<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 054</td>
<td>SS=D</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
<td>K 054</td>
<td></td>
<td>Smoke detector in front of room 601 was moved by Townsend electric to allow for three feet of clearance to the air supply vent. All smoke detectors were audited to ensure the required three feet of clearance from the air supply vent. Documentation of audits was completed on 4/6/11 by the Maintenance Supervisor Assistant. Results of the audit will be reported to administration at the monthly Safety Committee meeting by the Safety Director.</td>
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<tr>
<td>K 069</td>
<td>SS=D</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
<td>K 069</td>
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<td>Deep fryer has been centered under the suppression nozzles and is now under the kitchen hood system with fire suppression system. All kitchen and maintenance staff have been in-serviced on proper placement of deep fryer by the Maintenance Supervisor. Maintenance Supervisor Assistant will do random audits to ensure proper placement of deep fryer every week for four weeks, then monthly thereafter. Results of the audit will be reported to administration at the monthly Safety Committee meeting by the Safety Director.</td>
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<tr>
<td>K 072</td>
<td>SS=E</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
<td>K 072</td>
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This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to ensure that all smoke detectors had the required clearance from the air stream vents.

Observation of the secured unit on 4/4/11 at 12:45 PM, revealed a smoke detector in front of room 601 did not have 3 feet of clearance from the air supply vent.

This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to ensure the deep fryer was under the kitchen hood system with the fire suppression system.

Observation of the kitchen on 4/4/11 at 9:35 AM, revealed the deep fryer was not centered under the suppression nozzles.
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.

This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain a path of egress in 3 of 5 (100, 200 and 300 corridor) resident corridors.

The findings included:

1. Observation of the 100 corridor on 4/4/11 at 9:14 AM, revealed a mop bucket and mop unattended in the path of the fire doors by resident room 102. A housekeeping attendant returned at 9:20 AM, removed the mop from the bucket and walked to the exit at the end of the hall (76 feet away) and begin to mop the floor. The housekeeper left the mop bucket in the doorway.

Observations of the 100 corridor on 4/4/11 from 9:15 AM until 10:15 AM, revealed a hoyer lift connected to the electrical receptacle outside resident room 116 and resident room chairs were stored in the hallway outside rooms 105, 106, 109, 110 and 113.

2. Observation of the 200 corridor on 4/4/11 at 9:05 AM until 10:13 AM, revealed two high back chairs, a linen cart, and a gray rolling cart stored outside of rooms 205 and 206. Two hoyer lifts connected to the electrical receptacle were
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located outside resident room 209 and a third
hoyer lift was stored outside room 215.

3. Observations of the 300 corridor on 4/4/11
from 8:45 AM until 10:11 AM, revealed a night
stand, a high back chair, and a gray rolling cart
stored outside room 307 and a night stand and a
high back chair stored outside of room 308.