<table>
<thead>
<tr>
<th>Statement of Deficiencies and Plan of Correction</th>
<th>(X) Provider/Supplier Identification Number:</th>
<th>(X2) Multiple Construction</th>
<th>(X3) Date Survey Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Provider or Supplier: Henderson Health and Rehabilitation Center</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Henderson Health and Rehabilitation Center</td>
<td>445471</td>
<td>A. Building 01 - Main Building 01</td>
<td></td>
</tr>
<tr>
<td>09/29/2013</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>(X) ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-referenced to the Appropriate Deficiency)</th>
<th>(X) Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 052 SS=D</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
<td>K 052</td>
<td>Smoke detectors have been installed by qualified contactor in day room.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>All facility occupants could potentially be affected by this practice.</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>All common areas have been checked for compliance.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Administrator will be notified of any noncompliance and report to QA committee monthly.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>10/16/13</td>
<td></td>
</tr>
</tbody>
</table>

This STANDARD is not met as evidenced by:

Based on observation, it was determined the facility failed to provide a smoke detector in the facility's day room.

The findings included:

Observations in the facility day room on 9/29/13 at 11:23 AM, revealed there was no smoke detector present.

This finding was acknowledged by the Administrator and verified by the Maintenance personal at the exit conference on 9/29/13.

NFPA 101 LIFE SAFETY CODE STANDARD

Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10

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.

Received: 10/17/2013
K 072  Continued From page 1

This STANDARD is not met as evidenced by:
Based on observations and interview, it was determined the facility failed to ensure the path of egress was free from obstructions for 2 of 10 (500 and 600 hall) means of egress. One (1) of 10 (100 hall) means of egress had more than on releasing operation to exit.

The findings included:

1. Observations during the tour of the facility on 9/29/13 beginning at 8:26 AM revealed items stored in the hall obstructing the full means of egress as followed:
   a. The 500 hall - a chair sitting in the hall across from room 604, a chair by room 605 and 511 and a chair scales by room 513.
   b. The 600 hall - a desk sitting in the foyer.

2. Observations of the means of egress from the 100 hall on 9/29/13 at 8:35 AM, revealed there was more than one releasing operation of means of egress at the gate. In addition to the manual release gate there was a lock attached to a chain, requiring more that one releasing operation. The first look at the gate, it appeared the gate had a chain with a pad lock, locking the gate. The surveyor asked five staff members for the key to unlock the gate. All five staff members stated they did not have a key to the lock on the gate. A Register Nurse went to the gate and revealed the gate was not actually locked. The lock was attached to a chain. The chain had a spring clasp hook that when the spring latch was pulled back the chain was released. There was no key required to open the gate. The lock with the chain

K 072

Immobile items have been removed from corridors and lock removed from chain.

All facility occupants could potentially be affected by this practice.

Maintenance Director or designee will monitor all corridors and exits daily and log results weekly for 3 months.

Any noncompliance will be fixed immediately and log results will be reported to the QA committee monthly for 3 months.

10/16/13
| K 072 | Continued From page 2 and spring clasp release was removed at 9:00 AM. During an interview on 9/29/13 at 3:00 PM, the Administrator stated, "We inherited that [the lock attached to the chain with the spring lock release] when we took over [9/1/12]." There is no reason for it to be on the gate and we "have removed it." These findings were acknowledged by the Administrator and verified by the Maintenance personal at the exit conference on 9/29/13. NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. **This STANDARD is not met as evidenced by:** Based on observation, it was determined the facility failed to maintain all rated assemblies. The findings included: Observations on the 100 hall on 9/29/13 at 12:00 PM, revealed the fire wall in the attic above the 100 hall had a penetration around the water pipe and electrical wiring. This finding was acknowledged by the Administrator and verified by the Maintenance personal at the exit conference on 9/29/13. | K 072 |
| K 104 | SS=D | NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 | K 104 | 10/16/13 |

All found penetrations have been fixed All building occupants have the potential to be affected Maintenance Director or designee will monitor fire walls monthly for compliance Any found noncompliant will be repaired immediately
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<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
<th>ID PREFIX TAG</th>
<th>MULTIPLE CONSTRUCTION</th>
<th>DATE SURVEY COMPLETED</th>
</tr>
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<tbody>
<tr>
<td>K 130</td>
<td>Continued From page 3</td>
<td>K 130</td>
<td></td>
<td>10/16/13</td>
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This STANDARD is not met as evidenced by:
5.1.3.1.6 Locations containing central supply systems or cylinders containing only oxygen or medical air shall have their door(s) labeled as follows: CAUTION Medical Gases NO Smoking or Open Flame

This STANDARD is not met evidence by:

Based on observation, it was determined the facility failed to post signage to alert that oxygen was stored in the room.

The findings included:

Observations of the 500 hall oxygen storage room on 9/29/13 at 9:45 AM revealed there was no signage posted to alert that oxygen was stored in the room.

This finding was acknowledged by the Administrator and verified by the Maintenance personal at the exit conference on 9/29/13.

NFPA 101 LIFE SAFETY CODE STANDARD

Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:
- The corridor is at least 6 feet wide
- The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)
- The dispensers have a minimum spacing of 4 ft from each other
- Not more than 10 gallons are used in a single
K211 Continued From page 4

Smoke compartment outside a storage cabinet.

- Dispensers are not installed over or adjacent to an ignition source.
- If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 462.41, 483.70, 483.823, 485.623

This STANDARD is not met as evidenced by:

Based on observation, it was determined the facility had installed alcohol based hand rub dispensers above an ignition source.

The findings included:

Observations on 9/29/13 at 11:25 AM, revealed an alcohol based hand rub dispenser had been installed above the light lights in rooms 101, 102, 105, 107, 111, 112, 202, 203 and 204.

This finding was acknowledged by the Administrator and verified by the Maintenance personal at the exit conference on 9/29/2013.

K211

The noted Alcohol based sanitizer dispensers have been moved to a complaint location

All building occupants could be potentially affected

All alcohol based sanitizer dispensers have been checked for compliance

- Maintenance and
- Housekeeping staff have been in-serviced on LSC requirements with regard to alcohol based hand sanitizer dispensers. Any found to be noncompliant will be fixed immediately