee (QA&A) to ensure that the sprinkler system does not have any obstructions.	**3-6-13**
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: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: on 300 hall there was storage on the exit corridors(hoyer lift, and wheelchair at nurse station).	K 072		
K 144 SS=E	42 CFR 483.70(a) 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.	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345377	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/31/2013

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K 062	Continued From page 3 documentation that a 5 year obstruction investigation has been performed on sprinkler system. 42 CFR 483.70(a)	K 062	**K072** 1. The hoyer lift and wheelchair at the nurses station that were stored in the exit corridor were immediately removed to ensure that there was no items being stored at the exit corridor on the 300 hall. 2. All exit corridors in the facility were checked to ensure that items were not being stored in them. 3. All exit corridors will be check weekly x 4 weeks to ensure that items are not being stored in them. Following 1st 4 weeks the exit corridors will be checked monthly ongoing. 4. The results of these audits will be brought to the facility Quality Assurance & Assessment Committee (QA&A) to ensure that items are not being stored in the exit corridors.	**3-6-13**
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: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: on 300 hall there was storage on the exit corridors(hoyer lift, and wheelchair at nurse station).	K 072		
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K 144	Continued From page 4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: at time of survey, generator #1 did not crank and transfer in 10 seconds when tested. 42 CFR 483.70(a)	K 144	**K144** 1. When Generator #1 did not crank and transfer within 10 seconds Forrest Generators were called to the facility to adjust Generator #1. 2. After Forrest Generators came to facility to fix Generator #1 both generators were checked to ensure that they cranked and transferred within the required 10 seconds. 3. Both generators will be checked weekly x 4 weeks to ensure they are cranking and transferring within 10 seconds. Following 1st 4 weeks the generators will be checked monthly ongoing. 4. The results of these audits will be brought to the facility Quality Assurance & Assessment Committee (QA&A) to ensure that both generators crank and transfer within 10 seconds.	**3-6-13**