LIFE CARE CENTER OF CENTERVILLE

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X3) DATE SURVEY COMPLETED</th>
</tr>
</thead>
<tbody>
<tr>
<td>K018</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
<td>SS=D</td>
<td>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1% 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 the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</td>
<td>DEC 23, 2011</td>
</tr>
</tbody>
</table>

Roller latches are prohibited by CMS regulations in all health care facilities.

This STANDARD is not met as evidenced by:

Based on observation, it was determined the facility failed to maintain all doors.

The findings included:

Observation of the main kitchen door at 12/5/11 at 10:40 AM, revealed the door would not latch when closed.

This finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 12/5/11.

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<tr>
<td>K050</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
<td>SS=D</td>
<td>Maintenance associates observed facility Doors from 12/23/11 to 12/30/11 to confirm Doors latch when closed</td>
<td>DEC 23, 2011</td>
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Maintenance associates will audit kitchen door weekly for 16 weeks. Maintenance staff educated on 12/21/11 on maintaining facility doors. The results of these audits will be presented to the P.I committee.

4) How will the corrective action be accomplished for those residents found to have been affected by deficient practice?

Maintenance associates will audit kitchen door weekly for 16 weeks. Maintenance staff educated on 12/21/11 on maintaining facility doors. The results of these audits will be presented to the P.I committee.

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that its safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days from the date of the 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 participation.

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**K018: 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 1/2 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 the door closed. Dutch doors meeting 19.3.6.3 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:

Based on observation, it was determined the facility failed to maintain all doors.

The findings included:

Observation of the main kitchen door at 12/5/11 at 10:40 AM, revealed the door would not latch when closed.

This finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 12/5/11.

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The Maintenance Director will present
The findings of the Door Audit
to the Performance Improvement Committee
Meeting monthly for four consecutive months.
The P.I. Committee consisting of
The Executive Director, Medical Director,
Business Office Manager, Director of Medical Records, Director of Environmental Service,
Director of Maintenance, Director of
Social Services, Director of Admissions,
Director of Rehab Services, Director of Activities,
Director of Food and Nutrition Services, and
Director of Marketing will review the findings
and make recommendations and develop plans of action if any areas are noted to be non-compliant.

12/30/11
K 050: Continued From page 1

Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2

This STANDARD is not met as evidenced by:

Based on observation and review of fire drill procedures, it was determined the facility staff failed to perform their assigned duties according to the policies and procedures manual.

The findings included:

Observations of the fire drill conducted on the 200 hall on 12/5/11 at 2:07 PM, revealed the staff did not respond to the fire in resident room 226 until all other residents room doors had been closed and a fire extinguisher was brought to the area.

The facility’s fire drill policy and procedure stated that the staff will respond to the announced room when the fire alarm is sounded.

This finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 12/5/11.

1) What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

The facility will ensure that associates perform their assigned duties during fire drills.

12/30/11

2) How will you identify other residents having the potential to be affected by the same deficient practice?

A social worker completed an audit of all residents from 12/20/11 to 12/22/11 to confirm residents are satisfied with room placement. Residents audited are satisfied with current room placement.

12/30/11

3) What measures will be put into place or what systematic changes will you make to assure that the deficient practice will not recur?

Facility associates educated on assigned duties during fire drills on 12/21/11 by the Maintenance Director. The facility will conduct fire drills on all shifts each month for three months to audit associate performance. The results of these audits will be presented to the P.I. committee.

12/30/11

4) How will the corrective action be accomplished for those residents found to have been affected by deficient practice?
K 050: Continued From page 1

Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2

The STANDARD is not met as evidenced by: Based on observation and review of fire drill procedures, it was determined the facility staff failed to perform their assigned duties according to the policies and procedures manual.

The findings included:

Observations of the fire drill conducted on the 200 hall on 12/5/11 at 2:07 PM, revealed the staff did not respond to the fire in resident room 226 until all other residents room doors had been closed and a fire extinguisher was brought to the area.

The facility’s fire drill policy and procedure stated that the staff will respond to the announced room when the fire alarm is sounded.

This finding was acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit conference on 12/5/11.