STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345244	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORVIEW HEALTH CARE CENTER	812 SHEPARD ST MOREHEAD CITY, NC 28557

(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 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:	F 156	THIS FACILITY'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW. 1) The facility shall post the correct names, addresses, and telephone numbers of all pertinent State agencies. On 2/21/13 the facility posted the correct contact information for the State Division of Facility Services. The information is prominently displayed on bulletin boards on the second and third floors and in the vestibule area on the first floor. 2) The facility shall ensure that accurate State agency contact information is posted throughout the facility. On 2/21/13 the facility posted the correct contact information for the State Division of Facility Services on the second and third floor bulletin boards and in the vestibule area on the first floor. The facility will also provide written contact information for all State agencies to residents upon admission to the facility. 3) The Admissions Coordinator or designee will conduct a weekly visual check of all areas where the State contact information is posted times 12 weeks.	2/21/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Charl Howell	Administrator	3-5-13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345244	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORVIEW HEALTH CARE CENTER	812 SHEPARD ST MOREHEAD CITY, NC 28557

(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 156	Continued From page 1 A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's	F 156	Any state agency contact information that is updated will be immediately corrected throughout the facility. These changes will be disseminated immediately to appropriate departments and prominently displayed to ensure a deficient practice will not occur. 4) Any concerns or problems with this Plan of Correction will be brought to the monthly quality assurance committee meeting. The Admissions Coordinator or designee shall report her findings to the committee regarding the weekly visual checks times three months. Any problems with the implementation of updating State agency contact information will be brought to the attention of the Administrator and discussed with the interdisciplinary team for further recommendations. The Administrator or designee will be charged with ensuring that corrections are achieved and sustained. 5) Date of Compliance: 2/21/13	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345244	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 156	Continued From page 2 policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to post accurate state agency contact information in 2 of 2 locations in the facility. An observation on 2/18/13 at 3:37 PM revealed that the state contact information posted on the third floor bulletin board near the electrical room was incorrect. The name for the state agency was listed as Division of Facility Services and the phone numbers were not the current contact numbers for the agency. An observation on 2/19/13 at 12:07 PM revealed that the state contact information posted on the second floor bulletin board was incorrect and contained the same information that was listed on the third floor bulletin board. In an interview with the admissions director on	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345244	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORVIEW HEALTH CARE CENTER	812 SHEPARD ST MOREHEAD CITY, NC 28557

(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 156	Continued From page 3 2/21/13 at 2:30 PM, she stated that the ombudsman faxed a listing of the contacts for the state agency and she received all updates or changes to names or numbers from the ombudsman. She stated that the most recent fax she received with this information was in the last month or two and that the ombudsman was in the facility this week and did not provide any updated information. She reported that she did not check the listing for accuracy and gave the listing to the activities director to post. In an interview with the administrator on 2/21/13 at 3:25 PM, she stated that state agency contact information should be clearly posted and staff should also be able provide the information to residents and staff as requested. She stated that she would expect that all information posted would be accurate and that any changes would be made immediately. She said that they had realized that some of the listed numbers and nomenclature for the state agency were incorrect earlier in the day and they were in the process of updating the postings with the correct information.	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345244	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORVIEW HEALTH CARE CENTER	812 SHEPARD ST MOREHEAD CITY, NC 28557

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V construction, multi-story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	THIS FACILITY'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW.	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 3/12/13 at approximately noon the following building construction type was non-compliant, specific findings include; the front windows (two) in the waterfront solarium has a leak when it rains.	K 012	1) THE FACILITY HAS HAD THE WINDOW IN THE WATERFRONT SOLARIUM ON THE SECOND FLOOR INSPECTED BY PROFESSIONALS AND WILL BE REPAIRED IN A TIMELY FASHION. 2) THE MAINTENANCE DIRECTOR WILL INSPECT ALL WINDOWS DURING RAINFALL TO ENSURE NO LEAKS ARE OCCURING. IF LEAKS ARE FOUND, THE MAINTENANCE DIRECTOR WILL REPAIR OR CONTACT AN OUTSIDE PROFESSIONAL IF IT CANNOT BE REPAIRED IN HOUSE. 3) DURING TIMES OF RAINFALL, THE MAINTENANCE DIRECTOR WILL COMPLETE A FORM TO SHOW THAT EACH WINDOW WAS CHECKED AND WILL REPORT HIS FINDINDS TO THE ADMINISTRATOR OR DESIGNEE AND TO THE QUALITY ASSURANCE COMMITTEE. 4) DURING TIMES OF RAINFALL, THE MAINTENANCE DIRECTOR WILL COMPLETE A FORM TO SHOW THAT EACH WINDOW WAS CHECKED AND WILL REPORT HIS FINDINDS TO THE ADMINISTRATOR OR DESIGNEE AND TO THE QUALITY ASSURANCE COMMITTEE. 5) COMPLETION DATE: MAY 12, 2013	5/31/13
K 018 SS=D	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	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Chas Howard	Administrator	3-22-13

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.

DRW

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345244	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORVIEW HEALTH CARE CENTER	812 SHEPARD ST MOREHEAD CITY, NC 28557

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V construction, multi-story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	THIS FACILITY'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW.	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 3/12/13 at approximately noon the following building construction type was non-compliant, specific findings include; the front windows (two) in the waterfront solarium has a leak when it rains.	K 012	1) THE FACILITY HAS HAD THE WINDOW IN THE WATERFRONT SOLARIUM ON THE SECOND FLOOR INSPECTED BY PROFESSIONALS AND WILL BE REPAIRED IN A TIMELY FASHION. 2) THE MAINTENANCE DIRECTOR WILL INSPECT ALL WINDOWS DURING RAINFALL TO ENSURE NO LEAKS ARE OCCURING. IF LEAKS ARE FOUND, THE MAINTENANCE DIRECTOR WILL REPAIR OR CONTACT AN OUTSIDE PROFESSIONAL IF IT CANNOT BE REPAIRED IN HOUSE. 3) DURING TIMES OF RAINFALL, THE MAINTENANCE DIRECTOR WILL COMPLETE A FORM TO SHOW THAT EACH WINDOW WAS CHECKED AND WILL REPORT HIS FINDINDS TO THE ADMINISTRATOR OR DESIGNEE AND TO THE QUALITY ASSURANCE COMMITTEE. 4) DURING TIMES OF RAINFALL, THE MAINTENANCE DIRECTOR WILL COMPLETE A FORM TO SHOW THAT EACH WINDOW WAS CHECKED AND WILL REPORT HIS FINDINDS TO THE ADMINISTRATOR OR DESIGNEE AND TO THE QUALITY ASSURANCE COMMITTEE. 5) COMPLETION DATE: MAY 12, 2013	~~5/12/13~~ 5/31/13
K 018 SS=D	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	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Chas Howell — TITLE: Administrator — (X6) DATE: 3-28-13

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.

DRJ

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345244	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORVIEW HEALTH CARE CENTER	812 SHEPARD ST MOREHEAD CITY, NC 28557

(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 018	Continued From page 1 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: 42 CFR 483.70(a) By observation on 3/12/13 at approximately noon the following corridor door was non-compliant, specific findings include; the door to speach therapy, across from room 207, had a dead bolt that required more than one range of motion to exit the area.	K 018	1) THE DEAD BOLT WAS REMOVED FROM THE SPEECH THERAPY DOOR MAKING IT OPERABLE WITH ONE RANGE OF MOTION. 2) THE MAINTENANCE DIRECTOR WILL INSPECT ALL DOORS IN THE FACILITY AND ANY NEW DOOR INTATLLATIONS TO ENSURE COMPLIANCE WITH LIFE SAFETY CODE. 3) THE MAINTENANCE DIRECTOR WILL ENSURE THAT ANY NEW DOOR INSTALLATIONS ARE IN COMPLIANCE WITH LIFE SAFETY CODE. THE MAINTENACNE DIRECTOR WILL LOG DOOR REPAIRS AND REPORT COMPLIANCE TO THE QA COMMITTEE. 4) THE MAINTENANCE DIRECTOR WILL LOG ALL DOOR REPAIRS AND NEW DOOR INSTALLATIONS AND REPORT LIFE SAFETY CODE COMPLIANCE TO THE QA COMMITTEE. 5) COMPLETION DATE: 3/21/13	3/21/13
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4	K 076		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345244	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBORVIEW HEALTH CARE CENTER	812 SHEPARD ST MOREHEAD CITY, NC 28557

(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 076	Continued From page 2 This STANDARD is not met as evidenced by: By observation, oxygen cylinders were not properly chained or supported in a proper cylinder stand or cart. [NFPA 99 4-3.5.2.1b(27)] 42 CFR 483.70(a) By observation on 3/12/13 at approximately noon the oxygen storage was non-compliant, specific findings include; A. Oxygen cylinders were stored within 5 foot of combustibles. (4th floor oxygen storage) B. Full and empty oxygen cylinders were stored together without signage. If stored within the same enclosure, empty cylinders shall be segregated and designated (with signage) from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. [NFPA 99 4-3.5.2.2b(2)] (4th floor oxygen storage)	K 076	1) THE OXYGEN CYLINDERS WERE RELOCATED TO A SEPARATE STORAGE AREA ON THE THIRD FLOOR AND NOW INCLUDE APPROPRIATE SIGNAGE. 2) THE FACILITY WILL MAINTAIN ONLY ONE OXYGEN STORAGE AREA. 3) THE MAINTENANCE DIRECTOR WILL INSPECT THE OXYGEN STORAGE AREA ON A WEEKLY BASIS TIMES 9 WEEKS TO ENSURE COMPLIANCE WITH LIFE SAFETY CODE AND REPORT FINDINGS TO QA COMMITTEE. 4) THE MAINTENANCE DIRECTOR WILL INSPECT THE OXYGEN STORAGE AREA ON A WEEKLY BASIS TIMES 8 WEEKS TO ENSURE COMPLIANCE WITH LIFE SAFETY CODE AND REPORT FINDINGS TO QA COMMITTEE. 5) COMPLETION DATE: 3/28/13	3/28/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345244	A. BUILDING 02 - MAIN BUILDING 02 B. WING _____	03/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 construction, multi-story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows: There were no Life Safety Code Deficiencies noted at time of survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charles Howell

TITLE: Administrator

(X6) DATE: 3-25-13

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.

DRW