<table>
<thead>
<tr>
<th>ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
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<tbody>
<tr>
<td>F 164</td>
<td><strong>483.10(e), 483.75(<a href="4">4</a>) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</strong></td>
<td>F 164</td>
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<tr>
<td>SS=D</td>
<td>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</td>
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<td></td>
<td>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</td>
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<td></td>
<td>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</td>
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<td></td>
<td>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</td>
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<td></td>
<td>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</td>
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<td></td>
<td>This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to pull a privacy curtain around a resident's bed during a bed bath for 1 of 1 resident (Resident #5).</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 patient. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 30 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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<th>ID</th>
<th>F 164</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Findings included:</td>
<td></td>
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<tr>
<td></td>
<td>Review of the clinical record indicated resident #5 was admitted to the facility on 9/28/2003.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review of a Minimum Data Set (MDS) dated 3/8/2013 revealed resident #5 had moderate impairment for making daily decisions and required physical assistance from one person for bathing.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>During an observation on 4/17/2013 at 6:00 AM, Nursing Assistant #1 (NA) was providing care to resident #5. The resident was observed in the bed adjacent to the hallway. The NA closed the door to the hallway prior to the care but failed to pull the privacy curtain around the resident's bed prior to and during care. The resident was completely unclothed during care. Midway through the bath, a staff member knocked on the door and opened it and exposed the unclothed resident to the hallway. When asked how this made her feel, the resident smiled and nodded and made no response.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In an interview with NA #1 on 4/17/2013 at 7:00 AM, the NA reported she was supposed to pull the privacy curtain around the resident's bed prior to providing care. The NA gave no reason why this was not done.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>In an interview on 4/17/2013 at 9:00 AM, the Director of Nursing (DON) indicated privacy curtains were to be pulled completely around a resident's bed during care.</td>
<td></td>
</tr>
<tr>
<td>ID</td>
<td>F 164</td>
<td>This Plan of Correction is the center's credible allegation of compliance.</td>
</tr>
<tr>
<td></td>
<td>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. compliant will undergo further counseling and/or in-service training.</td>
<td></td>
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<td></td>
<td>4. The DNS and/or designee will monitor resident/dignity and privacy through observation and resident interview on a daily basis. The data will be reviewed and analyzed with a subsequent plan of action. The Performance Improvement Committee will review the log monthly x 3 months to validate overall compliance.</td>
<td></td>
</tr>
<tr>
<td>ID</td>
<td>F 253</td>
<td>Area was cleaned and treated on April 18, 2013. Also a complete building inspection was done.</td>
</tr>
<tr>
<td></td>
<td>483.15(n)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</td>
<td></td>
</tr>
<tr>
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<td>(X4) ID PREFIX TAG</td>
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</tbody>
</table>
| F 253             | Continued From page 2  
The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  
This REQUIREMENT is not met as evidenced by:  
Based on observations and staff interviews, the facility failed to clean mold from the ceiling in 1 of 1 resident's room (resident #72).  
Findings included:  
Record review indicated resident #72 was admitted to the facility on 10/21/2012 with cumulative diagnoses which included Alzheimer's dementia.  
In an observation on 4/15/2013 at 2:00 PM, 2 large areas were noted on the resident's ceiling black with a fuzzy appearance. One area was also surrounded by light brown and bulging. The resident was unable to voice how long the areas had been there.  
An observation on 4/16/2013 at 10:00 AM revealed no changes in the 2 areas.  
An observation on 4/17/2013 at 10:00 AM revealed no changes in the 2 areas.  
An observation on 4/18/2013 at 3:00 PM revealed no changes in the 2 areas.  
An interview was conducted on 4/18/2013 at 3:55 PM with the Housekeeping Manager (HM). The HM reported every resident's room is checked every day for any areas that need cleaning. The | F 253         | All areas in resident's rooms are checked daily by housekeeping manager. Any and all areas found to be not clean or in good repair and corrected immediately. If items requiring replacement or repair are needed, a maintenance request id filled out to follow up with the repair.  
On a monthly basis, the House Keeping Manager will do complete building inspections of all resident rooms and common areas, and report all areas to maintenance department for repair and document on monthly CQI audit sheet that is presented at the monthly CQI meeting. | | |

This Plan of Correction is the center's credible allegation of compliance.  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CJA IDENTIFICATION NUMBER:
345365

(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
04/19/2013

NAME OF PROVIDER OR SUPPLIER
KINSTON REHAB AND HEALTHCARE CTR

STREET ADDRESS, CITY, STATE, ZIP CODE
997 CUNNINGHAM RD
KINSTON, NC 28591

(X4) ID PREFIX
F 253

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F 253
Continued from page 3
HM further indicated the expectation was any issues that could not be addressed by housekeepers should be brought to his attention. The HM was not aware of any issues in the room of resident #72. The interview was continued in the room of resident #72 on 4/18/2013 at 4:00 PM. When the HM observed the 2 areas on the ceiling with a darkened substance, he reported this should have been brought to his attention.

The Administrator reported on 4/18/2013 at 4:15 PM, it was the expectation areas with mold should be addressed as soon as possible.

F 312
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 observation, staff interviews and record review, the facility failed to properly clean the perineal area of a resident for 1 of 1 resident (Resident #5).

Findings included:
Review of the clinical record indicated resident #5 was admitted to the facility on 9/26/2003.
Review of a Minimum Data Set (MDS) dated 3/8/2013 revealed resident #5 had moderate impairment for making daily decisions and

F 312
1. The SDC or designee will in-service CNA assigned to resident #5 on proper peri-care procedures. The CNA identified as having provided the care has been counseled regarding facility procedure for providing peri-care and respecting resident's privacy. The CNA will successfully perform a demonstration of incontinent care according to facility policy.
2. The DNS or designee will assess each resident's personal hygiene with special attention to incontinent care. Staff members identified as not providing appropriate personal hygiene to residents identified through this assessment process, will receive individual in-service by the DNS and/or designee and will be counseled by the DNS.
3. The SDC or designee will in-service the current nursing staff regarding providing proper peri-care. The DNS, SDC and their designees will observe
F 312  Continued From page 4
required physical assistance from one person for bathing.

During an observation on 4/17/2013 at 6:00 AM, Nursing Assistant #1 (NA) provided care to resident #5. The NA washed the resident's perineal area with a clean soapy washcloth. The NA cleaned at the front vaginal area and cleaned from front to back and cleaned the rectal area. The NA then used the soiled washcloth and again washed the front vaginal area with the soiled washcloth.

In an interview with NA #1 on 4/17/2013 at 7:00 AM, the NA reported she was supposed to clean from front to back and should have used the soiled washcloth to repeat cleaning of the vaginal area. The NA gave no reason why this done.

In an interview on 4/17/2013 at 9:00 AM, the Director of Nursing (DON) indicated resident's perineal area should be cleaned front to back, and a soiled washcloth should not be used again in the vaginal area.

F 371 483.35(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

The nursing staff performing peri-care. As necessary each employee will be re-in-services and/or counseled to assure compliance with facility policy. The SDC and/or designee will include peri-care in the orientation of new staff to the nursing department, to include observation of the employee providing peri-care.

4. The DNS or designees will monitor peri-care through direct observation of nursing staff the performing of peri-care and monitor through a Quality Assurance tool to assure compliance with facility policy. The DNS will also review concerns/grievances reports of this nature. This will be done weekly for 1 month, then monthly for the next three months, then quarterly. The Performance Improvement Committee will review QI tool monthly times 3 months to validate overall compliance. This Plan of Correction is the center's credible allegation of compliance.

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(Continued From page 5)

This REQUIREMENT is not met as evidenced by:

Based on observations and staff interviews the facility failed to maintain sanitary condition of one of one fans in the dish room as evidenced by a black, greasy buildup on the blades and covering of the fan.

Findings included:

Observation was made on 4/17/13 at 11:40 AM of the large, round wall fan approximately 6 feet off the ground in the dish room located on the wall above the clean side of the dish machine with a black, greasy build up.

An interview was conducted on 4/17/13 at 11:44 AM with the Certified Dietary Manager (CDM) who indicated that the fan had not been cleaned since November 2012 when she reviewed the calendar.

An interview with the Director of Maintenance on 4/18/13 at 12:00 PM indicated that the fan should be cleaned when other vents in the kitchen are cleaned. That would be on a 30 day basis.

F 441
483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
Continued From page 6

(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interviews and record review, the facility failed to properly dispose of a soiled washcloth following perineal care for 1 of 1 resident (resident #5).

Findings included:
Review of a facility policy dated 4/28/2010 entitled...
Continued From page 7
"Infection Control Work Practices" indicated that all procedures involving blood or potentially infectious materials are performed in such a manner as to minimize splashing, spraying, spattering and generation of droplets of those substances.

During an observation on 4/17/2013 at 8:00 AM, Nursing Assistant #1 (NA) provided perineal care to resident #5. Prior to cleaning the perineal area, areas of feces were observed in the resident's perineal area. The NA cleaned the resident's perineal area with a wet washcloth. The NA then laid the soiled washcloth on top of the resident's bedsheets which was on top of the bed. The NA took a shirt and a pair of pants of the resident's closet and laid both items on top of the soiled washcloth. The NA dressed the resident in the pants and shirt.

In an interview with NA #1 on 4/17/2013 at 7:00 AM, the NA reported she was supposed to dispose of the soiled washcloth in a bag after she used it. The NA gave no reason why this was not done.

In an Interview on 4/17/2013 at 9:00 AM, the Director of Nursing (DON) indicated staff should place a soiled washcloth in a plastic bag and dispose in the proper waste bin.

The facility must maintain an effective pest control program so that the facility is free of pests and rodents.

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This REQUIREMENT is not met as evidenced by:
Based on observations, record review, resident and staff interviews, the facility failed to maintain an effective pest control program so that the facility was free of roaches.

Findings Included:

- Review of facility forms entitled "Integrated Pest Management Pest Sighting Log" revealed the following sightings of roaches:
  - 1/11/2013 Roaches in Payroll and Rooms 304, 305,308.
  - 1/15/2013 Roaches on 100 and 200 Hall
  - 2/1/2013 Roaches Room 203
  - 2/5/2013 Roaches Rooms 103, 102 and 104
  - 2/7/2013 Desk and Bulletin Board and Room 206
  - 2/8/2013 Roaches Watercooler and Front Lounge
  - 2/11/2013 Roaches Rooms 4 Resident Rooms on the 300-400 Hall and 300 Hall Bathroom
  - 2/15/2013 Roaches Room 104
  - 2/27/2013 Roaches Resident Rooms on 200 Hall
  - 300 Hall Bathroom and Room 508
  - 2/28/2013 Roaches Rooms on 100, 300 and 400 Halls
  - 3/1/2013 Roaches Hall 200 Breakroom and Resident rooms on 300 and 500 Hall
  - Roach sightings were also documented every day in March 2013 except 3/20, 3/22/3/23 and 3/24.
  - Sightings were in numerous areas of the facility.

Review of resident council minutes indicated

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F 469

The Pest control company was called and arrived for treatment of pest control on building on April 19, 2013.

The Pest control company was also scheduled to repeat visits daily the following week. After that week, will continue weekly visits for the next three months at which point they will start a bi-monthly visit schedule.

Employees will be reeducated at next mandatory all staff meeting on May 9, 2013 on measures taken concerning Pest Control for the building.

During monthly facility rounds conducted by the housekeeping manager; all areas with sightings will be recorded, corrected, and noted on monthly CQI sheet and taken to monthly CQI meeting.
residents complained about roaches in the facility in the March 2013 and April 2013 meetings.

An observation in resident room 203 on 4/16/2013 at 6:00 AM revealed a roach crawling on the floor beside the resident's bed, a 2nd roach observed crawling under the resident's bed, a 3rd roach observed in a box of gloves on the resident's night table and a 4th roach crawling under the resident's night stand where food and drink were noted on the floor.

Nursing Assistant (NA) #1 was interviewed on 4/16/2013 at 6:00 AM, and stated "They are everywhere." When asked if she had seen the food on the floor, the NA stated, "It was here when I came on last night.  She reported it was her job to clean up food off the floor.  The NA further reported second shift should have cleaned it up, and "it got busy last night." The NA stated she reported seeing roaches to the nurse many times.

Staff Nurse #1 was interviewed on 4/16/2013 at 6:15 AM.  She reported there were roaches in the facility, and she indicated she turned in reports to maintenance when she saw roaches.  She reported she saw the food on the floor in the resident's room on the 200 hall when she came on duty last night, and she revealed she was too busy to clean it up and stated it was the duty of staff to clean food up if they saw it.

In an interview on 4/17/2013 at 9:00 AM, the Director of Nursing (DON) indicated the expectation was staff should clean up spilled food and drink off the floor when they see it in an effort to control roaches.
In an interview with the Administrator on 4/17/2013 at 10:50 AM, the Administrator reported the facility had a roach issue for several months. She reported extensive efforts had been implemented in efforts to get rid of the roaches that included staff inservices, changing exterminating companies, exterminator coming at least weekly, fumigating rooms, but the problem was ongoing.

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<td>K 000</td>
<td><strong>INITIAL COMMENTS</strong></td>
<td></td>
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<td></td>
<td>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. Facility is using NC special locking system. The deficiencies determined during the survey are as follows: No LSC deficiencies noted at time of survey. 42 CFR 483.70(a)</td>
<td>K 000</td>
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Kinston Rehab and Healthcare CTR

K000 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. Facility is using NC special locking system.

The deficiencies determined during the survey are as follows:

K012 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:
Surveyor: 27871
Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliant, specific findings include: door assembly in smoke wall in attic on 500 hall did not close for smoke tight seal. Also, rated access door in rated ceiling on 500 hall did not close and latch (no springs on door).

K067 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD

Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's

K000 K-012

Door assembly in smoke wall in attic was repaired within 24 hours. Also, ceiling access door to be replaced with new door.

All smoke doors and ceiling access doors were checked throughout the facility for proper operation and compliance.

K012 All smoke doors and ceiling access doors to be checked monthly during preventative maintenance rounds and logged.

All preventative rounds records to be brought to quarterly CQI meeting for their approval.

K067 All access doors as well as smoke doors to be repaired or replaced no later than June 13, 2013.

K-067 All units inspected and found not to have access doors for inspection and or cleaning.

Administrator 6-28-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting pending it is determined that other safeguards provide sufficient protection. (See instructions.) Except for nursing homes, the findings stated above are disposable 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 required to continued program participation.
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<td>K 067</td>
<td>Continued From page 1 specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</td>
<td>K 067</td>
<td>All HVAC units to have doors installed for cleaning and inspection purposes.</td>
<td>6-13-13</td>
</tr>
<tr>
<td></td>
<td>This STANDARD is not met as evidenced by: Surveyor: 27971</td>
<td></td>
<td>All units sensor within HVAC units to be checked during monthly preventative maintenance rounds and logged.</td>
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<tr>
<td></td>
<td>Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliant, specific findings include: at time of survey, no access doors were in duct to view duct detector tubes for cleanliness (in attic, facility wide).</td>
<td></td>
<td>All preventative rounds records to be brought to quarterly CQI meeting for their approval.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>42 CFR 483.70(a)</td>
<td></td>
<td>All access doors to be installed and operational by June 13, 2013.</td>
<td></td>
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