K 017

1. No residents were identified as having been affected. A new entrance door to the dining room has been ordered by manager of Carolina Doors on 12/20/13.

2. The Maintenance Director and maintenance assistants assessed all fire doors for proper closing to seal off the passage of smoke in all areas on 12/9/13. No other doors were affected.

3. The maintenance assistants were in-service by the Maintenance Director 12/23/13 on proper closing and sealing of the fire doors.

4. The Maintenance Director will audit all fire doors monthly to ensure proper closing and sealing of fire doors and ongoing during monthly preventative maintenance rounds. Results of findings will be reviewed by the Administrator or Maintenance Director in the Quality Assurance Performance Improvement Committee for 3 months and/or until one hundred percent compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records and Environmental Department.

This STANDARD is not met as evidenced by:
Based on observation and testing, the facility failed to have corridor doors capable of resisting the passage of smoke.

The findings include:

Based on observation and testing on December 9, 2013 at 11:20 a.m. revealed the dining room entrance door on the right, would not close within its frame enough to resist the passage of smoke. When the door was closed, the top of the door was warped and would not close within the door frame to form a smoke resistant barrier.

This finding was verified by the maintenance director and acknowledged by the administrator.

1/13/14
K 017  Continued From page 1
during the exit conference on December 9, 2013.
K 029
NFPA 101 LIFE SAFETY CODE STANDARD
SS=E
One hour fire rated construction (with 3/4 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:
Based on observation, the facility failed to have self-closing doors to hazardous areas.

The findings include:
Observation on December 9, 2013 between 6:00 a.m. and 11:30 a.m. revealed the following rooms were greater than 50 square feet and were being used for storage of combustibles. These storage room doors were not self-closing:
1. Room 822
2. Room 706
3. Room 708
4. Room 710
5. Room 711
6. Room 712
7. Room 714
8. Room 715

K 029
1. No residents were identified as having been affected. Door closures were placed on rooms 822, 706, 708, 710, 711, 712, 714, and 715 by 12/20/13 by the maintenance staff.
2. The Maintenance Director and maintenance assistants assessed the rooms used for storage greater than 50 square feet for door closures on 12/20/13. No other rooms were affected.
3. The maintenance assistants were in-serviced by the Maintenance Director 12/23/13 on rooms used for storage greater than 50 square feet must have a door closure.
4. The Maintenance Director will audit all non-patient rooms to ensure storage rooms greater than 50 square feet have door closures monthly and ongoing during preventative maintenance rounds. Results of findings will be reviewed by the Administrator or Maintenance Director in the Quality Assurance Performance Improvement Committee for 3 months and/or until one hundred percent compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records and Environmental Department.

1/13/14
<p>| K 047 | 1. No residents were identified as having been affected. The electrician with MaGaha has ordered the two illuminating signs for the exit doors leading back into the building from the courtyard on 12/18/13. |
| K 047 | 2. The Maintenance Director reviewed all the signs in the facility on 12/9/13. No other exit signs needing illumination were found. The electrician with MaGaha will place the illuminating signs at the doors in the courtyard by 12/30/13. |
| K 047 | 3. The maintenance assistants were in-service by the Maintenance Director 12/23/13 regarding the illuminating and directional exit signs must be placed and seen from any location of the interior courtyard. |
| K 047 | 4. The Maintenance Director will audit all illuminating signs monthly and ongoing to ensure the signs are illuminating during monthly preventative maintenance rounds. Results of findings will be reviewed by the Administrator or Maintenance Director in the Quality Assurance Performance Improvement Committee for 3 months and/or until one hundred percent compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records and Environmental Department. |</p>
<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>
</tr>
</thead>
<tbody>
<tr>
<td>K 056</td>
<td>Continued From page 3 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 systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</td>
<td>K 056</td>
<td>1. No residents were identified as having been affected. 2. The facility have no other elevators that would be affected. Morristown Sprinkler will sprinkle the elevators pits by January 13, 2014. 3. The maintenance assistants were in-serviced by the Maintenance Director 12/23/13 the elevators pits must be sprinkled because the elevators are hydraulic. 4. The Maintenance Director will audit monthly to ensure the sprinklers are maintained in reliable operating condition times 3 months and ongoing during monthly preventative maintenance rounds. Results of findings will be reviewed by the Administrator or Maintenance Director in the Quality Assurance Performance Improvement Committee for 3 months and/or until one hundred percent compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records and Environmental Department.</td>
</tr>
</tbody>
</table>

This STANDARD is not met as evidenced by: Based on observation, the facility failed to have all areas of the facility fully sprinkled.

The findings include:

Observation on December 9, 2013 at 7:53 a.m. revealed the elevator pits do not have sprinkler coverage. The facility elevators are hydraulic.

This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on December 9, 2013.

K 062 SS=F NFPA 101 LIFE SAFETY CODE STANDARD

Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5

This STANDARD is not met as evidenced by: Based on observation and record review, the
Continued From page 4

facility failed to maintain the automatic sprinkler system.

The findings include:

Observation and record review on December 9, 2013 between 7:00 a.m. and 11:00 a.m. revealed the following:
1. The two (2) connecting breezeways for the nursing home and nursing home rehab have mixed matched sprinkler heads of quick response and standard response type sprinkler heads.
2. Record review revealed the 5 year obstruction investigation test is past due.
3. Record review revealed the water motor gong is inoperable.
4. Record review revealed the annual main drain test cannot be conducted due to the sprinkler riser room flooding.

These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on December 9, 2013.

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 specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2

This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to maintain the heating, ventilating, and air conditioning (HVAC) in accordance with NFPA
mittee consists of the Administrator, Director of Nursing, Staff Development Coordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records and Environmental Department.

K 067

1. No residents were identified as having been affected. The four year fire and smoke damper maintenance was started on 12/17/13 by Premier Services and will be completed by 12/31/13.

2. Premier Services will complete the fire and smoke damper maintenance on all dampers by 12/31/13.

3. The Maintenance Director was in-serviced by the Administrator on 12/13/13 the fire and smoke damper maintenance must be performed every 4 yrs.

4. The Maintenance Director will audit all dampers to ensure the fire and smoke dampers are functioning monthly and ongoing during monthly preventative maintenance rounds and Premier Services will perform maintenance on the fire and smoke dampers every four years.
<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>K067</td>
<td>Continued From page 5 90A.</td>
<td>ongoing. Results of findings will be reviewed by the Administrator or Maintenance Director in the Quality Assurance Performance Improvement Committee for 3 months and/or until one hundred percent compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records and Environmental Department.</td>
<td>1/13/14</td>
</tr>
<tr>
<td>K067</td>
<td>The findings include:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K072</td>
<td>Record review and interview with the maintenance director on December 9, 2013 at 7:05 a.m. revealed the facility failed to perform the 4-year fire and smoke damper maintenance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K072</td>
<td>This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on December 9, 2013.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K072</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SS=D</td>
<td>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</td>
<td>1. No residents were identified as having been affected. The carts, beds, and general items were removed from the corridor by the maintenance staff on 12/13/13.</td>
<td></td>
</tr>
<tr>
<td>K072</td>
<td>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to have the means of egress continuously maintained free of all obstructions or impediments.</td>
<td>2. No other areas were identified for obstructions. All items were removed from the 700 hall leaving the hall clear.</td>
<td></td>
</tr>
<tr>
<td>K072</td>
<td>The findings include:</td>
<td>3. All staff will be in-serviced by their department to not store anything in the hallway on the 700 hall or any other hallway which could cause an obstruction as this is an exit route. All will be in-serviced by 12/31/13.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Observation and interview with the maintenance director on December 9, 2013 at 11:05 a.m. revealed that over the weekend staff would store items out in the 700 wing corridor. At 6:00 a.m. on the general tour of the facility the 700 wing exit corridor was being used for storage. There were</td>
<td>4. The maintenance director will audit all hallways monthly and ongoing to ensure there are no items stored on any hallway during monthly preventative maintenance rounds. Results of findings will be reviewed by the Administrator or Maintenance Director in the Quality Assurance Performance Improvement Committee for 3 months and/or until one hundred percent compliance is achieved. The Quality Assurance Performance Improvement Committee for 3 months and/or until one hundred percent compliance is achieved.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>ongoing. Results of findings will be reviewed by the Administrator or Maintenance Director in the Quality Assurance Performance Improvement Committee for 3 months and/or until one hundred percent compliance is achieved. The Quality Assurance Performance Improvement Committee for 3 months and/or until one hundred percent compliance is achieved.</td>
<td>1/13/14</td>
<td></td>
</tr>
</tbody>
</table>
K 072

Continued From page 6

numerous carts, beds, and general items in this
corridor. The 700 wing is no longer being used for
patient use but it is still an exit corridor for the
facility.

This finding was verified by the maintenance
director and acknowledged by the administrator
during the exit conference on December 9, 2013.
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.

K 144

This STANDARD is not met as evidenced by:
Based on observation, the facility failed to have a
remote annunciator for the emergency generator
in a continuously monitored location.

The findings include:

Observation on December 9, 2013 at 8:30 a.m.
revealed the remote annunciator is located in an
area of the building that is not in a continuously
monitored location. The remote annunciator is
located in the attached assisted living, which is no
longer providing services. The attached assisted
living does not have any offices or staff areas that
are occupied twenty four hours a day.

Committee consists of the Administrator,
Medical Director, Director of Nursing, Staff
Development Coordinator, Environmental
Services, Dietary, Social Services Director,
Business Office Manager, MDS Coordinator,
Rehabilitation Department, Medical Records
and Environmental Department.

1. No residents were identified as having been
affected.

2. No other areas were identified as being af-
fected by location of annunciator alarm/panels
as the other floors are in place. A baby moni-
tor will be placed near the annunciator panel
and monitored by the 2nd floor nurse
24hrs/7 days a week. Maintenance will
check annunciator panel twice daily Monday
through Friday and Weekend Nurse Super-
visor will check annunciator panel twice daily
on the weekends until floor is opened.

3. Licensed nursing staff and maintenance
staff will be in-serviced by their department
regarding the monitoring of the annunciator
panel until the floor is opened. All will be in-
serviced by 1/2/14.

4. The Maintenance Director will audit the an-
nunciator panel twice daily Monday through
Friday and Weekend Nurse Supervisor will
audit the annunciator panel twice daily on the
weekends until floor is opened to ensure there
are no alarms sounding on the annunciator
panel. After the floor opens, then the Mainten-
ance Director will audit the annunciator panel
monthly with preventive monthly maintenance
1/13/14
## K 144

Continued From page 7

This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on December 9, 2013.

### K 147 NFPA 101 LIFE SAFETY CODE STANDARD SS=D

Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2

This STANDARD is not met as evidenced by: Based on observation and testing, the facility failed to maintain electrical outlets.

The findings include:

Observation and testing on December 9, 2013 at 6:20 a.m. and 11:00 a.m. revealed the following electrical outlets in the corridor were not secured into the wall:

1. Corridor by room 508.
2. Corridor by room 514.
3. Corridor by room 213.
4. Corridor by room 608.

These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on December 9, 2013.

## K 144

Results of findings will be reviewed by the Administrator or Maintenance Director in the Quality Assurance Performance Improvement Committee for 3 months and/or until one hundred percent compliance is achieved. The Quality Assurance Performance Improvement Committee consists of the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records and Environmental Department.

## K 147

1. No residents were identified as having been affected. The Maintenance Director and maintenance assistants secured the following outlets to the wall: corridor by room 508, corridor by room 514, corridor by room 213, and corridor by room 608 by 12/19/13.

2. All corridors were checked by the Maintenance Director for loose electrical outlets by 12/19/13. No other loose electrical outlets were found.

3. The Maintenance Director was in-service by the Administrator on 12/13/13 on ensuring the electrical outlets being secured.

4. The Maintenance Director will audit all electrical outlets every 3 months x2, then every 6 months ongoing to ensure the electrical outlets are secure in the corridors. All findings will be reviewed in the Quality Assurance Performance Improvement Committee for 3 months and/or until one hundred percent compliance is achieved. The Quality Assur-
<table>
<thead>
<tr>
<th>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>COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>K147</td>
<td></td>
<td></td>
<td>ance Performance Improvement Committee consists of the Administrator, Medical Director, Director of Nursing, Staff Development Coordinator, Environmental Services, Dietary, Social Services Director, Business Office Manager, MDS Coordinator, Rehabilitation Department, Medical Records and Environmental Department.</td>
<td></td>
</tr>
</tbody>
</table>