STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345317	A. BUILDING _____ B. WING _____	02/23/2011

MAR 22 2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & RETIREMENT	204 DAIRY RD CLAYTON, NC 27520

(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 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM 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 interview the facility failed to routinely monitor blood pressure and pulse for 1 of 1 sampled residents receiving antihypertensive medications (resident #28). Findings include: Resident #28 was admitted to the facility on 1/7/11 , with diagnosis in part of hip fracture from	F 329	F329 The facility will continue to routinely monitor blood pressure and pulse for residents receiving Beta Blocker antihypertensive medications. **Resident identified to have been affected by the alleged deficient practice:** Resident #28 was discharged on 2/23/11 and re-admitted on 3/1/11. Resident #28 was admitted to Hospice services per family request on 3/3/11 and has an order for comfort care on 3/5/11. Previous scheduled medications including anti-hypertensives were discontinued on this date. **Residents with the potential to be affected by the alleged deficient practice:** Residents with Beta Blocker antihypertensive medications were identified on 3/15/11. Physician orders were received for monitoring blood pressure and pulse as indicated and added to the Medication record.	3/5/11

ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Melissa Sullivan | TITLE: Administrator | (X6) DATE: 3-17-11

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that r safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days wing 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 s following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ram participation.

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F 329	Continued From page 1 fall at home, hypertension, paroxysmal atrial fibrillation, status post pacemaker placement, and history of congestive heart failure. Record review of the resident ' s clinical record revealed physician orders dated 1/7/11, Atenolol 50 mg(milligram) 1 tablet by mouth two times a day, Lisinopril 10mg (milligram) 1 tablet by mouth once a day, (used to treat hypertension) Cardizem (diltiazem) CD (long-acting) 240mg 1 capsule by mouth once a day(used to treat hypertension and chronic ischemic heart disease) and Lasix (furosemide) 40mg 1 tablet once daily(used to treat edema and hypertension). Amiodarone hydrochloride 100mg daily, (used to treat an abnormal and fast heart rate). Review of care plan -Pacemaker dated 1/24/11, indicated Resident #28 was at risk for cardiopulmonary complications, in part Evaluate for proper functioning of pacemaker by monitoring vital signs as indicated. The facility did not indicate how often the vital signs should be taken. Review of care -Potential Medication Toxicity dated 1/26/11, indicated risk of toxicity due to the thyroid hormone replacement. No other medications were indicated. The goal was to have no medication toxicity through the next review: three months. Approach in part; obtain VS as indicated (vital signs). The facility did not indicated how often to obtain vital signs. Nursing Drug Handbook, 27th Edition Indicated when taking Cardizem Nursing considerations in part, were " If Systolic blood pressure (the top number) is below 90mmHg (millimeters of mercury) or heart rate is below 60 beats/minute, withhold dose and notify prescriber. " In the	F 329	A list of Beta Blocker antihypertensives has been added to each MAR for easy identification by licensed personnel. Licensed nursing staff were re-educated on identifying Beta Blocker antihypertensive medications, monitoring of blood pressure and pulse and notification of physician to establish monitoring parameters by the Staff Development Coordinator to be completed on 3/24/11. Going forward licensed nurses will receive education regarding identifying Beta Blocker antihypertensive medications, monitoring of blood pressure and pulse and notification of physician to establish monitoring parameters in orientation.	3/24/11

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F 329	Continued From page 2 same nursing reference material indicated nursing considerations when administering Atenolol were " Check apical pulse before giving drug; if slower than 60 beats/minute, withhold drug and call prescriber. Monitor patient ' s blood pressure. " Lisinopril nursing considerations include impart, " Monitor blood pressure frequently. If drug doesn ' t adequately control blood pressure, Diuretics (a fluid pill, such as lasix) may be added. " Nursing consideration when administering lasix state in part; " Alert: Monitor weight, blood pressure and pulse rate routinely with long-term use and during rapid diuresis. Use can lead to profound water and electrolyte depletion. " Nursing consideration for Amiodarone hydrochloride, include in part Monitor blood pressure and heart rate and rhythm frequently. Notify prescriber of significant change in assessment result. Adverse effects of these medications are in part, hypotension, bradycardia, and dizziness . Record review of the flow sheet of vital signs from 1/7/11 through 2/23/11 revealed blood pressures and pulses were recorded on the following dates: 1/7/11- blood pressure (BP) 130/68 and pulse (P) 76 1/19/11- BP 131/61 and P 85 1/26/11 - BP 90/72 and P 93 Review of the nursing notes from 1/7/11 through 2/23/11 revealed blood pressures and pulses were recorded on the following dates: 1/07/11- BP 128/64 and P 74 1/18/11- BP 103/55 and P 69 1/19/11- BP 131/61 and P 85 1/26/11- BP 90/72 and P 73 Record review revealed physician orders dated	F 329	**Systematic Measures:** Facility Nursing Administrative staff including but not limited to Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing and/or other designee will monitor blood pressures and pulses. Starting March 16, 2011, new admissions will be reviewed on the first business day by the above during morning meeting to ensure proper blood pressure and pulse monitoring for beta blocker antihypertensive medications are in place. All new physician orders will be reviewed as well to ensure proper monitoring of blood pressures and pulses. An audit tool will be completed on a weekly basis x 4 weeks and monthly thereafter x 3 months by the DON or designee. The facility Director of Nursing will report findings of audit to Quality Assurance committee x 3 months and develop and	3/16/11

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F 329	Continued From page 3 2/7/11 to decrease Lasix to 20mg daily. Review of the facility ' s pharmacy consultant report recommendation dated 2/9/11, : Atenolol and Cardizem " Recommendation: Please consider monitoring blood pressure and pulse at least weekly, or as advised by prescriber. " Review revealed the Director of Nursing (DON) signed the recommendation on 2/11/11. During an interview on 2/23/11 at 10:15 am, Nurse #1 stated the vital signs were documented on the medication administration record(MAR). Nurse #1 indicated there were no standing orders to document vital signs. Nurse #1 stated vital signs were checked per MD order and then the order for blood pressures was transcribed onto the MAR. When asked what the physicians orders for Resident #28 were, she flipped through the MAR and indicated there was no order for vital signs. Nurse #1 indicated the vital signs may be documented in the nursing notes. When asked what the facility policy was for documentation of vital signs, Nurse #1stated that all Medicare residents vital signs were done weekly. During an interview on 2/23/11 at 10:20 am, Aide #1 stated when vital signs are done the hall nurses gave the names of the residents they were to do. She stated most vital signs were done on Wednesdays. During an interview on 2/23/11 at 10:47 am, the Unit Coordinator (UC) indicated the facility policy was for the Medicare part A residents to have blood pressures checked every Wednesday. She indicated she had never seen any facility policy or procedure regarding vital signs. She further revealed standard nursing practice determined	F 329	implement interventions identified to ensure continued compliance.	

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F 329	Continued From page 4 when vital signs are taken. She stated new admissions had vital signs taken and the nurses knew what they were supposed to do. She stated the aides obtain the vital signs and the nurses were responsible for documenting the vital signs on the flow sheet in the chart or on the nursing notes. After reviewing the chart, the UC indicated the vital signs were not documented on the nursing notes or the flow sheet. She stated the vital signs had not been done. During an interview on 2/23/11 at 11:03am, the Director of Nursing (DON) indicated Resident # 28 was a skilled nursing patient and should have her vital signs taken at least once per day. She stated the vital signs would be in the acute care book. The DON flipped through the acute care book and the UC indicated the resident did not have daily vital signs. While the DON and the UC were present, Nurse #1 was asked how she knew when she was to take vital signs daily. Nurse #1 indicated it would be written in the MAR. She flipped through the MAR and indicated a second time there was not an area to document daily vital signs. The DON was asked what system was in place to ensure medications were effective and to monitor vital signs. The DON indicated she would have to research it. During an interview with the facility consultant on 2/22/11 at 11:36am, she indicated vital signs were taken based on basic nursing practice. She stated if the nurse feels the resident needs vital signs she will take them. She stated if the pharmacy consultant recommended vital signs be taken, the recommendation would be sent over to the doctor which takes up to two weeks to get the physician ' s reply. She stated the nurse could	F 329		

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F 329	Continued From page 5 always expedite the request. She stated the facility did not have a policy regarding the monitoring of medications or when vital signs were to be taken. During an interview on 2/23/11 at 1:52 pm, the administrator, DON and the Assistant Director of Nursing (ADON) revealed there were no standing orders or guide in reference to monitoring vital signs. The DON stated nursing standard practice was the expectation, The DON indicated Resident #28 was on a beta blocker(Atenolol) should be monitored every 6 hours for heart rate and blood pressure . The DON stated resident # 28 ' s blood pressure and pulse were taken today before the 10:00am dose. The DON stated the resident ' s BP was 112/50 and heart rate was 68. The DON stated the recommendation from the pharmacy consultant was given to the nurses and should have been followed through. The DON stated the physician would expect the nurses to take the resident ' s blood pressure without an order. The DON stated the physician expected the nurses to take blood pressures when residents were on medications in which monitoring of the blood pressure was a nursing consideration. During an interview on 2/23/11 at 2:00pm, the Administrator indicated there was no system in place for monitoring vital signs and medications. The administrator stated they had some work to do.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		

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F 428	Continued From page 6 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 interviews, the facility failed to act upon pharmacist recommendations for monitoring blood pressure and pulse for 1 of 7 sampled residents (Resident #25). Findings include: Resident #28 was admitted to the facility on 1/7/11, with diagnosis in part of hip fracture from fall at home, hypertension, paroxysmal atrial fibrillation, status post pacemaker placement, and history of congestive heart failure. Review of Resident #28's monthly physician order sheets for the month of February 2011 revealed an order Cardizem CD 240 milligrams (mg) one time a day and Atenolol 50 mg two times a day. Both medications were used to treat hypertension. Review of the pharmacy consultant review documentation for Resident #28, on 02/09/11, revealed the pharmacist had recommended monitoring of blood pressure and pulse at least weekly, or as advised by prescriber, in reference to the medications of Atenolol and Cardizem CD. The consultation was signed by the Director of Nursing (DON) on 2/11/11.	F 428	F428 The facility will continue to act upon nursing pharmacy recommendations. **Resident identified to have been affected by the alleged deficient practice:** Resident #28 was discharged on 2/23/11 and re-admitted on 3/1/11. Resident #28 was admitted to Hospice services per family request on 3/3/11 and has an order for comfort care on 3/5/11. Previous scheduled medications including anti-hypertensives were discontinued on this date. **Residents with the potential to be affected by the alleged deficient practice:** February, 2011 nursing pharmacy recommendations were re-assessed for proper completion by the DON, SDC and Unit Coordinator on 3/15/11.	3/5/11 3/15/11

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F 428	Continued From page 7 Review of the medication administration record (MAR) revealed no documentation of pulse or blood pressures 2/1/11-2/11/11. During an interview on 2/23/11 at 1:52 pm, the DON indicated the communication from the pharmacy consultant was a recommendation that was given to the nurses and should have been followed through.	F 428	Licensed nursing staff were re-educated regarding nursing pharmacy recommendations and completion to be completed by 3/24/11. **Systematic Measures:** The DON and/or designeee will audit all nursing recommendations for completion x 3 months. The facility Director of Nursing will report findings of audit to Quality Assurance committee x 3 months and develop and implement interventions identified to ensure continued compliance.	3/24/11

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	345317	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/23/2011

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K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Surveyor: 26594 Based on observation on Wednesday 3/23/2011 between 8:30 AM and 1:00 PM the following was noted: 1) The fire damper located in the Medication room at Nurse Station #1 was tripped and not maintained in good condition. 2) The sheetrock in the attic that is part of the one hour fire resistance rating for the corridors was not maintained in good condition. Throughout the area there were hole in the sheetrock that were not sealed and/or repaired.. 42 CFR 483.70(a)	K 012	K012 The fire damper located in the Medication Room was repaired on 4/8/11. This same damper was cleaned on 3/31/11. All fire dampers were checked and cleaned by 3/31/11. Facility fire dampers are to be cleaned monthly by the Maintenance Supervisor and/or designee. The Maintenance Supervisor will report and present to QA&A committee monthly x 3 months. The sheetrock in the attic has been assessed for repair by the Maintenance Supervisor and an independent contractor. A bid has been submitted in the amount of $24,760 for repairs. The work will be completed by 5/7/11. The Maintenance Supervisor will inspect the attic monthly for any repair needed. The Maintenance Supervisor will report and present to QA&A committee monthly x 3 months. RECEIVED APR 12 2011	4/8/11 3/31/11
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025		5/7/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melissa Sullivan	Administrator	4/8/11

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K 025	Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 26594 Based on observation on Wednesday 3/23/2011 between 8:30 AM and 1:00 PM the following was noted: 1) The smoke wall located in the attic area on 300 hall has holes and/or penetrations that were not sealed in order to maintain the required fire resistance rating of the wall. 42 CFR 483.70(a)	K 025	K 025 The sheetrock in the attic has been assessed for repair by the Maintenance Supervisor and an independent contractor. A bid has been submitted in the amount of $24,760 for repairs. The work will be completed by 5/7/11. The Maintenance Supervisor will inspect the attic monthly for any repair needed. The Maintenance Supervisor will report and present to QA&A committee monthly x 3 months.	5/7/11
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051	K051 The smoke detector in the corridor outside resident room 214 will be replaced by 4/15/11. Facility smoke detectors were checked for proper installation on 3/31/11. The Maintenance Supervisor and/or designee will inspect facility smoke detectors monthly. The Maintenance Supervisor will report and present to QA&A committee monthly x 3 months.	4/15/11 3/31/11

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K 051	Continued From page 2 This STANDARD is not met as evidenced by: Surveyor: 26594 Based on observation on Wednesday 3/23/2011 between 8:30 AM and 1:00 PM the following was noted: 1) The smoke detector in the corridor outside resident room 214 was missing and not installed at the time of the survey. 42 CFR 483.70(a)	K 051	K056 The sprinkler heads in the kitchen were replaced on 3/25/11. Facility sprinkler heads were checked for proper temperature classification on 3/25/11. The Maintenance Supervisor and/or designee will inspect sprinkler heads on monthly basis for good repair and proper temperature classification. The Maintenance Supervisor will report and present to QA&A committee monthly x 3 months.	3/25/11
K 056 SS=D	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 systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Surveyor: 26594 Based on observation on Wednesday 3/23/2011 between 8:30 AM and 1:00 PM the following was noted: 1) There are sprinkler heads in the Kitchen rated for Intermediate Temperature Classification, Glass Bulb Color Green of (200°F) in place of Ordinary Temperature Classification, Glass Bulb Color Red with a temperature rating of (155°F). 42 CFR 483.70(a)	K 056		

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K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4 This STANDARD is not met as evidenced by: Surveyor: 26694 Based on observation on Wednesday 3/23/2011 between 8:30 AM and 1:00 PM the following was noted: 1) The cigarettes were found to be improperly disposed of in the trash receptacles in place of the butt cans. (Smoking policy was not being followed.) 42 CFR 483.70(a)	K 066	K 066 The trash receptacle was emptied of cigarette butts on 3/23/11. Education will be completed for all smoking staff by 4/30/11 to ensure no butts are to be placed in the trash receptacle, but instead the provided butt can. The Maintenance Supervisor, Housekeeping Director and/or designee will monitor the trash receptacle daily. The Maintenance Supervisor will report and present to the QA&A Committee monthly x 3 months. K067 The Fire Alarm Inspection report was completed on 4/6/11. Seven duct smoke detectors were tested and all passed. The Fire Alarm Inspection will be completed per manufacturer's specifications from this point forward. The Maintenance Supervisor will monitor the system monthly.	3/23/11 4/30/11 4/6/11
K 067	NFPA 101 LIFE SAFETY CODE STANDARD	K 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345317	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 067 SS=F	Continued From page 4 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: Surveyor: 26594 Based on observation on Wednesday 3/23/2011 between 8:30 AM and 1:00 PM the following was noted: 1) Upon review of the Fire Alarm Inspection report it was stated in the report that 6 out of 7 smoke duct detectors could not be checked because access could not be gained. 42 CFR 483.70(a)	K 067	Fire alarm inspection reports and issues will be reported and presented to the QA&A Committee monthly. K 076 The half full oxygen cylinder was removed from the full oxygen cylinders on 3/23/11. Signs were posted 3/30/11 designating full and empty storage areas for oxygen cylinders. Nursing staff will be re-educated on oxygen cylinder storage by 4/30/11. The storage areas will be monitored daily and as needed by the Director of Nursing, Staff Development Coordinator and/or designee. The Director of Nursing will present a report to the QA&A committee on a monthly basis x 3 months.	3/23/11 3/30/11 4/30/11
K 076 SS=D	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 This STANDARD is not met as evidenced by:	K 076		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345317	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/23/2011

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K 076	Continued From page 5 Surveyor: 26594 Based on observation on Wednesday 3/23/2011 between 8:30 AM and 1:00 PM the following was noted: 1) Full and empty oxygen cylinders were stored together. If stored within the same enclosure, empty cylinders shall be segregated and designated (with signage) from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. [NFPA 99 4-3.5.2.2b(2)] (oxygen storage near the nurses station #1) 42 CFR 483.70(a)	K 076	K147 Items stored on lights located above resident beds will be removed by 4/15/11. Staff will be re-educated regarding no storage of items on lights located above resident beds to be completed by 4/30/11. Resident Ambassadors will make rounds on a weekly basis to ensure no items are stored on the lights above resident beds. The Maintenance Supervisor will report and present to QA&A monthly x 3 months.	4/15/11 4/30/11
K 147 SS=F	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: 26594 Based on observation on Wednesday 3/23/2011 between 8:30 AM and 1:00 PM the following was noted: 1) Throughout the facility the lights located above there resident room beds have material and/or items stored on them that pose a potential fire hazard. 2) The ceiling can lights installed in the bath/shower room on 300 hall were not properly enclosed in the attic area. 42 CFR 483.70(a)	K 147	The ceiling can lights in the bath/shower room on 300 hall will be properly enclosed in the attic area by May 7, 2011. All other ceiling can lights will be properly enclosed by May 7, 2011 as well. The Maintenance Supervisor will inspect the attic monthly for any repair needed. The Maintenance Supervisor will report and present to QA&A committee monthly x 3 months.	5/7/11