JUN 2 5 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345309	A. BUILDING ______ B. WING ______	05/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY	101 CAROLINE AVENUE WELDON, NC 27890

(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, staff interviews, and record reviews, the facility failed to maintain fingernails and toenails in clean, trimmed condition for 1 (Resident #55) of 3 sampled residents who required assistance of staff for activities of daily living. Findings included: Resident #55 was re-admitted to the facility on 10/25/12. Diagnoses included late effects of a Cerebrovascular Accident (stroke), aphasia (language disorder/difficulty due to a stroke), Diabetes Mellitus Type II, and dementia. Review of the resident ' s annual Minimum Data Set assessment of 4/3/13 revealed the resident had long and short term memory problems, severely impaired decision making skills, and was rarely/never understood. The resident ' s functional status was documented and having required extensive assistance of one person for personal hygiene and bathing. Review of the resident ' s Care plan of 3/21/13 revealed a problem identified as " I require assistance with ADLs (activities of daily living)	F 312	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. **Corrective Action for Resident Affected** Resident # 55 fingernails and toenails were cleaned and trimmed 5/31/13. **Corrective Action for Resident Potentially Affected** All residents that need assistance for activities of daily living have the potential to be affected by this alleged deficient practice. All residents were reviewed by DON by 6/13/13 to ensure that fingernails and toenails were clean and trimmed.	6/14/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 6/13/13

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 and am risk for complications related to dependence " . An observation of the resident on 5/30/13 at 8 AM revealed the resident ' s fingernails on his left hand were untrimmed and had a build up of dark brown matter under each nail. The resident ' s bare feet were out from the under the bed linen. The left great toe had a V-shaped chip and had an extended band of white nail 1 millimeter from the toe. The resident's 2nd, 3rd and 4th nails on the left foot were long with a 1 millimeter white band of nail that extended past the toe. The resident's right great toe nail, 3rd and 4th toenails were long and extended 1 millimeter past the toe. An observation of the resident on 5/31/13 at 8:05 AM revealed the fingernails on the resident ' s left hand remained untrimmed and the brown matter build up under each nail. The resident ' s toenails were not visible at the time of the observation. An observation of a bed bath provided for the resident was made on 5/31/13 at 9:30 AM. After the resident ' s bath was given, Nursing Assistant #1 proceeded to dress the resident, and began to clean up the bathing items. The NA stated she didn't notice the resident's toenails were long or the fingernails were untrimmed and dirty. The NA reported if a resident was a diabetic, she reported to the nurse the nails needed cut, but had not reported Resident #55 needed the toenails cut. An interview was conducted with Nurse #1 on 5/31/13 at 10:05 AM. The nurse stated when a resident was a diabetic, NAs were not to cut the nails, but report them to the nurse and the nurse cut the nails. Nurse #1 stated no one reported	F 312	**Systemic Changes** Point Click Care has been implemented and we are assigning specific task to CNA's so nail care will be provided on a shower day once a week. Staff nurses have been scheduled diabetic nail care every two weeks. An in-service was conducted on 6/4/13 by the DON. Those who attended were RNs, LPNs, and CNAs, and PRN. Agencies that are used for staffing needs were sent the facility specific in-service and instructed to provide training for staff prior to assigning them to the facility for temporary assignments. Hospice providers were included because they do provide ADL assistance in the facility. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included ADL care required and expected for all residents. Including nails should be cleaned daily as needed and nurses should check diabetic nails every two weeks for length and clean them if needed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.	

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LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY	101 CAROLINE AVENUE WELDON, NC 27890

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F 312	Continued From page 2 the resident's long toenails to her. An observation was made of the resident's nails with the Director of Nursing (DON) on 5/31/13 at 10:15 AM. The DON stated the nurses were expected to cut the resident's toenails when the resident was a diabetic or referred for services by the podiatrist. The DON stated NAs were expected to report long nails to the nurse to be cut when a resident was a diabetic, and the resident's fingernails and toenails were expected to be clean and trimmed.	F 312	**Quality Assurance** The Director of Nursing or MDS Coordinator will monitor this issue using the "Survey QA Tool for care of Fingernails and Toenails". The monitoring will include verifying that all residents that need assistance with ADL's will have their fingernails and toenails monitored. See attached monitoring tool. This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads. To be completed 6/14/13.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews the facility failed to implement new interventions after falls for 1 of 1 sample resident (resident #62) who had multiple falls. Findings include: Resident #62 was readmitted on 12/24/12 with diagnosis which included Congestive Heart Failure, History of Fall, and Senile Dementia. Review of the resident most recent Minimum	F 323	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of	6/14/13

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F 323

Continued From page 3

Data Set (MDS), a quarterly assessment of 4/29/13, indicated the resident was cognitively intact and required limited assistance of 2 people for bed mobility; limited assistance of one person for locomotion on/off unit; and extensive assistance with 2 or more persons for toileting

Review of the resident ' s care plan of 5/5/13 revealed a problem identified as " My fall risk is increased due to possible side effects from medications; unsteady gait, poor safety awareness " . The goal was written as: My risk for falls and injuries would be minimized via current interventions x 90 days. Interventions were listed in part as: encourage resident to call for assistance, keep the equipment used frequently near for easy access, bed alarm, chair alarm, fall mat, non-skid socks, and monitor side effects of all medication that may increase gait disturbance.

A facility fall report regarding Resident #62 revealed staff found the resident on 4/11/13 at 9:25 PM sitting on the floor in front of the closed bathroom door in the resident ' s room. The resident reported to staff the wheel chair had thrown him. No injury was noted. The resident ' s alarm was found in the chair. The alarm was working properly. A hand written note on the bottom of report read: " reminded to lock wheelchair " .

An interview was conducted with the Director of Nursing (DON) on 5/30/13 at 6:03 PM. The DON indicated members of Quality Assurance (QA) reminded the resident to lock his wheelchair. The resident was re-educated on locking his wheelchair at that time.

F 323

compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.

Corrective Action for Resident Affected
Resident # 62: anti-rollbacks were ordered (6/4/13) and assembled to the wheelchair (6/10/13). We also ensured the reacher, that had already been given, was available for the resident (6/4/13).

Corrective Action for Resident Potentially Affected
All residents with multiple falls have the potential to be affected by this alleged deficient practice. Residents were reviewed by DON on 6/15/13 to ensure that interventions were present for all residents who have fallen.

Systemic Changes
Fall interventions will be put on the Kardex in Point Click Care so the CNA's will know to check daily by 6/14/13. An in-service was conducted on 6/10/13 by the Corporate QA Nurse Consultant. Those who attended: the entire Interdisciplinary Team. .The in-service topics included Preventing

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F 323	Continued From page 4 A facility reported regarding the resident for falls revealed the staff found the resident on 4/18/13 at 1:51 AM sitting on the floor beside a fall mat between the resident and the bed. A note was made on the QA report which read in part: had pad alarm in the chair, put a tab alarm on resident. During an interview conducted with the DON on 5/30/13 at 6:03 PM, the DON revealed the QA investigation had found out the resident was trying to get his shoes from beside his bed prior to his fall and the resident was given a long handled reacher device for assistance. The DON was unsure if the resident still had the long handle reacher. A facility report regarding Resident #62's fall on 4/30/13 at 6:00 AM, revealed staff found resident standing up in front of his doorway with the wheelchair behind him. The resident attempted to sit down before the staff could assist, and the wheelchair which was not locked moved. The report indicated the resident fell on his right side and did not hit his head during the fall. A bruise was noted purplish in color, 2 centimeters x 2 centimeters on the resident right upper arm. The post-immediate intervention was documented as: staff encouraged the resident to call for help when transferring and to lock his wheelchair. No new intervention was noted on the report. A facility fall incident report was made for 5/5/13, indicated at 9:21 AM staff were called to the resident room. Upon arrival they found the resident sitting on the floor on top of the wheel chair cushion, completely undressed. Resident #62 reported " he had slid out of his chair to the floor to take his bath. " The chair pad alarm was	F 323	Falls and Fall Interventions. There was also an in-service given by SDC on 6/4/13 to all nursing staff on falls and fall interventions. **Quality Assurance** The Administrator or DON will monitor this issue using the "Survey QA Tool for Fall Interventions". The monitoring will include verifying that all residents who have falls have new and appropriate interventions with each fall. See attached monitoring tool. This will be done weekly for three months on all falls or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads. To be completed by 6/14/13	

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F 323	Continued From page 5 not sounding. The tab chair alarm was found attached to his clothes on the bed. Redness was noted on the resident ' s right side. In an interview conducted with the DON on 5/30/13 at 6:03 PM she revealed they were unsure why the chair alarm had not sounded off. The staff were expected to check the alarms prior to the start of the 7:00 AM shift. The DON reported staff had failed to check the alarms prior to the start of the shift. A facility fall incident report for 5/13/13 indicated at 12:34 AM the staff found the resident sitting on the fall mat beside the bed. The resident had taken the chair alarm tab off. A skin tear was noted on the resident ' s left elbow. No new interventions were noted on the report. A second fall incident report was made for 5/13/13 at 10:00 AM. The staff found the resident on the floor in his bathroom. The report read in part: the resident ' s head was against the wall and the wheelchair was at his back. A bruise was noted on the resident ' s left rear. No new interventions were noted on the report. A facility report regarding the resident for a fall on 5/29/13 at 11:19 PM revealed staff heard the resident yell for help. The staff found the resident sitting undressed on the floor in his room. The resident reported to the staff he had fallen while trying to undress. No injuries noted. No new interventions were noted on the report. During an interview conducted with the DON on 5/30/13 at 6:03 PM she revealed no new interventions were initiated for the resident ' s falls	F 323		

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F 323	Continued From page 6 on 4/30/13, 5/5/13, a second fall on 5/13/13, and 5/29/13. The DON reported that she expected the staff to go to the site of the fall and replay the occurrence and develop new interventions at that time.	F 323		
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 This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to date opened refrigerated food items in 1 of 1 walk in refrigerators; the facility failed to date opened spice containers; the facility failed to discard a Jello container that was outdated and one that was undated when made, and undated or outdated spices; and the facility failed to maintain 1 of 1 meat slicers and 1(sugar bin) of 3 dry food storage bins in clean condition. Findings included: 1) An observation of the walk-in refrigerator on 5/28/13 at 10 AM, with the Cook, revealed a clear plastic bag of browned celery was stored on a shelf. The bag was stored with no date when it was opened. A two-inch thick package of sliced	F 371	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. **Corrective Action for Resident Affected** An audit tool was put into place to check walk-in, stand up cooler, and dry storage daily to ensure everything is dated, clean, and with-in an acceptable date to be used. **Corrective Action for Resident Potentially Affected** All residents have the potential to be affected by this alleged deficient practice. All items were discarded on 5/30/13. The audit tool began on 6/11/13 to monitor walk-in and dry storage.	6/14/13

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F 371	Continued From page 7 turkey was stored on the shelf. The stack of turkey had a ham slice at the bottom of the stack and was wrapped with a cellophane wrap. No date was written on the package for when the turkey packaging was opened. A deep metal storage pan 4" wide by 9" long was filled with red Jello and covered with cellophane. The cellophane cover had no date to document when the contents were made. The Cook reported dietary staff were expected to date any package that was opened. A 12" by 24" clear plastic, shallow pan with a clear plastic cover was half filled with red Jello. The date on the lid was documented as 5/4/13. The cook stated the Jello should not have been kept more than 3 to 5 days after being made and should have been thrown out 2) An observation was made of the dry storage area on 5/28/13 at 10:30 AM with the Cook and revealed a 2.1 ounce bottle of non-perils rainbow candies were opened and not dated. 30 ounce containers of cinnamon maple sprinkles, garlic salt, poultry season, cayenne light chile powder, 2 containers of taco seasoning, onion powder, black pepper, and grilled chicken seasoning were opened and had no opened date. The observation revealed 30 ounce containers of ground clover dated 9/25/09, cayenne pepper dated 2/3/10, whole bay leaves dated 1/6/10, celery salt dated 12/6/09, and a container of taco seasoning was dated 11/2/(no year visible) and the year was not visible. The Cook reported the seasonings should have been dated when opened and the containers from 2009 and 2010 should have been removed from use. 3) An observation was made of the large sugar	F 371	**Systemic Changes** An in-service was conducted on 6/11/13 by Ellen Anderson, RD. Those who attended were all dietary staff. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included sanitary food storage, preparation, and storage. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all Dietary employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **Quality Assurance** The Dietary Manager or Administrator will monitor this issue using the "Survey QA Tool for dietary sanitation, proper food storage, and cleaning". The monitoring will include verifying that everything is dated, cleaned, and within normal dates for consumption. All areas will be monitored daily. See attached monitoring tool. This will be done daily for four weeks and then weekly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as	

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F 371	Continued From page 8 container on 5/29/13 at 11:15 AM with the Dietary Manager. Dried tan/brownish splatter was observed on the inside of the bin and on the front outer rim of the container. The Manager stated the bin was expected to have been clean and have no dried spatter inside or outside of the container. 4) An observation of the meat slicer on 5/29/13 at 11:20 AM with the Dietary Manager revealed a thin coating of a dried, milky white matter around the edged surface of the blade. The Manager reported she expected the blade was cleaned after each use and the blade to have been clean. The Dietary Manager was unsure of the last time the meat slicer was used An interview was conducted with the Dietary Manager on 5/29/13 at 11:30 AM. The Manager reported she expected foods to be stored with an opened date when the packages were opened and Jello was discarded after 3 to 4 days when not used. The Dietary Manager stated the spice containers were expected to be dated when opened and discarded after one year. An interview was conducted with the Administrator on 5/31/13 at 4:45 PM. The Administrator stated she expected foods were stored with opened dates, left over Jello was discarded after 3 to 4 days, spices were dated when opened and discarded after a year, and kitchen equipment was clean.	F 371	appropriate. Results of the audits will then be shared in the Quarterly QA Meeting with the Medical Director with verification of his attendance along with all members of the QA Team and Department Heads. To be completed 6/14/13.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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RECEIVED JUL 17 2013 CONSTRUCTION SECTION

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	345309	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/02/2013

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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 V construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000		
K 015 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:30 am onward, the following items were noncompliant, specific findings include: 1. facility could not provide documentation that wood paneling in room 110 meets class A and B,C rating required for nursing homes.	K 015	**K 015 SS=E** **Corrective Action** Facility could not provide documentation that wood paneling in room 110 meets class A and B, C rating required for nursing homes. **Identification of related safety hazards potentially affecting Residents** **Systemic Changes** The maintenance director coated walls with Class A fire retardant on July 8, 2013. **Quality Assurance** The maintenance director will coat the walls quarterly and keep a record on file of this.	7/12/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	7/12/13

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	345309	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	07/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY	101 CAROLINE AVENUE WELDON, NC 27890

(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 015	Continued From page 1 42 CFR 483.70(a)	K 015		
K 025 SS=D	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 12:30 am onward, the following items were noncompliant, specific findings include: smoke barrier (attic access in room 123) had unsealed penetrations that does not meet the 1/2 hour fire resistance rating. 42 CFR 483.70(a)	K 025	**K 025 SS=D** **Corrective Action** The following items were noncompliant, specific findings include: smoke barrier (attic access in room 123) had unsealed penetrations that does not meet the ½ hour fire resistance ratings. **Identification of related safety hazards potentially affecting Residents** **Systemic Changes** The maintenance used fire stop caulk to patch the hole in the fire wall on July 12, 2013. **Quality Assurance** The maintenance director will check fire walls quarterly to ensure all fire walls are properly sealed.	7/12/13
K 038 SS=E	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	K 038	**K 038 SS=E** **Corrective Action** The following items were found to be noncompliant, specific findings include: MDS Coordinator requires two motion of hand to open door. **Identification of related safety hazards potentially affecting Residents**	7/12/13

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
	345309	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	07/02/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIBERTY COMMONS NSG AND REHAB CTR OF HALIFAX CTY	101 CAROLINE AVENUE WELDON, NC 27890

(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 038	Continued From page 2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 12:30 am onward, the following items were noncompliant, specific findings include: MDS Coordinator and requires two motion of hand to open door. 42 CFR 483.70(a)	K 038	**Systemic Changes** The maintenance director changed the door knob on July 12, 2013 to ensure the door can be opened from the inside even when locked. **Quality Assurance** The maintenance director went through the entire building and replaced all door knobs that were not in compliance.	
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 12:30 am onward, the following items were noncompliant, specific findings include: Kiosk system ked pad protrudes greater than 7 inches in to corridor(does not retract back) 42 CFR 483.70(a)	K 072	**K 072 SS=E** **Corrective Action** The following items were noncompliant, specific findings include: Kiosk system key pad protrudes greater than 7 inches in to corridor (does not retract back). **Identification of related safety hazards potentially affecting Residents** **Systemic Changes** The maintenance director removed all key pads from all 3 Kiosk on July 10, 2013. **Quality Assurance** We will be looking into other alternatives for the Kiosk to have key pads but will be sure they meet the requirements set forth by DHHS.	7/12/13