

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

*Received 2/23/12  
@ 9 AM from DON / KW*

PRINTED: 02/09/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  346177	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 01/26/2012
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NAME OF PROVIDER OR SUPPLIER  MANOR CARE HEALTH SVCS PINEHURST	STREET ADDRESS, CITY, STATE, ZIP CODE 205 RATTLESNAKE TRAIL PINEHURST, NC 28374
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(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 000	INITIAL COMMENTS	F 000		
F 156 SS=C	<p>No deficiencies were cited as a result of the complaint investigation Event ID# MLJV11.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered</p>	F 156	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p style="text-align: center;">F156</p> <p>It is the practice of the facility to provide residents both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.</p> <p style="text-align: center;">I.</p> <p>No one resident was cited as having been affected by the alleged deficient practice.</p>	

LABORATORY DIRECTOR'S, OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE  
*Soni Williams* *Administrator* *2/22/12*

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

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F 156	<p>Continued From page 1</p> <p>under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and</p>	F 156	<p><b>II.</b></p> <p>Each resident has the potential to have been affected by the alleged deficient practice. Updated contact information was placed on the bulletin board in the main hallway the day it was identified.</p> <p>A meeting of the Resident Council has been scheduled for 2/22/12 at 2pm to inform them of the updated information.</p> <p><b>III.</b></p> <p>Any future updates of state contact information will be completed by Administrator once facility has been notified of those changes.</p> <p><b>IV.</b></p> <p>An audit will be done annually in December during facility license renewal by the Administrator, to validate whether any changes have taken place related to contact information for state agencies. To be reviewed in the monthly Quality Assurance Committee meeting in December.</p> <p>02/23/12</p>		

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F 156	<p>Continued From page 2</p> <p>provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain current state contact information. The findings include:</p> <p>On 01/23/2012 at 4:40pm, during a general tour of the facility, the bulletin board located on the main hallway identified the state agency as Division of Facility Services. The contact address for the state as well as the phone number was outdated.</p> <p>On 01/24/2012 at 10:00am, the contact information for the state agency remained the same as an earlier observation.</p>	F 156		

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F 156	Continued From page 3 The Administrator was interviewed on 01/26/2012 at 10:35am. She was informed that the state contact information did not reflect the changes that were made July, 2007. She relayed that she was not sure how it was overlooked but that she would make immediate corrections to the posting.  On 01/26/2012 at 2:55pm, the Activities Director was interviewed. She stated that she facilitated the Resident Council meetings and regularly discussed with the residents, the chain of command to address their concerns, which included the option to contact the state. She commented that she was unaware that the state contact information, posted in the facility was incorrect.	F 156			
F 159 SS=B	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS  Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.  The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)  The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.	F 159	<b>F159</b>  It is the practice of the facility to hold, safeguard, manage and account for the personal funds of the resident deposited with the facility.  <b>I.</b> For resident #107 Resident's Personal Trust Fund Account (RPTF) has been reduced to \$100.44, secondary to funeral arrangements made by responsible party. (RP) For resident #38, the RPTF has been reduced to \$912.16 secondary to funeral arrangements made by resident.		

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F 159	<p>Continued From page 4</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy and record review as well as staff interviews, the facility permitted 2 of 3 sampled (Residents # 107 and #38) residents with trust funds accounts, who received Medicaid benefits; balances to exceed the \$2,000.00 resource limit. The findings include:</p> <p>On 1/26/2012 at 10:50am, the Business Office Manager and Administrative Staff #2 were interviewed to provide information about resident</p>	F 159	<p><b>II.</b> An audit was completed by the Business Office Manager (BOM) the RPTF custodian and the Administrator to identify other residents who may have been affected by the alleged deficient practice. Residents identified as having funds greater than, equal to or within \$200 of the \$2000 limit will be corrected prior to 2/23/12.</p> <p><b>III.</b> An audit of the RPTF will be done by the BOM, RPTF custodian and the Administrator monthly to ensure RPTF's remain less than \$200 of the \$2000 limit.</p> <p><b>IV.</b> Results of the RPTF audit will be reviewed during the monthly QAPI meeting.</p> <p style="text-align: right;">02/23/12</p>		

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F 159	<p>Continued From page 5</p> <p>trust funds accounts. A copy of the facility's undated policy titled, "Resident's Personal Trust Fund Agreement" was presented for review. It read, "If you receive Medicaid benefits, we will notify you when the amount in your account reaches two hundred and 00/100 dollars (\$200.00) less than the social security income (SSI) resource limit for one person and that, if the amount in the account, in addition to the value of your other nonexempt resources, reaches the SSI resource limit for one person, you may lose eligibility for Medicaid and SSI."</p> <p>1. Resident #107 was admitted to the facility on 6/20/2009 and was later re-admitted on 2/7/11. A copy of Resident #107's Resident Trust Statement, dates 07/01/2001-01/25/2012 was presented by the Business Office Manager for review. Resident #107 received a monthly income from his social security check for \$1,228.00. His personal medical liability (PML) was \$784.15 on 08/03.2011; \$783.00 on 09/02/2011, then it reduced to \$305.00 for the remaining months.</p> <p>Resident #107 trust funds balance on 10/04/2011 was \$2,5291.58 after his PML was deducted from his account. His balance on 11/07.2011 was \$3,218.42 after his PML was deducted from his account. His balance on 12/02/2011 was \$4,441.19.</p> <p>On 01/26/2012 at 11:13am, the Administrative Staff #2 explained that she was responsible for reviewing the monthly trust funds account and then she will notify the Business Office Manager whenever the account nears \$1,500-\$1,800, per the medical office's instructions. The Business Office Manager will then make a call to the</p>	F 159			

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F 159	<p>Continued From page 6</p> <p>Responsible Party (RP) and notify them of the balance and ask if they can spend down the account, based on the resident's needs, in order to maintain Medicaid eligibility.</p> <p>The Administrative Staff #2 continued saying that she had made a call to a family member of Resident #107 and told her that his account was over \$3,000.00. The Resident Trust Statement, reflected that a payment was made on Resident #107's behalf for \$1,198.00 on 12/5/2011, reducing his balance to \$3,243.19. She stated that they continued to have discussion with the RP who decided to purchase a funeral plan for him as well.</p> <p>The Trust Statement reflected that another deposit was made to Resident #107's account on 01/03/2012 for \$1,272.00, raising his balance to \$4,510.63. On 01/12/2012, a check was sent to the funeral home for \$3,243.19, reducing his balance to \$1,267.44.</p> <p>2. Resident #38 was admitted to the facility on 06/17/2004. A copy of Resident #38's Resident Trust Statement, dates 11/01/2011 to 01/26/2012 was presented by the Business Office Manager for review. It revealed that Resident #38 received a monthly income of \$1,067.82, \$1,078.00 and \$282.00, totaling \$2,427.82.</p> <p>On 11/03/2011, her balance was \$2,575.66 before a PML payment of \$2,398.00 was applied on 11/07/2011. On 12/02/2011, her balance had reached \$2,587.08. Her PML was reduced to \$252.00 on 12/05/2011, reducing her balance to \$2,335.08. In January, 2012, her social security</p>	F 159			

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F 159	Continued From page 7 income was reduced to \$2,284.62 a month. On 01/04/2012, she had \$4,339.41 in her account. A PML payment for \$2,091.48 was made on 1/10/2012, reducing her balance to \$2,247.93.  On 01/26/2012 at 10:50am, an interview was conducted with the Business Office Manager. She explained that started working as the Business Office Manager on 11/28/2011. On 01/20/2012, she contacted the Medicaid caseworker and discussed Resident #38's account balance and verified that it needed to be spent down. She stated that she was advised to contact Resident #38's family member and inquire about her medical bills. She spoke to a family member on 01/24/2012 who stated that she had unpaid medical bills that he would bring in, so that they could be applied to her account. She shared that she was hoping to meet with the family member soon.	F 159		
F 160 SS=B	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH  Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.  This REQUIREMENT is not met as evidenced by: Based on record review, policy review and staff interviews, the facility failed to convey resident trust funds within 30 days, after the death of 2 of 3 residents (Residents #6 and #128). The findings include:	F 160	<b>F160</b>  It is the practice of the facility to upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds to the individual or probate jurisdiction administering the resident's estate.  <b>I.</b> Resident #6 check was mailed to the Moore County Clerk of Court, sent back to the facility with instructions to send it to Montgomery County Clerk of Court. The check was then sent. Resident #128 check was sent to the Moore County Clerk, sent back to the facility with instructions to send it to Harnett County CSC in Lillington, NC. The check was then sent.	



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F 160	<p>Continued From page 8</p> <p>A copy of the facility's undated Resident Personal Trust Fund Agreement, stated that "Upon your discharge or death, the balance of your account will be promptly released to the private party or public agency required by law."</p> <p>1. A record review was conducted with the Business Manager and it revealed that Resident #6 was admitted to the facility on 10/01/2010. On 10/20/2011, she expired in the hospital, leaving \$535.68 in her resident trust funds account. A check for \$535.68 was sent to the clerk of courts on 1/10/2012, payable to her estate.</p> <p>On 01/26/2012 at 10:45am, the Administrative Staff #2 was interviewed. She stated that when a resident dies with a resident trust funds account, she contacts the family and tells them that they must produce a death certificate so that she can submit it with the refund check to the clerk of courts. She shared that the local clerk of courts will send back their check if it is not accompanied by a death certificate. Therefore she explained, that there was no timeframe for conveyance of funds because it all depended on how fast the family can produce the death certificate, regardless if the resident died in the facility or not.</p> <p>On 01/26/2012 at 2:40pm, the Administrator was interviewed. She stated that residents with trust funds must have their funds conveyed within 30 days from the date of death.</p> <p>2. A record review was conducted with the Business Manager and it revealed that Resident #128 was admitted to the facility on 10/10/2011. On 12/20/2011, he expired at the facility, leaving</p>	F 160	<p>II. <sup>rw</sup> An audit was conducted on <sup>2/9/12</sup>2/9/12 by the BOM and Administrator to determine if other residents had been affected by the alleged deficient practice and any issues were addressed.</p> <p>III. An audit will be conducted monthly by Administrator and BOM to ensure compliance with policy to convey funds within 30 days of discharge or expiration</p> <p>IV. The BOM will report monthly to the QAPI Committee the results of conveyance of funds.</p> <p>02/23/12</p>		

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F 160	Continued From page 9 \$ 59.86 in his resident trust funds account. A check for \$59.86 was sent to the clerk of courts on 1/23/2012, payable to his estate.  On 01/26/2012 at 10:45am, the Administrative Staff #2 was interviewed. She stated that when a resident dies with a resident trust funds account, she contacts the family and tells them that they must produce a death certificate so that she can submit it with the refund check to the clerk of courts. She shared that the local clerk of courts will send back their check if it is not accompanied by a death certificate. Therefore she explained, that there was no timeframe for conveyance of funds because it all depended on how fast the family can produce the death certificate, regardless if the resident died in the facility or not.  On 01/26/2012 at 2:40pm, the Administrator was interviewed. She stated that residents with trust funds must have their funds conveyed within 30 days from the date of death.	F 160			
F 161 SS=B	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS  The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure that the surety bond for the resident trust funds account had adequate coverage. The findings include:	F 161	<b>F161</b>  It is the practice of the facility to maintain a surety bond to assure the security of all personal funds of residents deposited with the facility.  <b>I.</b> No one resident was identified as having been affected by the alleged		

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F 161	<p>Continued From page 10</p> <p>On 01/26/2012 at 10:45am, a record review was conducted with the Business Office Manager and the Administrative Staff #2. A copy of the current Surety Bond was reviewed and it revealed that the resident trust fund was listed as obligee. The bond had an increase on 07/01/2009 from \$25,000.00 to \$35,000.00. It was also renewed on 09/01/2011.</p> <p>The Business Manager shared that she was hired on 11/28/2011 as she produced copies of the November, 2011 through January, 2012 financial summaries of resident trust fund for review. A Resident Trust Funds bank statement, with dates ranging from 11/30/2011 through 12/30/2011, had a ledger balance with sums totaling \$35,859.11 to \$45,558.93.</p> <p>A Resident Trust Funds Account Reconciliation report, dated 12/31/2011 revealed that the total amount received was \$41, 376.87.</p> <p>The Resident Trust Summary Report, dated 01/25/2012 documented that the account had a balance of \$29,287.71, however during the month; it had a total of cash receipts of \$46,219.04 and disbursements of \$48,405.62.</p> <p>The Administrative Staff #2 stated during this review that residents who are new admissions are strongly encouraged to open up Resident Trust funds accounts, so there had been an increase in activity since the last rider to increase the bond. She stated that she would relay to the Administrator that another rider might have to be issued in order to increase the funds covered in the Resident Trust account.</p>	F 161	<p>deficient practice.</p> <p>II. Each resident had a potential to have been affected by the alleged deficient practice.</p> <p>III. A new surety bond has been obtained on 2/8/12 in the amount of \$50,000 to ensure resident funds are protected. The Administrator and BOM will review account balances monthly to ensure amounts do not exceed the amount of the surety bond.</p> <p>IV. A review of the RPTF account balance and surety bond amount will be reviewed during the QAPI meeting to ensure adequate monitoring.</p> <p>02/23/12</p>		
F 164	483.10(e), 483.75(l)(4) PERSONAL	F 164			

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F 164 SS=D	Continued From page 11 <b>PRIVACY/CONFIDENTIALITY OF RECORDS</b>  The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.  Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.  The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.  The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law, third party payment contract; or the resident.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to provide privacy during an observation of urinary catheter care for one (1) of three (3) residents (Resident #104). Findings included:	F 164	<b>F164</b>  <b>It is the practice of the facility to provide personal privacy to include accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups.</b>  <b>I.</b> <b>Aide that provided care to resident#104 was in-serviced 1:1 by the ADNS on 1/26/12 on providing privacy while performing care.</b>  <b>II.</b> <b>Each resident has the potential to be affected by the alleged deficient practice.</b>  <b>III.</b> <b>In-service training was completed for certified nursing assistants prior to 2/23/12 by the ADNS on providing privacy while performing care. All nursing assistants were in-serviced.</b>  <b>The ADNS or Assistant Director of Nursing will perform random rounds (of actual care being given) on all shifts to include weekends</b>	

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F 164	Continued From page 12  Resident #104 was originally admitted to the facility 05/10/2011. Cumulative diagnoses included: Dementia without behavioral disturbance, anxiety and depression.  A Quarterly Minimum Data Set (MDS) dated 1/11/12 indicated Resident # 104 had a urinary catheter. Extensive assistance was required for bed mobility, personal hygiene and toilet use. Total dependence was required for dressing and bathing.  During an observation on 1/26/12 at 10:12 AM., Nursing Assistant (NA) #3 was observed providing urinary catheter care for Resident # 104. The resident lived in a private room. There was one window in her room that had blinds and was facing the front entrance of the property. There were no vehicles noted at the main entrance at the beginning of the procedure. NA #3 pulled back the covers, opened the incontinent brief and exposed the perineal area and urinary catheter. The window blinds remained open during perineal/ catheter care. At the completion of the procedure, there was one car noted at the main entrance of the facility with the vehicle facing Resident #104's window. On completion of perineal/ catheter care, NA #3 was asked regarding the window blind being open during perineal care. She stated she should have closed the blind but just forgot.  On 1/26/2010 at 1:45 PM, the Director of Nursing confirmed that the window blind should have been closed when care was given.	F 164	weekly for two (2) weeks, then monthly for three (3) months. An audit tool was developed for the purpose of patient care with privacy.  IV. The Human Resource Director will report annually in December on the completion of Resident's Rights in-service training by staff. Results of audits will be reviewed in monthly QAPI meeting.  02/23/12	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

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F 226	Continued From page 13  The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.  This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility failed to investigate and to report an allegation of misappropriation of resident's property for 1 (Resident # 74) of 4 allegations of abuse, neglect and misappropriation of resident's property reviewed. The finding includes:  The facility's policy on abuse, neglect and misappropriation of resident's property dated 07/02/99 was reviewed. The policy under investigation read in part, "The administrator and the abuse prevention coordinator are to be responsible for the initial reporting, investigation of alleged violations and reporting of results to the proper authorities. The center must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress".  Resident #74 was admitted to the facility on 12/13/11 and was re-admitted on 12/26/11 with multiple diagnoses including Cerebrovascular Accident (CVA), Hypertension, Diabetes Mellitus and Congestive Heart Failure.  The MDS assessment dated 12/20/11 indicated that Resident #74's cognitive status was intact and had no behavior problem.	F 226	<b>F226</b>  <b>It is the practice of the facility develop to and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property.</b>  <b>I.</b> <b>Report and investigation submitted to state agency on 1/30/12.</b>  <b>II.</b> <b>Each resident has the potential to be affected by the alleged deficient practice.</b>  <b>ADNS and Administrator will investigate any allegations of abuse, neglect and mis-appropriation of funds will be invested and submitted to the state per reporting guidelines.</b>  <b>III.</b> <b>A review of the facility and state/federal regulations on Abuse and Neglect Policy and Procedure has been reviewed by the Administrative Staff to ensure understanding of reporting requirements. In-service of all administrative staff was completed on 2/15/12 by the Administrator and ADNS.</b>	

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F 226	<p>Continued From page 14</p> <p>On 01/24/12 at 10:00 AM, Resident #74 was interviewed. She stated that she had lost money a week and a half ago and she had reported it to the office. She further stated that the facility had informed the police who came and interviewed her. She added, "I want my money back."</p> <p>Review of the concern form completed by the facility revealed that on 01/11/12, Resident #74 had reported that she was missing \$700 from her drawer that her sister had given her on 01/09/12. The form indicated that the police department was notified. The form did not indicate that the allegation was reported nor was investigated.</p> <p>On 01/26/12 at 9:03 AM, the Director of Nursing was interviewed. She stated that she did not report the allegation to the state and she did not do an internal investigation. She further indicated that she had reported it to the police and the police would do the investigation.</p> <p>On 01/26/12 at 9:50 AM, the social worker was interviewed. She stated that she was aware of the resident's allegation about the missing money and that the police was notified. She further stated that the facility did not do the internal investigation because the police would do it. She also indicated that the administrator and the Director of Nursing were responsible for the reporting.</p> <p>On 01/26/12 at 10:05 AM, interview with the administrator was conducted. She stated that she should have reported the allegation of misappropriation of resident's property to the state but did not. She also stated that she had</p>	F 226	<p>IV. Investigations will be reviewed monthly during the QAPI meeting.</p> <p>02/23/12</p>	

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F 226	Continued From page 15 reported the allegation to the police and the police would do the investigation by interviewing the staff members.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to promote dignity while dining by allowing resident to pick up food from the floor and to feed self with a dirty spoon for 1 (Resident # 64) of 2 sampled residents. The findings include:  Resident #64 was admitted to the facility on 02/21/09 with multiple diagnoses including Huntington's chorea, a neurodegenerative genetic disorder that affects muscle coordination. The quarterly Minimum Data Set (MDS) assessment dated 11/20/11 indicated that Resident #64 had moderate cognitive impairment, needed extensive assist with eating and no behavioral symptoms and no rejection of care noted.  The care plan dated 12/20/11 included (problem) ADL (activity of daily living) self care deficit as evidenced by need for assistance related to disease process, (goal) will receive assistance necessary to meet ADL needs AEB (as evidenced by) clean, neat well dressed	F 241	<b>F241</b>  It is the practice of the facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  <b>I.</b> Resident #64 was evaluated on 2/21/12 by SLP. Diet downgraded to Pureed diet with thin liquids. Screened by OT on 2/22/12 with recommendations for short and long term goals for increased independence in ADL self-feeding. Prior to completion of therapy services, staff will be trained by therapy on resident's needs for continued independence in ADL self-feeding.  <b>II.</b> Prior to 2/23/12, other residents (needing extensive assistance with meals) that have the potential to have been affected by the alleged deficient practice, have been reviewed by therapy and nursing and appropriate assistive devices have been put in place.	



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F 241	<p>Continued From page 16</p> <p>appearance thru next review and (approaches) assist with daily hygiene, grooming, dressing, oral care and eating as needed.</p> <p>On 01/23/12 at 5:10 PM, Resident #64 was observed sitting on a broda chair on the front table of the dining room. She was observed to have continuous involuntary movements of her upper and lower extremities. Her lunch tray was in front of her with a can of soda and a glass of water. She was observed to spill the whole glass of water on the table (table cloth was wet). Resident #64 was trying to feed self but was having difficulty picking up the spoon. She was able to feed self but most of the food was spilled to the table and to the floor. It was observed that her spoon fell on the floor several times and she picked it up and she fed herself again with same spoon. There was no staff member observed to supervise the resident during the whole dining observation.</p> <p>On 01/23/12 at 5:56 PM, NA #1 (nursing assistant) was interviewed. She stated that Resident #64 was able to feed herself but was spilling food on the floor every meal due to the involuntary movements. NA #1 stated that there was no staff member assigned to assist/supervise the resident because she did not want to be fed.</p> <p>On 01/24/12 at 12:00 PM, Resident #64 was observed during lunch. She was sitting on a wheelchair on the front table of the dining room. Her lunch tray was in front of her with a can of soda and a glass of tomato juice. She was observed to have continuous involuntary movements of her upper and lower extremities.</p>	F 241	<p><b>III.</b></p> <p><b>Staff has been in-serviced by ADNS on dignity and respect for individuality, and the needs of resident #64 during the dining experience.</b></p> <p><b>Dining room observations will be completed and documented daily by Administrative Staff daily for two (2) weeks, then two (2) times weekly for two (2) weeks, then monthly for three (3) months.</b></p> <p><b>IV.</b></p> <p><b>ADNS will bring results of the dining observations to the monthly QAPI meeting for review.</b> <b>2/23/12</b></p>	

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F 241	Continued From page 17 She tried to feed herself but had difficulty grabbing the spoon. When she was able to grab the spoon and fed herself most of the food spilled to the table and to the floor. She was observed several times to pick up food from the floor and put it in her mouth. It was also observed that her spoon fell to the floor at least five times and she picked it up and used it to feed herself. She was observed to spill her tomato juice on her tray. On one occasion, a staff member who was feeding another resident on the near table saw her picking up spoon from the floor, she went to remove the dirty spoon and gave her a new one.  On 01/24/12 at 12:41 PM, NA #2 was interviewed. She stated that the resident was able to feed herself and did not want to be fed. She also stated that she has always spilled food/drink and has picked up food/spoon from the floor.  On 01/26/12 at 2:54 PM, the MDS Nurse was interviewed. She stated that she had observed Resident #64 eating in the dining room during meals and she acknowledged that it was not in a dignified manner. She spilled food everywhere. She stated that she would discuss it in the morning meeting and see what could be done to maintain her dignity while allowing her to eat independently.	F 241			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further	F 318	<b>F318</b>  <b>It is the practice of the facility based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent decrease in range of motion.</b>		

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F 318	<p>Continued From page 18 decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to maintain therapeutic interventions for 1 (Resident #122) of 3 residents, identified with contractures. The findings include:</p> <p>Resident #122 was admitted to the facility on 8/12/2010 with the following cumulative diagnoses: muscle weakness, cerebrovascular accident and diabetes mellitus type II. On his quarterly Minimum Data Set (MDS) dated 11/15/2011, he was coded as having memory problems with moderate impairment in cognitive skills for decision making. He also had weakness on one side of his upper and lower extremities.</p> <p>On 1/23/2012 at 4:47pm, Nurse # 4 was interviewed. She stated that Resident #122 had a contracted left arm and that he did not wear a splint and that he used to receive therapy.</p> <p>On 1/25/2012 at 9:00am, Resident #122 was observed lying in bed; a splint was not present on his left arm.</p> <p>On 1/25/2012, a record review was conducted, and revealed that on 8/31/2010 an Occupational Therapy Consultation Evaluation was completed and assessed Resident #122 as having a contracture on his left finger, hand and elbow. The recommendation was for him to receive occupational therapy to address the problems</p>	F 318	<p><b>I.</b> Resident#122 has been evaluated by the therapy department and is now on the therapy department caseload.</p> <p><b>II.</b> An audit was completed prior to 2/23/12 on residents to identify those with contractures. Residents identified with contractures have been screened by therapy and picked up for treatment as ordered.</p> <p><b>III.</b> Admissions are reviewed in the Morning Meeting by the Interdisciplinary Team. The Director of Rehab or designee will evaluate any resident identified on nursing 24 hr report as having difficulty with Range of Motion and screen/evaluate as appropriate.</p> <p><b>IV.</b> Monthly an 802 Matrix will be reviewed during the QAPI meeting to assist in identifying residents with new issues in ROM. Residents were placed on a Restorative program as appropriate. 02/23/12</p>		

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F 318	<p>Continued From page 19</p> <p>with his left side weakness in order to maximize his functional return to independence. The plan of care, included that Resident #122 would tolerate a left wrist splint for 4 hours a day.</p> <p>On 9/14/2010, an Occupational Therapy (OT) Summary was completed on Resident #122. It read that Resident #122 received occupational therapy three times a week before having left elbow fracture and a sling placed for protection. Resident #122 was placed on hold for therapy as of 9/13/2010. Therapy would await the results of his orthopedic visit on 9/16/2010, to learn of any restrictions for therapy. On 9/21/2010, the OT summary reported that Resident #122 left arm was placed in a cast and had an ace bandage wrap applied. The recommendation was for him to receive no therapeutic interventions for two weeks until his next orthopedic appointment.</p> <p>On 9/28/2010, the OT Summary reported that Resident #122 would continue to receive no therapeutic interventions, since the orthopedic surgeon had restricted the use of left upper extremities until the next appointment. Resident #122 was noted to be making good progress with self-feeding and Activities of Daily Living transfers with reminders, and was discharged from therapy on 9/29/2010.</p> <p>A Physician 's Progress Note, dated 10/6/2011 revealed that Resident #122 had contractures present on his left upper extremity.</p> <p>A Care Plan, dated 12/2/2011, identified that Resident #122 was at risk for pain related to a contracture of his left hand. Interventions to be used included, pain control with medication and</p>	F 318			

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F 318	Continued From page 20 reporting any signs of pain to the physician. He would receive physical and/or occupational therapy evaluation and treatment, per orders.  On 1/26/2012 at 10:11am, the Administrative Staff #3 was interviewed. He shared that Resident #122 had a left finger contracture but was right hand dominant. He stated that his original goal during therapy in 2010 was to strengthen his self feeding skills. At the time that he was enrolled in therapy, he was seeing the OT therapist 3x a week until he sustained a left elbow fracture, then it was suspended because the orthopedist recommended that he have no upper extremity motion. He relayed that after the fracture healed; it would be the responsibility of the nurse to notify therapy of any decline in his functional abilities.  Administrative Staff #3 continued, stating that when Resident #122 began therapy in 2010, there was no baseline measurement taken to determine the extent of his contractures. If a new OT assessment determined that Resident #122 's contracture worsened, then therapy would apply the splint.  On 1/26/12 at 5:30pm, another observation was made of Resident #122. He was in bed, being fed by Nurse Aide # 4. Resident #122 held a rolled washcloth in his left hand. The nurse aide stated that he works with Resident #122 about twice a week and had never seen him with a rolled washcloth or any type of device, placed in his hand. He shared that Resident #122 fingers on his left hand are usually contracted.	F 318			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332			

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F 332	Continued From page 21  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to maintain their medication error rate 5% or below by not following the doctor's orders. There were three errors of 55 opportunities resulting to 5.45 % error rate. The findings include:  1a. Resident #143 was admitted to the facility on 12/22/11 with multiple diagnoses including Diabetes Mellitus. On 12/22/11, the attending physician had ordered " Novolin 70/30 - inject 5 units SQ (subcutaneous) with supper for Diabetes Mellitus. The administration time listed on the MAR (Medication Administration Record) was 5:30 PM.  On 01/25/12 at 4:13 PM, Nurse #1 was observed to prepare and to administer Novolin 5 units SQ to Resident #143.  On 01/25/12 at 5:05 PM, Nurse #1 was interviewed. She stated that the resident had not had supper yet when she administered the insulin. She stated that the supper cart was scheduled to arrive on the floor around 5 PM. She further indicated that she can administer the medications 1 hour before and 1 hour after the scheduled time.	F 332	<b>F332</b>  It is the practice of the facility to ensure that it is free of medication error rates of five percent or greater.  <b>I.</b> Medication times were corrected for Resident's #143 and #61 per physician's orders. Medication error forms were completed for Resident's #143 and #61.  <b>II.</b> An audit of mediations and administration times was conducted on 1/27/12 by the pharmacy consultant and recommendations were given to address with the physician. Pharmacy consultant to evaluate medication administration times upon monthly visits. MD orders are reviewed in the Morning meeting.  <b>III.</b> Nursing staff were required as in-service training to watch the Medication Administration video prior to 2/23/12. ADNS to ensure that all nurses have seen video and that all new nurses watch the video. Video includes training on administering oral medications, eye meds, inhalers, patches and medications via G tube.	

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F 332	<p>Continued From page 22</p> <p>1b. Resident #143 was admitted to the facility on 12/22/11 with multiple diagnoses including Diabetes Mellitus. On 12/22/11, the attending physician had ordered Actos 45 mgs (milligram) 1 tablet by mouth everyday with dinner for Diabetes Mellitus. The administration time listed on the MAR was 4:30 PM.</p> <p>On 01/25/12 at 4:14 PM, Nurse #1 was observed to prepare and to administer Actos 45 mgs 1 tablet to Resident #143 with water.</p> <p>On 01/25/12 at 5:05 PM, Nurse #1 was interviewed. She stated that the resident had not had supper yet when she administered the Actos. She stated that the supper cart was scheduled to arrive on the floor around 5 PM. She further indicated that she can administer the medications 1 hour before and 1 hour after the scheduled time.</p> <p>2. Resident #61 was admitted to the facility on 04/26/11 with multiple diagnoses including overactive bladder. On 12/05/11, the attending physician had ordered Oxybutynin (for overactive bladder) 10 mgs 1 tablet by mouth everyday (separate from Potassium by 2 hours).</p> <p>On 12/15/11, the attending physician had ordered Klor-con (for Hypokalemia) 20 meq (mill equivalent) 2 tablets by mouth in the morning and 1 tablet by mouth at dinner time (separate from Oxybutynin dose by at least 2 hours).</p> <p>On 01/26/12 at 8:22 AM, Nurse #2 was observed during the medication pass. Nurse #2 was</p>	F 332	<p><b>ADNS, DCD, or RN Supervisor will observe medication passes with nurses on each shift. Medication pass QAPI audit tool will be used. 5 Random audits (night/day shift, weekdays/weekend included) will then be conducted weekly for two (2) weeks, then monthly times three (3) months, then yearly prior to evaluation to ensure compliance with medication pass policy.</b></p> <p><b>IV.</b> <b>ADNS or designee will report medication errors to the QAPI Committee monthly for evaluation of need for continued monitoring.</b> 02/23/12</p>	

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F 332	Continued From page 23 observed to prepare and to administer the resident's medications including Klor-con and Oxybutynin.	F 332			
F 425 SS=D	On 01/26/12 at 8:30 AM, Nurse #2 was interviewed. She acknowledged that she was not aware of the order to administer the Klor-con and the Oxybutynin separately by 2 hours apart. She stated that she would change the timing on the MAR and she would notify the doctor of the error. 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the	F 425	F425  It is the practice of the facility provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving dispensing and administrating of all drugs and biologicals) to meet the needs of each resident.  I. No one resident was identified as having been affected by the alleged deficient practice.  II. Each resident has the potential to have been affected by the alleged deficient practice. Expired and unlabeled vials of PPD solution disposed of upon notification of findings. A review of the med carts and med room did not reveal any other issues.		



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F 425	<p>Continued From page 24</p> <p>facility failed to discard a multidose vial of a tuberculin diagnosic agent thirty (30) days after opening and failed to date a multidose vial of a tuberculin agent when it was opened in one (1) of two (2) medication storage rooms. Findings included:</p> <p>A Facility Medication Expiration Monthly Inspection Report read in part "#12 PPD (Aplisol) 30 days after opened."</p> <p>On 1/25/2012 at 11:00 AM., the refrigerator on the Masters/ Heritage nursing unit was inspected. Observation revealed one multidose tuberculin (PPD) vial opened and dated 12/11/2011 and one opened, undated vial of PPD.</p> <p>PPD is a diagnostic agent used as a skin test for tuberculosis. The manufacturer's product information for storage requirements read in part "A vial of PPD which has been entered and in use for thirty (30) days must be discarded." The manufacturer's label on the PPD vial read "Discard opened product after 30 days." Oxidation and degradation may occur after 30 days resulting in reduced potency and possible inaccurate test results.</p> <p>On 1/25/2012, at 11:10 AM, Nurse # 3 stated the facility policy is to date vials when they are opened and there should have been a date on the vial when it was opened. She further indicated the vial dated 12/11/2011 should have been discarded.</p> <p>On 1/25/2012 at 11:15 AM., Administrative staff #1 stated tuberculin vials should be dated when opened and discarded 30 days after opening.</p>	F 425	<p><b>III.</b></p> <p><b>Nursing staff were in-serviced by ADNS prior to 2/23/12 for labeling newly opened multi dose vials and dating as well as time frame for usage prior to disposal.</b></p> <p><b>ADNS, DCD or RN Supervisor will complete an audit for expired medications on each medication cart and in medication rooms daily for two (2) weeks, then weekly for two (2) weeks then once monthly for 3 months.</b></p> <p><b>IV.</b></p> <p><b>Results of the audits will be reviewed by the QAPI Committee for further need of continued monitoring.</b></p> <p style="text-align: right;"><b>02/23/12</b></p>	

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K 018  
SS=E

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 1/4 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

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

K 018

The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.

**K018**  
Criteria One:  
What corrective action(s) will be accomplished by the facility to correct the alleged deficient practice;

Doors for resident room numbers 129,133, and 131 have been ordered and will be replaced as soon as they are received.

Criteria Two:  
How you will identify other life safety issues having the potential to affect residents by the same alleged deficient practice and what corrective action will be taken;

An audit has been completed on all resident room doors. Any area of concern will be corrected.

K 025  
SS=E

42 CFR 483.70(a)  
NFPA 101 LIFE SAFETY CODE STANDARD

Smoke barriers are constructed to provide at

K 025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Joni Williams Administrator</i>	TITLE	(X6) DATE <i>March 9, 2012</i>
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any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following 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 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 025	Continued From page 1 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	Criteria Three: What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur;  An audit will be completed quarterly by the Maintenance Director to identify doors with greater than 1/8 gap in closure.	
K 038 SS=F	This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliance, specific findings include: smoke barrier had unsealed openings in wall which were not seal to maintain the construction rating(on half hour) of building. Location of smoke barrier is at room 113 and 114.  42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1  This STANDARD is not met as evidenced by: Surveyor: 27871	K 038	Criteria Four: How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place;  The quarterly audit will be added to the monthly Quality Assurance and Assessment Committee (QAPI) to be review and further follow up.  An extension of 8 weeks has been requested for completion of K018.  K025 Criteria One: What corrective action(s) will be accomplished to correct the alleged deficient practice;  Smoke barriers at room 113 and 114 have been sealed as of 2/28/12.	

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K 038	Continued From page 2 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliance, specific findings include: facility does not meet requirements for Delayed Egress locking system. Facility does not have the capability of unlocking doors by a signal at nurse station.  42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD	K 038	Criteria Two: How you will identify other life safety issues having the potential to affect residents by the same alleged deficient practice and what corrective action will be taken;  Surveyor and Maintenance Director did a walk through to identify other unsealed smoke barriers. None were found.	
K 056 SS=F	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: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliance, specific findings include: tamper switch failed to give an audlle/visual signal at fire control panel on test(riser room).  42 CRT 483.70(a)	K 056	Criteria Three: What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?  A yearly audit of all smoke wall systems will be conducted by the Maintenance Director. Any penetrations will be sealed to ensure maintenance of smoke wall system.  Criteria Four: How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place;  The yearly audit of the smoke wall system will be reviewed by the QAPI committee for further follow up.  4/9/12	

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K 072 SS=E	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	K 072	<i>Continues on next pg.</i>		
	This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliance, specific findings include: storage of wheelchairs and chairs were in corridor reducing width of exit egress to exit access(rehab. hall)  42 CFR 483.70(a)				

K038

**Criteria One:**

What corrective action(s) will be accomplished by the facility to correct the alleged deficient practice;

We have contracted with South Med for hard wired control switches to be placed at each nurse's station.

**Criteria Two:**

How you will identify other life safety issues having the potential to affect residents by the same alleged deficient practice and what corrective action will be taken;

For further security measures a wireless transmitter and controller will be placed at the reception desk to control access to the building.

**Criteria Three:**

What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?

New panic bars have been added on all resident halls to prevent entrance from the outside.

**Criteria Four:**

How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place;

All doors are audited weekly by the Maintenance Director for operation and proper release. The audits will be reviewed monthly during the QAPI meeting for further follow up.

4/9/12

K056

Criteria One:

What corrective action(s) will be accomplished by the facility to correct the alleged deficient practice;

Simplex Grinnel has been contracted to replace the faulty tamper switch.

Criteria Two:

How you will identify other life safety issues having the potential to affect residents by the same alleged deficient practice and what corrective action will be taken;

An audit was done by the Maintenance Director and Simplex Grinnel Representative to ensure that all safety devices were working properly.

Criteria Three:

What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?

Maintenance Director to ensure the items are checked during the quarterly and annual sprinkler inspections. Both parties will be required to sign off items have been checked.

Criteria Four:

How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place;

Results of quarterly and annual sprinkler inspections are to be reviewed by the QAPI committee to ensure compliance.

4/9/12



K072

Criteria One:

What corrective action(s) will be accomplished by the facility to correct the alleged deficient practice;

All devices were removed from the corridor.

Criteria Two:

How you will identify other life safety issues having the potential to affect residents by the same alleged deficient practice and what corrective action will be taken;

A walk through of the building by the Surveyor and Maintenance Director did not reveal any other areas reducing width of exit egress to exit access.

Criteria Three:

What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?

In-service training for facility staff will be completed prior to 4/9/12 on keeping corridors free of obstructions.

Monitoring of the back hall will be added to the daily maintenance check list of doors to ensure the alleged deficient practice has resolved.

Criteria Four:

How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place;

Maintenance Director will bring to the monthly QAPI meeting the results of the hall monitoring for review.

4/9/12