STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345487	A. BUILDING _____ B. WING _____	07/11/2013

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CHERRY POINT BAY NURSING AND REHABILITATION CENTER	110 MCCOTTER BLVD HAVELOCK, NC 28532

(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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews, the facility failed to develop a comprehensive care plan that addressed the use of antidepressant medications for 1 of 7 sampled residents (Resident #40) receiving antidepressant medications. The findings included: Resident #40 was admitted to the facility on 1/18/11 with diagnoses including depressive disorder and insomnia.	F 279	Cherry Point Bay Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Cherry Point Bay's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Cherry Point Bay reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Courtney Collier	Administrator	7/25/13

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 279	Continued From page 1 A review of Resident #40 ' s medical record revealed she was followed by psychiatric services for insomnia with a history of depressive disorder. She had been treated with 50 mg trazodone (an antidepressant medication that has sedative/hypnotic properties) taken as 1 tablet every night at bedtime since 10/12. Review of Resident #40 ' s last annual Minimum Data Set (MDS) assessment dated 11/19/12 indicated she received an antidepressant medication on 7 of the 7 days prior to completion of the assessment. The Care Area Assessment (CAA) Summary dated 11/29/12 indicated Mood State and Psychotropic Drug Use were among the triggered conditions and noted these areas of concern were addressed in the resident ' s care plan. A review of the resident ' s Care Plan updated on 12/27/12 revealed no plan of care had been included to address the resident ' s mood or use of an antidepressant. On 1/14/13, Resident #40 ' s Primary Care Provider (PCP) identified her as having a depressed condition and indicated she may need psychiatric services to address this concern. The medical record revealed Resident #40 was seen for a psychiatric consultation on 1/15/13 with a follow-up consultation on 2/14/13. The resident was reported to be sad, tearful, and having feelings of hopelessness. Weight loss was also noted at that time. She was started on 5 mg escitalopram (an antidepressant medication) taken once daily in addition to the 50 mg trazodone previously prescribed.	F 279	F 279 SS=D 483.20(d). 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS Resident #40 was reviewed on 7/10/2013 by the MDS Nurse and updated to include moods and anti-depressant usage. Care plans for all residents in the facility on an anti-depressant medication were reviewed on 7/10/2013 by the MDS Nurse with no further deficiencies noted. MDS nurse will obtain a list of all residents on an anti-depressant medication weekly and compare this to their care plan to ensure it is accurately documented. The resident census will be used as a QI tool where these comparisons will be recorded. The quality improvement committee will meet weekly x4 weeks and then monthly x3 months to discuss findings and make recommendations.	8/1/13

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The medical record indicated another psychiatric consultation was completed on 3/14/13 for Resident #40. The dose of escitalopram was increased to 10 mg daily due to mood instability, increased sadness and depressive symptoms.

Review of the medical record revealed a follow-up psychiatric consultation was made on 4/18/13. At that time, the resident was assessed as being stable on the current doses of the medications prescribed.

The most recent quarterly Minimum Data Set (MDS) assessment dated 5/9/13 indicated the resident had moderately impaired cognitive skills for daily decision making. She required extensive assistance to total dependence for all of her activities of daily living (ADLs) with the exception of only needing supervision for eating. The quarterly MDS indicated Resident #40 continued to receive one or more antidepressant medications on 7 of the 7 days prior to completion of the assessment.

Review of the medical record indicated a psychiatric follow-up was completed on 5/16/13. The resident was reported to have episodes of increased sadness. The provider ' s plan included monitoring Resident #40 and consideration of a medication increase in the future if mood did not improve. The resident continued to receive 50 mg trazodone once daily and 10 mg escitalopram once daily.

Review of Resident #40 ' s Care Plan updated on 6/6/13 revealed no plan of care had been included to address either the areas of mood or use of the antidepressant medications

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(escitalopram and trazodone). The Care Plan did include a focus area/goal/interventions related to the resident ' s nutritional status and history of weight loss. This care area was updated on 6/6/13 but did not include the potential impact of mood or use of antidepressant medications for the resident.

Review of the Physician Orders dated 6/11/13 revealed the resident ' s PCP ordered a gradual dose reduction for the prescribed trazodone by reducing the dose from 50 mg to 25 mg daily. Resident #40 continued to receive 10 mg escitalopram once daily as previously ordered.

Further review of Resident #40 ' s medical record revealed three notations had been made in the Progress Notes regarding the resident ' s behavior. These notations included the following: 6/11/13 nursing staff indicated the resident refused her medications and was noted as, " being very nasty with this nurse; " 6/20/13 the resident was noted to yell at her roommate and required redirection from the nurse; and on 6/27/13 the resident was noted to require reorientation from the nurse. No notations related to Resident #40 ' s depressed mood or efficacy of the antidepressant medications were made in the Progress Notes over the past 30 days.

An interview was conducted with the MDS Coordinator on 7/10/13 at 11:43 AM. Upon review of Resident #40 ' s care plan, the MDS Coordinator acknowledged that the use of psychotropic medications had not been care planned for this resident. Review of the CAA Triggers Summary dated 11/29/12 confirmed use of antidepressant medication(s) had triggered the

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condition. This area of concern had also been identified as being addressed in the care plan. The MDS Coordinator stated, " It is not on the care plan. It ' s my human error. " The MDS Coordinator stated the use of antidepressants was always included on the care plan for a resident. She also indicated the use of antidepressants had been noted on the MDS but " got missed " being put on the care plan.

On 7/11/13 at 8:00 AM, an observation was made of Resident #40 in bed with a breakfast tray within reach on a bedside table. The breakfast meal had been set up for her but the resident had not yet begun eating. The resident stated breakfast was her favorite meal and she had just gotten started on eating it.

An interview was conducted with Nurse #2 on 7/11/13 at 8:35AM. Nurse #2 reported Resident #40 ' s mood will vary and her meal intake will as well, depending on how she was feeling. Nurse #2 indicated the resident has stated, "What's the point? " to her on occasions during medication pass. She also noted that Resident #40 appeared sad at times.

An interview was conducted with Nursing Assistant (NA) #1 on 7/11/13 at 8:40AM. NA #1 also noted the resident moods were changeable. She noted the resident would become agitated at times and her meal intake was variable from day to day, depending on her mood.

On 7/11/13 at 8:40 AM, a follow-up observation was made of the resident eating breakfast in her room. Less than 10% of the meal had been eaten from the tray.

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F 279	Continued From page 5 An interview was conducted with the Director of Nursing (DON) on 7/11/13 at 9:51 AM. The DON reported that physician orders were reviewed daily and care plans updated accordingly. She indicated her expectation would be for all psychotropic medications, including antidepressants, to be included in the resident ' s plan of care. The DON indicated she was aware of the care plan issue related to psychotropic medications and that it had already been corrected. A focus area, goal, and interventions related to the topic of psychotropic medications had been added to Resident #40 ' s care plan on 7/10/11 by the MDS Coordinator. An interview was conducted with the facility ' s Administrator and Facility Consultant on 7/11/13 at 10:38AM. The Administrator stated, " We know she (the MDS Coordinator) has already fixed it and she's already done an audit to be sure all the other antidepressants are care planned. "	F 279		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.	F 356	F 356 SS=C 483.30(e) POSTED NURSE STAFFING INFORMATION The daily nurse staffing sheet was moved by the Administrator on 7/10/2013 to a new designated area in the front hallway directly next to the front lobby entrance where it is easily accessible to families and visitors. In-service with 100% of nurses by the Staff Facilitor regarding the designated area for posting daily staffing sheets will be completed by 7/31/2013. Posting of the nurse staffing sheet will be monitored daily by the Administrator or designee using a QI tool. The quality improvement committee will meet weekly x4 weeks and then monthly x3 months to discuss findings and make recommendations.	8/1/13

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F 356	Continued From page 6 The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to post daily staffing in a location that was easily accessible to residents and visitors. On 07/08/2013 at 12:15 PM, the daily staffing was observed posted in the nursing station on a door marked "Medical Prep". The posting was not observed in a readiliy accessible area to residents and visitors. A tour was conducted of the entire facility, and no other staff postings were observed. On 07/09/2013 at 10:15 AM, the daily staffing was observed posted in the nursing station on a door marked "Medical Prep". The posting was not observed in a readiliy accessible area to residents and visitors. A tour was conducted of the entire facility, and no other staff postings were observed.	F 356		

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F 356	Continued From page 7 On 07/10/2013 at 2:00 PM, the daily staffing was posted in the nursing station on a door marked "Medical Prep". The posting was not observed in a readiliy accessible area to residents and visitors. A tour was conducted of the entire facility, and no other staff postings were observed. In an interview with Staff Nurse #1 on 7/10/2013 at 2:15 PM, the nurse indicated the area where the staff posting was hung was off limits to visitors and residents. In an interview with the facility administrator on 7/10/2013 at 2:30 PM, the Administrator reported the expectation was staffing should be posted in an area easily accessible to residents and visitors.	F 356	F 431 SS=D 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 100% of all medication carts and the medication room were checked for expired medications on 7/11/2013 by the DON and QI Nurse. Any expired medications were returned to pharmacy or discarded as appropriate. In-service with 100% of nurses by the Staff Facilitator regarding correctly checking and removing expired medications from the med carts and med room will be completed by 7/31/2013. The DON or designee will monitor the med carts and med room for expired medications 3x per week x4 weeks, then weekly x4 weeks, and then monthly x3 months using a QI tool. The quality improvement committee will meet weekly x8 weeks and monthly x3 months to discuss findings and make recommendations.	
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. 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	F 431		8/1/13

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F 431	Continued From page 8 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 observations and staff interviews, the facility failed to remove expired medications from one of one medication store rooms and one of two medication carts (the 200/300/400/500 halls ' medication cart). The findings included: 1) An observation of the medication store room on 7/11/13 at 10:20 AM revealed two boxes of albuterol / ipratropium 3.0 / 0.5 milligrams inhalation solution (a medication used for asthma and/or chronic obstructive pulmonary disease) were kept past the manufacturer ' s expiration date. One box of the expired albuterol/ipratropium inhalation solution was labeled for Resident #5 and contained 11 sealed foil pouches with an	F 431		

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expiration date of June 2013. Each sealed foil pouch contained five 3 ml vials for a total of 55 vials of inhalation solution. A review of Resident #5 ' s July 2013 Physician Orders revealed there was a current order for the medication to be given as 1 premixed unit via a nebulizer every three hours as needed for shortness of breath and/or wheezing.

The second box of expired albuterol/ipratropium inhalation solution was labeled for Resident #43 and contained 11 sealed foil pouches with an expiration date of May 2013. Each sealed foil pouch contained five 3 ml vials for a total of 55 vials of inhalation solution. A review of Resident #43 ' s July 2013 Physician Orders revealed this medication had been discontinued.

An interview was conducted with Nurse #2 on 7/11/13 at 10:20 AM regarding the expired boxes of albuterol/ipratropium inhalation solution. The nurse indicated the resident-labeled medications kept in the store room were overflow medications for the hall medication carts. These medications were stored in the medication room until needed for the med cart. She acknowledged the two boxes of albuterol/ipratropium inhalation solution were out-dated and would need to be discarded.

During an interview with the Director of Nursing (DON) on 7/11/13 at 10:30 AM, the DON reported staff nurses (particularly the 11 PM to 7 AM shift nurses) were responsible to check expiration dates for medications stored in the medication room. She also indicated the consultant pharmacist came to the facility every month and was expected to go through the medication room to check for expiration dates as well. The DON

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confirmed the overflow medication stock kept in the medication store room would be used for the residents as the medication cart stock ran out. The DON indicated her expectation was for all expired medications to be identified, pulled, and returned to the pharmacy.

2) An observation of the 200/300/400/500 halls ' medication cart on 7/11/13 at 9:13 AM revealed an opened bottle of calcitonin spray 200 units/actuation (an intranasal spray used for osteoporosis) in the medication cart drawer for Resident #81. The bottle was dated as being opened on 6/8/13. Supplemental labeling from the dispensing pharmacy for the calcitonin spray included, " Expires 30 days after opening. " The manufacturer ' s product information indicated an opened product may be stored at room temperature for up to 30 days. A review of Resident #81 ' s July 2013 Physicians Orders revealed there was a current order for the calcitonin spray to be given as one spray in one nostril daily. An additional note on the July 2013 Physician ' s Orders indicated, " Discard 30 days after opening. "

An interview was conducted with the nurse assigned to the 200/300/400/500 halls ' med cart (Nurse #2) on 7/11/13 at 9:15 AM. During the interview, Nurse #2 acknowledged the opened bottle of calcitonin spray was expired and stated, " It ' s no good. " The nurse indicated the medication would need to be discarded and another bottle of calcitonin spray ordered for the pharmacy for Resident #81.

During an interview with the Director of Nursing (DON) on 7/11/13 at 9:51 AM, the DON

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F 431	Continued From page 11 addressed the issue as to when an opened bottle of calcitonin would expire. The DON reported her expectation was that an opened bottle of calcitonin be discarded 30 days after opening. She indicated an opened bottle of calcitonin held more than 30 days would be considered an expired medication. She stated, " We do cart audits ourselves as does the pharmacy. " The DON indicated she was encouraging nurses to do weekly cart checks where expired medications would be pulled from the cart and sent back to the pharmacy. During an interview with the facility ' s Administrator and Facility Consultant on 7/11/13 at 10:38 AM, the Administrator indicated she would expect staff to check expiration dates on medications from the carts daily as they were working. She also indicated the 11 PM to 7 AM third shift staff was responsible for doing an extra check on these expiration dates each day. The Administrator indicated her expectation would be for all expired medications to be pulled off of the medication cart and sent back to the pharmacy. 3) An observation of the 200/300/400/500 halls ' medication cart on 7/11/13 at 9:13 AM revealed three prochlorperazine rectal suppositories (a medication used for the treatment of nausea and vomiting) kept on the cart were kept past the manufacturer ' s expiration date of May 2013. An interview was conducted with the nurse assigned to the 200/300/400/500 halls ' med cart (Nurse #2) on 7/11/13 at 9:15 AM. During the interview, Nurse #2 acknowledged the prochlorperazine rectal suppositories were outdated and indicated they would need to be	F 431		

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F 431	Continued From page 12 discarded. During an interview with the Director of Nursing (DON) on 7/11/13 at 9:51 AM, the DON reported her expectation would be for all expired medications to be removed from the medication carts. She stated, " We do cart audits ourselves as does the pharmacy. " The DON indicated she was encouraging nurses to do weekly cart checks where expired medications would be pulled from the cart and sent back to the pharmacy. During an interview with the facility ' s Administrator and Facility Consultant on 7/11/13 at 10:38 AM, the Administrator indicated she would expect staff to check expiration dates on medications from the carts daily as they were working. She also indicated the 11 PM to 7 AM third shift staff was responsible for doing an extra check on these expiration dates each day. The Administrator indicated her expectation would be for all expired medications to be pulled off of the medication cart and sent back to the pharmacy.	F 431		

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	345487	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/06/2013

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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 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V (111) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Cherry Point Bay Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance. Cherry Point Bay's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Cherry Point Bay reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.	
K 029 SS=D	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 August 6, 2013 at approximately 10:00 Am onward the following was noted: 1) The dietary storage room door did not close latch and seal when released. 2) The corridor door to the oxygen storage room did not close, latch and seal when released. 42 CFR 483.70(a)	K 029	K 029 SS=D 1)The dietary storage room door closure was replaced by the Maintenance Director on 8/7/2013 and it now closes, latches, and seals appropriately. 2) The corridor door to the oxygen storage room had the hinges adjusted by the Maintenance Director on 8/7/13 and it now closes, latches, and seals appropriately.	9/17/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Courtney Collier — TITLE: Administrator — (X6) DATE: 8/23/13

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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K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation on August 6, 2013 at approximately 10:00 Am onward the following was noted: 1) Additional illumination from the hall exit to the public way is needed. Lighting must be arranged to provide light from the exit discharge leading to the public way (parking lot). The walking surfaces within the exit discharge shall be illuminated to values of at least 1 ft-candle measured at the floor. Failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candles in any designated area. NFPA 101 7.8.1.1, 7.8.1.3, and 7.8.1.4. 42 CFR 483.70(a)	K 045	100% of all storage doors will be audited by the Maintenance Director to ensure they close, latch, and seal appropriately on or before 9/17/2013. In-service will be completed with 100% of employees on or before 09/06/13 to submit a work order to the maintenance director for any door found not to close, latch, and seal correctly. Storage doors will be monitored X1 monthly for 3 months by the Maintenance Director or designee. K 045 SS=D 1)Flood light installed on backside of building close to dietary by the Maintenance Director on 8/16/13 that illuminates the means of egress/sidewalk. Exterior discharge illumination will be reviewed by the Maintenance Director or designee X1 monthly for 3 months to ensure lighting is operating properly.	8/16/13
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	K 052 SS=F On 8/19/13 the facility's fire alarm system was inspected by the company representatives from *Simplex*. 3 chips in the fire alarm panel were found to be outdated. The replacement parts were ordered on 8/19/13 and are expected to arrive and be installed on or before 8/26/13. Following the installation,	8/26/13

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K 052	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation on August 6, 2013 at approximately 10:00 Am onward the following was noted: 1) A fire drill was conducted and a pull station was activated and sounded the Fire Alarm system activate. Once the Fire Alarm System was silenced a smoke head on the opposite side of the building was tested. The Fire Alarm Control Panel (FACP) system failed to sound an alarm when the or any other smoke head on the opposite side of the building was tested. 42 CFR 482.41(a)	K 052	the panel and the entire alarm system will be reevaluated by the company representatives from *Simplex* to ensure it is working correctly. *Simplex* will continue to inspect the panel and fire alarm system on their required schedule. The maintenance director or designee will do an extra check on the panel and fire alarm system monthly to ensure system continues to operate correctly. K 056 SS=D 1)2 Sprinkler heads in freezer found to be not in good external condition will be replaced by representatives from the company *Sunland* on or before 8/26/13. *Sunland* will continue to do quarterly and annual inspections. Any deficiencies noted on those inspections will be monitored by the Maintenance Director and Administrator to ensure timely correction of deficiencies listed. Representatives from the *Sunland* company will also be checking other sprinkler heads to ensure no further areas are in poor condition. 2)A sprinkler head wrench has been ordered and will be obtained by the Maintenance Director on or before 8/26/13.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 056		8/26/13

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K 056	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation on August 6, 2013 at approximately 10:00 Am onward the following was noted: 1) Upon review of the Sprinkler inspection report Dated June 10, 2013 the following deficiencies were noted in the report. - Sprinkler heads were not in good external condition. - A sprinkler head wrench is need for the sprinkler heads. 42 CFR 482.41(a)	K 056	K 144 SS=D 1)The utility light for the transfer switch on the generator was replaced on 8/16/13 by representatives from the *Clarke Power Generation Inc.* company. The utility light for the transfer switch will be checked weekly X4 weeks and monthly X2 months by the Maintenance Director or designee to ensure it is operating correctly. 2) The generator run light for the generator enunciator panel at the nurses station was inspected by representatives from the *Clarke Power Generation Inc.* company on 8/16/13 and it was determined that the motherboard needs replaced. This was ordered on 8/16/13 and is expected to arrive and be installed on or before 8/26/13. The generator run light on the enunciator panel at the nurses' station will be checked weekly by the Maintenance Director or designee to ensure it is operating correctly.	8/26/13
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 August 6, 2013 at approximately 10:00 Am onward the following was noted: 1) The utility light for the transfer switch was not operation at the time of the survey. 2) The generator run light for the generator annunicator panel at the nurse station did not operate at the time of the survey. 42 CFR 483.70(a)	K 144	K 147 SS=D 1)The ground fault receptacle at the meat prep sink in the kitchen was replaced by the Maintenance Director on 8/7/13. All receptacles in the kitchen were inspected by the Maintenance Di-	

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K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation on August 6, 2013 at approximately 10:00 Am onward the following was noted: 1) The Ground Fault Receptacle at the meat prep sin in the kitchen did not trip when tested. 2) The electrical cover plate for the coffee pot in the kitchen was bent and pulled away from the wall. 42 CFR 482.41(a)	K 147	rector on 8/7/13 with 2 others found that were also corrected 8/7/13. 2)The electrical cover plate for the coffee pot in the kitchen was replaced on 8/7/13 by the Maintenance Director. All electrical cover plates in the kitchen were replaced on 8/7/13 by the Maintenance Director. Receptacles and electrical cover plates in the dietary department will be monitored during daily rounds by the Dietary Manager and the Maintenance Director.	8/7/13