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

PRINTED: 11/17/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	345431		11/10/2011

NOV 28 2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR COMMUNITY HOSPITAL	921 JUNIOR HIGH SCHOOL ROAD SCOTLAND NECK, NC 27874

(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 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES 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 observation, record review and staff interviews the facility failed to ensure that resident ' s personal care equipment was labeled for one of two halls (300 Hall). The findings include: 1. The facility policy dated 4/2009 and titled Storage of BedPans and Wash Basins read: " Each resident will have their own bedpan, if needed, and will also be provided with a wash basin. All resident care items will be labeled or marked with their name and room number. " On 11/07/11 at 4:51 PM one unlabeled bath basin and one unlabeled bed pan was observed in the bathroom shared by the 3 residents in rooms 301 and 303. On 11/08/11 at 9:14 AM one unlabeled bath basin and one unlabeled bed pain was observed in the bathroom shared by the 3 residents in rooms 301 and 303. On 11/10/11 at 8:55 AM two unlabeled bath basins, one sitting inside the other and one unlabeled bed pan was observed in the bathroom shared by the 3 residents in rooms 301 and 303. The Director of Nursing stated in an interview on 11/10/11 at 9:30 AM that bath basins and bed	F 253	The requirement has been met and will continue to be met as evidenced by proper labeling of individual bedpans, wash basins, and urinals. For those residents in rooms 301 and 303 (3), 305 and 307 (3), 306 and 308 (4) and 309 and 311 (4), immediate action was taken and items were labeled correctly with resident's name and room number. Bedpans and wash basins are labeled per facility policy and will be stored in plastic bags. They will be cleaned after each use and replaced as needed. The nursing staff in conjunction with the housekeeping staff will ensure that these items are labeled at the time of admission and will monitor during facility rounds and room checks to assure compliance. The DNS will delegate the ADON or the SDC to monitor and report any problems at quarterly Quality Assurance Committee x 12 months. (on-going) The facility policy re: Storage of Bedpans and Wash Basins has been reviewed with nursing staff and the housekeeping staff.	11/18/11 11/14/11 11/18/11 11/23/11 11/18/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
T.K. Majure, CEO by Claudia Middleing	DNS	11-23-11

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 253	Continued From page 1 pans should be labeled. Nursing Assistant #1 stated in an interview on 11/10/11 at 10:30 AM that bed pans and bath basins were supposed to be labeled with the resident ' s name. 2. The facility policy dated 4/2009 and titled Storage of BedPans and Wash Basins read: " Each resident will have their own bedpan, if needed. All resident care items will be labeled or marked with their name and room number. " On 11/07/11 at 4:55 PM one unlabeled bed pan was observed in the bathroom shared by the 4 residents in rooms 305 and 307. On 11/08/11 at 9:40 AM one unlabeled bedpan was observed in the bathroom shared by the 4 residents in rooms 305 and 307. The Director of Nursing stated in an interview on 11/10/11 at 9:30 AM that bed pans should be labeled. Nursing Assistant #1 stated in an interview on 11/10/11 at 10:30 AM that bed pans were supposed to be labeled with the resident ' s name. 3. The facility policy dated 4/2009 and titled Storage of BedPans and Wash Basins read: " Each resident will have their own bedpan, if needed. All resident care items will be labeled or marked with their name and room number. " On 11/08/11 at 9:00 AM one unlabeled bed pan was observed in the bathroom shared by the 4	F 253		

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F 253	Continued From page 2 residents in rooms 306 and 308. On 11/10/11 at 9:00 AM one unlabeled bed pan was observed in the bathroom shared by the 4 residents in rooms 306 and 308. The Director of Nursing stated in an interview on 11/10/11 at 9:30 AM that bed pans should be labeled. Nursing Assistant #1 stated in an interview on 11/10/11 at 10:30 AM that bed pans were supposed to be labeled with the resident ' s name. 4. The facility policy dated 4/2009 and titled Storage of BedPans and Wash Basins read: " Each resident will be provided with a wash basin. All resident care items will be labeled or marked with their name and room number. " On 11/08/11 at 10:03 AM an unlabeled bath basin was observed in the bathroom shared by the 4 residents in rooms 309 and 311. On 11/10/11 at 9:04 AM an unlabeled bath basin was observed in the bathroom shared by the 4 residents in rooms 309 and 311. The Director of Nursing stated in an interview on 11/10/11 at 9:30 AM that bath basins should be labeled. Nursing Assistant #1 stated in an interview on 11/10/11 at 10:30 AM that bath basins were supposed to be labeled with the resident ' s name.	F 253		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		

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F 329 SS=D	Continued From page 3 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to monitor a resident on antipsychotic medications by not completing an Abnormal Involuntary Movement Score test every 6 months for 1 of 3 sampled residents reviewed for antipsychotic medications (Resident #48). The findings include:	F 329	The requirement has been met as evidenced by completion of the Abnormal Involuntary Score (AIMS) on Resident #48. All records, for those residents receiving antipsychotic medications, have been reviewed by the DNS. A list of those residents will be maintained and updated by the DNS. A copy of the list has been posted at the nurse's station for their review and to avoid omissions of AIMS testing. Nurses who review/check monthly MD orders have been instructed by the DNS to indicate the AIMS due date on those monthly orders and to obtain verbal order for any new admissions. For new admissions, the admitting nurse will add the resident's name to the list and he/she will notify the DNS, or designee. The policy for Antipsychotic Medications and AIMS Testing has been revised and reviewed with the nursing staff. A copy of the policy has also been given to the Pharmacist and to the attending physician.(Attachment # 1-A) The DNS, or designee, will monitor for compliance and ensure that residents who are admitted to the facility on antipsychotic medications will have an AIMS done within 24 hours and every 6 months thereafter	11/9/11 11/14/11 11/11/11 11/18/11

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F 329	Continued From page 4 The facility policy dated 2008 under Antipsychotic Medications read: " An AIMS evaluation will be done on any resident receiving an antipsychotic medication. This will be done within 24 hours of admission and every 6 months after that in order to monitor for potential side effects. Resident #48 was re-admitted to the facility on 03/22/11 and had diagnoses including Paranoid Personality and Obsessive-Compulsive Disorder. A review of the resident ' s medical record showed that the resident was re-admitted to the facility on an antipsychotic medication. There was one AIMS test on the medical record and was dated 03/23/11. The quarterly Minimum Data Set Assessment dated 09/23/11 showed that the resident was on an antipsychotic medication. The resident ' s physician ' s orders for September, October and November 2011 showed that the resident continued to receive an antipsychotic medication. The Director of Nursing (DON) stated in an interview on 11/09/11 at 3:30 PM that she did the AIMS test on residents receiving antipsychotic medications every 6 months. The DON was observed to check the resident ' s computerized medical record and stated that the AIMs test was past due. The DON stated that she had a list of residents on antipsychotic medications that she reviewed on a monthly basis and did not know how she missed this one.	F 329	A report will be present at the next Quality Assurance Committee Meeting addressing any problems, concerns, outcomes, and resolutions x 12 months. Random chart reviews will be done after that time, and action will be taken immediately to correct any issues as needed.	11/23/11 11/18/11
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371		

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F 371	Continued From page 5 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 upon observations and staff interviews the facility failed to label and date prepared and opened food items. Also the facility stored dented food cans in the dry storage food area. Findings Include: 1. An initial kitchen tour was conducted on 11/7/11 at 8:09am with the Head Cook. A pot of cooked peas and container of cooked chicken was located in the reach-in refrigerator. These food items were not labeled and dated. The walk-in freezer contained a plastic bag of opened frozen miniature pizzas. This food item was not labeled and dated. The dry storage food area contained an opened bag of grits. This food item was not labeled and dated. An interview on 11/7/11 at 8:20am with the Head Cook revealed that the food items should have been labeled and dated. An observation on 11/9/11 at 11:58pm with the Dietary Manager (DM) revealed an opened bag of corn meal located in the dry storage area. This food item was not labeled and dated. There were 2 plastic bags of opened luncheon meat located	F 371	The facility must store, distribute and serve food under sanitary conditions. The requirement is met and will continue to be met as evidenced by disposal of all foods without proper date opened, foods improperly stored and all dented cans. None of these foods were served to residents. The Certified Dietary Manger (CDM) provided in-service education on: • Proper labeling, dating and storing potential food hazardous. (Attachment # 2) • How to complete date labels and how to store in tightly closed container or food storage bag. (Attachment # 4) • Policy and procedure review for labeling and dating potential food hazards. (Attachment #1) Dietary Manager or dietary supervisor will make daily rounds at 0615 to monitor for unsafe foods, i.e., no label, no date, for dented cans and improperly stored foods. If found, the manager or designee will dispose of per facility policy.	11/9/11 11/21/11 11/21/11 11/21/11

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F 371	Continued From page 6 in the walk-in freezer. These food items were not labeled and dated. An interview with the DM on 11/9/11 at 2:38pm revealed any prepared or opened food item should be covered, labeled and dated. 2. An initial tour was conducted on 11/7/11 at 8:09am with the Head Cook. A dented 8 ounce can of a nutritional supplement was stored on the middle shelf of the walk-in refrigerator. There were 2 dented #10 size cans of lemon pudding and 1 dented #10 size can of pears located on the middle shelf of the dry storage area. All of the dented canned food items were stored with other food items. An observation on 11/9/11 at 11:58am with the DM revealed 1 dented #10 size can of fruit cocktail located on the middle shelf in the dry storage area. This can of fruit cocktail was stored with other canned food items. An interview on 11/9/11 at 2:38pm with the DM revealed she had removed the dented can shelf from the dry storage room. She decided to keep a list of her dented cans in her office. The dining staff is supposed to check it daily and notify her if there are any dented cans. The dented cans are supposed to be placed on the top shelf of the rack next to the food prep area. The DM revealed it was unsafe to have dented cans stored with useable food products. .	F 371	All dietary staff will be re-trained/in-serviced bi-monthly on proper food storage, dating, and labeling of stored foods. All new staff will be trained during orientation process on proper food storage, dating, and labeling in order to prevent food hazards. All new staff will perform demonstration of completing a labeling form. (Attachment # 4) (on-going) The dietary manager, or designee, will submit to Quality Assurance Committee each month a report on any problems found during daily rounds and the corrective action. All dented cans were disposed of by the CDM. The dented cans (purchased Nov) were moved to a designated area in the kitchen with sign posted for staff. Staff has been made aware of location and to place all dented cans in that area for pick-up by vendor(s). In-service provided to dietary staff by CDM. Dented can policy reviewed at that time. (Attachment # 5) Employees will inspect cans for dents prior to placing on shelf. (Dented Can Report Form – Attachment #6)	11/21/11 11/23/11 11/9/11 11/21/11
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		

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F 428	Continued From page 7 The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and staff and pharmacist interviews the facility ' s Consultant Pharmacist failed to report that an AIMS test was due for 1 of 3 sampled residents reviewed for antipsychotic medications (Resident #48). The facility policy dated 2008 under Antipsychotic Medications read: " An AIMS evaluation will be done on any resident receiving an antipsychotic medication. This will be done within 24 hours of admission and every 6 months after that in order to monitor for potential side effects. Resident #48 was re-admitted to the facility on 03/22/11 and had diagnoses including Paranoid Personality and Obsessive-Compulsive Disorder. A review of the resident ' s medical record showed that the resident was re-admitted to the facility on an antipsychotic medication. The quarterly Minimum Data Set Assessment dated 09/23/11 showed that the resident was on an antipsychotic medication. The physician ' s orders for September, October and November of 2011	F 428	The requirement has been met and will continue to be met as evidenced by monthly drug regimen review by the Consultant Pharmacist. The Consultant Pharmacist reports irregularities through "Consultant Pharmacist Resident Review" report. The report/review will be given to the DNS and will be reviewed with the attending physician. Any reports with irregularities will be acted upon immediately. A copy will be returned to the Consultant Pharmacist after completion and a copy will be retained in the DNS office. (on-going) The Consultant Pharmacist will include in his quarterly report the Quality Assurance Committee any problems/trends which have been noted and also for any delinquent AIMS. The pharmacist has been given a copy of the revised Antipsychotic Medications and AIMS Testing policy. In order to assure compliance of the requirements of the regulation, the Pharmacist has been made aware of the list of residents requiring AIMS testing and has been notified that the nurse(s) will write the AIMS due date on the monthly orders.	11/10/11 11/10/11 11/23/11 11/21/11

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F 428	Continued From page 8 showed that the resident continued to receive an antipsychotic medication. The only AIMS test found on the resident ' s medical record was dated 03/23/11. The Director of Nursing (DON) was observed to review the resident ' s medical record on 11/09/11 at 3:30 PM and stated that the AIMs test was overdue. The DON stated that the consulting pharmacist was good about reminding her when an AIMs test needed to be done. On 11/09/11 at 4:16 PM the Consulting Pharmacist stated in an interview that the last AIMs for this resident was done in March of 2011. The Pharmacist stated that they were usually done every 6 months and that he did not see where he made a recommendation for an AIMS to be done for this resident. The Pharmacist stated: " Looks like I missed this one. "	F 428	Medications will be reviewed with the pharmacist by the admitting nurse, and those residents who require AIMS testing will be identified, added to the list, and the DNS will be notified.	11/18/11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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RECEIVED
DEC 29 2011
CONSTRUCTION SECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345431	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 12/06/2011
NAME OF PROVIDER OR SUPPLIER OUR COMMUNITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 921 JUNIOR HIGH SCHOOL ROAD SCOTLAND NECK, NC 27874	

COPY

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K 029 SS=E	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: Surveyor: 27871 Based on observation and staff interview at approximately 8:30 am onward, the hazardous area was non-compliant, specific findings include: doors to rooms 107 and 108 were not self closing. Rooms are being used for storage.	K 029	Storage removed from room 108. Closure installed on room 107. Head of Maintenance or designee will monitor rooms for storage and remove or install closure on door. Any problems will be brought to the QA committee on a quarterly basis.	12/23/11
K 056 SS=E	42 CFR 483.70(a) 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	K 056		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE CEO (X6) DATE 12/20/11

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K 029 SS=E	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	K 029	RECEIVED DEC 22 2011 CONSTRUCTION SECTION	
	This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observation and staff interview at approximately 8:30 am onward, the hazardous area was non-compliant, specific findings include: doors to rooms 107 and 108 were not self closing. Rooms are being used for storage.		Storage removed from room 108. K Closure installed on room 107.	12/23/11
	42 CFR 483.70(a)			
K 056 SS=E	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	K 056		

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D K Mayne	CEO	12/20/11

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.

GW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345431	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/06/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OUR COMMUNITY HOSPITAL	921 JUNIOR HIGH SCHOOL ROAD SCOTLAND NECK, NC 27874

(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)	(X6) COMPLETION DATE
K 056	Continued From page 1 systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056		
	This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following item were noncompliant, specific findings include: on test of tamper switch connected to PIV did not transmit a visual signal at fire alarm control panel.		On schedule to be corrected by Telecommunications of Greenville before January 10, 2012. Will be checked quarterly.	1/10/12
K 076 SS=F	42 CFR 483.70(a) 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	Oxygen policy has been reviewed with nursing staff. Oxygen signs have been placed on rooms 204 and 311 and all other rooms where oxygen is in use. CNO, or designee, will monitor during daily rounds. Any problems will brought to Quality Assurance quarterly for resolution.	12/7/11
	This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following item			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	345431		12/06/2011

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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
K 076	Continued From page 2 were noncompliant, specific findings include: rooms 204 and 311 did not have proper signage indicating that oxygen was in use.	K 076		
K 144 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following item were noncompliant, specific findings include: generator failed to crank and transfer in 10 seconds when tested.	K 144	Fixed on December 7, 2011. Will monitor monthly by maintenance staff and yearly by National Power.	12/7/11
K 147 SS=E	42 CFR 483.70(a) 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: Surveyor: 27871 Based on observations and staff interview at	K 147		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345431	A. BUILDING 01 - MAIN BUILDING 01 B. WING	12/06/2011

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K 147	Continued From page 3 approximately 8:30 am onward, the following item were noncompliant, specific findings include: room 104 is using multi plug outlet for microwave for power. Also clock radio was plugged into extension cord to get power from outlet. 42 CFR 483.70(a)	K 147	Power outlets and extension cords removed from room 104 on December 7, 2011. Maintenance will monitor weekly with scheduled room checks. Staff in-service on electrical wiring and equipment will be added to our Fire Safety In-Service.	1/10/12