STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345172	A. BUILDING _____ B. WING _____	06/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRIAD CARE AND REHABILITATION CENTER	707 NORTH ELM STREET HIGH POINT, NC 27262

(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 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to perform a gastrostomy tube (GT) check prior to the administration of medications for 1 of 1 sampled residents. Resident #163 The findings include: Resident #163 was admitted to the facility on 01/15/2010. Resident #163 diagnoses included cerebral palsy, ulcer of esophagus and difficulty swallowing. The most recent MDS dated 11/4/10 and coded as a quarterly assessment. The facility has assessed Resident #163 as having short and long-term memory problems and as being impaired in daily decision-making. He was also assesses as requiring extensive assistance with his activities of daily living (ADL ' s) and receiving his nutrition and hydration through a feeding tube. A care plan for gastrostomy tube to maintain nutritional status revised on 11/29/10 for Resident #163. The care plan ' s interventions included checking the position of the gastrostomy tube prior to feeding and giving water flushes as ordered. On 06/09/11, the Staff Development Coordinator	F 281	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Triad Care & Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." **F281** 1. The Director of Nursing Services assessed resident #163's gastrostomy tube for placement on 6/7/11, no change is resident's condition noted. Nurse #1 was re-educated by the Staff Development Coordinator on 6/6/11 related to checking the gastrostomy tube for placement prior to administering medications.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Angela Chewning Josey RNBNS for Alyce Hopping, Administrator 7/19/11

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F 281	Continued From page 1 (SDC) provided a copy of a facility policy titled; " Care of a Gastrostomy (G) Tube " The policy was not dated. The Care of a Gastrostomy (G) Tube " policy read in part: methods of checking tube placement are " aspirating to check for stomach contents " and " injecting 10 centimeters of air into the gastrostomy tube. " Review of the June 2011 monthly physician orders for Resident #163 had orders to keep the head of the bed elevated and to check the gastrostomy tube for residual every six hours. A medical nutrition assessment for 04/18/11 documented Resident #163 dependent on tube feeding for primary nutrition and hydration needs. A medication administration observation on 06/06/11 at 5:00PM was conducted for Resident # 163. Licensed nurse # 1 (LN) crushed the medications and mixed with water. Resident #163 was lying in bed with the head of the bed elevated during the medication administration observation. LN #1 removed the cap from the gastrostomy tube and inserted a 60 cc syringe into the tubing. LN #1 poured the medication into the 60 cc syringe. LN # 1 flushed the gastrostomy tube with water after administering the medications. LN # 1 was not observed checking placement of the gastrostomy tube by aspirating stomach content or injecting 10 centimeters of air into the gastrostomy tube prior to medication administration. During an interview with LN #1, she stated that checking placement for gastrostomy tube is not required for an existing or old gastrostomy tube. She further indicated there was not a physician	F 281	2. Residents with gastrostomy tubes were checked for placement by the Unit Manager on June 30, 2011 to assure gastrostomy tubes were in the stomach. 3. Nurses will be re-educated by the Staff Development Coordinator on or before 7/7/11 related to checking placement of gastrostomy tubes prior to medication administration, as well as completing the G-Tube Competency Skill's Test. New nurses will complete the G-Tube Competency Skill's Test and return demonstration during new hire orientation.	

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F 281	Continued From page 2 order to check placement for gastrostomy tube prior to medication administration During an interview with Director of Nursing (DON) and Staff Development Coordinator (SDC) at 8:00am on 06/09/11, they revealed LN #1 was in-serviced on the facility's policy of Caring for a Gastrostomy tube on 08/05/10 and again on 06/06/11. The SDC provided documentation showing that LN # 1 was in- serviced on the facility ' s policy for the " Care of Gastrostomy Tube " on 08/05/10 and 06/06/11. The in-service included how to check placement of gastrostomy tube prior to nutrition or medication administration. The DON stated the licensed nurses are required to check placement of gastrostomy tube prior to medication administration.	F 281	4. The Staff Development Coordinator will complete gastrostomy tube competency on 4 nurses per week x 4 wks, then monthly x 2 months to ensure checking of the gastrostomy tube placement is completed correctly. A report will be submitted to the Performance Improvement Committee monthly x 3 months. The Administrator and Director of Nursing Services are responsible for overall compliance. Date of compliance July 7, 2011.	

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	345172	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/06/2011

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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 This STANDARD is not met as evidenced by: Based on observation on Wednesday 7/6/11 between 8:15 AM and 12:00 PM the following was noted: 1) The smoke wall located in the Rehab room above the ceiling on 1st floor north hall has holes and penetrations that were not sealed in order to maintain the required rating of the smoke barrier. 42 CFR 483.70(a)	K 025	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Triad Rehabilitation and Care Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." K 025 1. The Maintenance Director repaired the holes on 7/7/2011 in the Rehab room above the ceiling on the 1st floor, north hall holes and penetration. Repairs were made with Fire Stop Sealant. 2. The Maintenance Director audited smoke walls and deemed smoke walls on 7/7/2011 with repairs made as needed. Monitoring of smoke walls and deemed smoke walls will be put on the Preventative Maintenance Program. 3. The Maintenance Director was re-educated by Jerry Mayse, Director of Construction and Engineering on 7/20/2011 related to requirement of holes and ceiling penetrations. 4. The Maintenance Director will monitor the smoke walls and deemed smoke walls weekly for 1 month and monthly for 2 months. A report will be submitted to the Performance Improvement Committee monthly for 3 months. The Maintenance Director and Administrator will be responsible for over all compliance.	
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ 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	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Adm — 7/20/2011

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	345172	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/06/2011

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K 029	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation on Wednesday 7/6/11 between 8:15 AM and 12:00 PM the following was noted: 1) The corridor doors to the clean side of the laundry room did not close latch and seal and the corridor door to the soiled side of the laundry room was not self closing. 2) The soiled linen corridor door on 2 south, and 2 north did not close latch and seal when checked. 3) The House Keeping closet corridor door on first floor service area did not close latch and seal when checked. 42 CFR 483.70(a)	K 029	Date of compliance: 7/20/11 K 029 1. Doors to clean side to the laundry room and the corridor door to the soiled side of the laundry were repaired with replacement of self closers by the Maintenance Director on 7/8/2011. The soiled linen corridor door on 2 South and 2 North were repaired by the Maintenance Director on 7/8/2011. 2. An audit was completed by the Maintenance Director on 7/6/2011 related to corridor doors self closing and latching with repairs made as needed. Monitoring of doors will be put on the Preventative Maintenance Program.	
K 072 SS=F	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 This STANDARD is not met as evidenced by: Based on observation on Wednesday 7/6/11 between 8:15 AM and 12:00 PM the following was noted: 1) The exit corridor outside the laundry area had several janitorial carts blocking the means of egress.	K 072	3. The Maintenance Director was re-educated by Jerry Mayse, Director of Construction and Engineering on 7/20/2011, related to the requirements of doors self closing and latching. 4. An audit of corridor doors will be completed by the Maintenance Director weekly for 1 month and then monthly for 2 months to ensure doors are self closing and latching. A report will be submitted to the Performance Improvement Committee monthly for 3 months. The Maintenance Director and Administrator is responsible for over all compliance. Date of Compliance: 7/20/2011	

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K 072	Continued From page 2 2) On first floor front cross hall and other areas through-out the facility there was storage on the exit corridors. (hoyer lifts, gerri chairs, wheelchairs, transfer chairs, .) 42 CFR 483.70(a)	K 072	K072 1.) The janitorial carts blocking the egress, they were removed by Craig LeSane, Housekeeping Director on 7/6/2011. The items blocking the exit corridors were removed by Craig LeSane, Housekeeping Director on 7/6/2011. 2.) An observation of exit corridors was completed by Robert Culbreth , Director of Maintenance on 7/6/2011to ensure no exit corridors were being blocked. 3) Staff were re-educated by Staff Development on 7/6/11 related to the requirements of not blocking exit doors and egress areas. 4) Audits of exit doors and egress areas will be completed by the Maintenance Director or Designee 2 x weekly for 1 month and then monthly for 2 months to ensure these areas remain free from objects. A report will be submitted to the Performance Improvement Committee monthly for 3 months. The Staff Development Coordinator and Housekeeping Supervisor is responsible for over all compliance. Date of Compliance: 7/20/11	
K 076 SS=E	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: Based on observation on Wednesday 7/6/11 between 8:15 AM and 12:00 PM the following was noted: 1) At both nurse station oxygen storage areas on first floor oxygen cylinders were not properly chained or supported in a proper cylinder stand or cart. [NFPA 99 4-3.5.2.1b(27)] 42 CFR 483.70(a)	K 076		
K 144 SS=F	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		

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K 144	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation on Wednesday 7/6/11 between 8:15 AM and 12:00 PM the following was noted: 1) The Emergency Generator when tested did not crank and transfer load within 10 seconds when tested. System took 12 seconds to transfer load. 42 CFR 483.70(a)	K 144	K076 1) The oxygen cylinders were chained and supported in the cylinder stand immediately by Robert Culbreth, Director of Maintenance on 7/6/11. 2) An audit was conducted by the Maintenance Director on 7/6/2011 to ensure the oxygen cylinders were chained and supported in the cylinder stand with corrections made as needed. 3) Staff were re-educated on 7/6/11 by the Staff Development Coordinator related to placement and storage requirements of oxygen tanks either empty or full. 4) Audits will be conducted by Director of Nursing Services or Designee weekly 1 month and then monthly for 2 months to ensure oxygen is being stored according to required guidelines. A report will be submitted to the Performance Improvement Committee monthly for 3 months. The Director of Nursing or designee will be responsible for overall compliance. Date of completion: 7/20/2011	

K144

1.) On 7/7/11 Cummins Atlantic, made a service call to check the generator. They checked and did a completed test on the generator and the generator fired in 3 seconds and transferred in 8 seconds. Reset T.D.'s 1 second start and 1 second transfer.

2) The Maintenance Director will have generator setup on weekly checks every Monday morning. Generator "Fires up" at 7:35AM and runs until 8:05AM with 10 minutes cool down. Every 3rd Monday of the month the generator "Fires Up" under load at 7:35 AM and runs until 8:05 AM with a 30 minute cool down.

3) The Maintenance Director was re-educated by Jerry Mayse, Director of Construction and Engineering on 7/20/2011related to the requirements of the emergency generator.

4) The emergency generator will be monitored by the Maintenance Director weekly for 1 month then monthly for 2 months to ensure the generator in functioning within required guidelines. A report will be submitted to Performance Improvement Committee monthly for 3 months. The Maintenance Director and Administrator is responsible for overall compliance.

Date of Compliance: 7/20/2011