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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345140	A. BUILDING ______ APR 11 2012 B. WING ______	03/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTMOOR NURSING CENTER	610 WEST FISHER STREET SALISBURY, NC 28145

(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 160 SS=D	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 and staff interviews the facility failed to forward expired resident ' s funds to the Executor of the Estate or Clerk of Courts for 1 of 2 fund accounts reviewed. (Resident # 32) Findings include: Review of facility records revealed Resident # 32 was discharged from the facility to the hospital on 10/28/11. According to the county Deputy Register of Deeds, the resident expired on 10/30/11. On 11/8/11 the facility wrote a check in the amount of $483.90 payable to a funeral home with the notation for " Name of Resident # 32 / Services " . During an interview on 3/21/12 at 2:45 pm the facility bookkeeper indicated Resident # 32 was discharged from the facility on 10/28/11 and expired at the hospital. He indicated the check was written to the funeral home from Resident # 32 ' s personal funds account because the resident ' s family requested the funds for the funeral home because they did not have any money and the funeral home would not start	F 160	**THIS FACILITY'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW.** • F:160 **ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:** Since the resident has expired there is no corrective action for this specific resident. However a system has been implemented that will audit the funds of any expired residents by the Administrator to make sure the funds are disbursed within 30 days to the Clerk of Court. This will be documented on a QA Form "Expired Resident's Funds". **ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:** The following is the new system for distribution of funds after a resident has expired: 1. The Bookkeeper is responsible for ensuring that when a resident expires the funds will be disbursed to the Clerk of Court within 30 days. 2. A copy of the check will be given to the Administrator by the Bookkeeper.	04/05/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Adm (X6) DATE: 4-9-12

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.

3. At that time the new form named "Expired Resident Funds" will be completed by the Administrator which includes the following information: Resident Name, Date of Death, to whom money was disbursed, and Date money was sent.
4. All this information will be collected on each resident at the time of death and placed in a binder in the Administrator's office.
5. A list of expired residents will be printed from the computer and attached to the Expired Resident Funds Form to make sure all expired residents have been identified.

ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR:

On April 4, 2012 an In-service was conducted by the Administrator with the Bookkeeper and Social Worker. The following information was discussed:

1. The Bookkeeper is responsible for ensuring that when a resident expires the funds will be disbursed to the Clerk of Court within 30 days.
2. A copy of the check will be given to the Administrator by the Bookkeeper.
3. At that time the new form named "Expired Resident Funds" will be completed by the Administrator which includes the following information: Resident Name, Date of Death, to whom money was disbursed, and Date money was sent.

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F 160	Continued From page 1 services without being paid. The bookkeeper stated he knew they were not supposed to write a check from personal funds to a funeral home. On 3/21/12 at 2:50 pm the Administrator stated if a resident expired with money in their trust fund, the money would go to the responsible party if the responsible party was executor of the estate and if the responsible party was not executor of the estate, the money went to the Clerk of Courts. She recalled the Bookkeeper said the Social Worker got a call from Resident # 32 ' s daughter stating the funeral home would not touch the body without payment and requested a check written to the funeral home. The Social Worker mailed a check to the funeral home. The Administrator stated the Social Worker conveyed funds after death-she worked hand in hand with the Bookkeeper. On 3/21/12 at 3:15 pm the Social Worker stated she wrote the check to the funeral home from Resident # 32 ' s personal funds account. She stated at the time, she did not know the check could not be written to the funeral home. The Social Worker stated she now understood when a resident expired, the check from personal funds should be written to the Clerk of Courts. On 3/21/12 at 3:31 pm the Administrator stated she vaguely remembered the issue with the check to the funeral home and was confused at the time if the check was written for something pre-arranged, of if the funds were conveyed after death. She indicated it was not her understanding at the time the funds were conveyed after death.	F 160	4. All this information will be collected on each resident at the time of death and placed in a binder in the Administrator's office. 5. A list of expired residents will be printed from the computer and attached to the Expired Resident Funds Form to make sure all expired residents have been identified. INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: The Administrator will be responsible to bring to the QA Committee on a Monthly basis the QA form named "Expired Resident Funds" along with a list of expired residents printed from the computer to make sure all expired residents have been identified and any monies have been distributed to the proper source and in a timely manner. The QA Committee is responsible to ensure that correction is achieved and sustained.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

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F 312	Continued From page 2	F 312		

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews and record review, the facility failed to provide proper incontinence care, and failed to clean the fingernails for one of one resident (Resident # 16) dependent on staff for activities of daily living.

Findings include:

1a. Record review revealed Resident # 16 was last admitted to the facility on 4/19/11 with a cumulative diagnosis of advanced dementia, diabetes mellitus, renal failure, hypertension, bradycardia, aphasia, dysphasia, anemia, hyperthyroidism and history of urinary tract infections.

The last completed Minimum Data Set (MDS), dated 12/20/11 revealed the resident had long and short term memory loss, severe cognitive impairment, was incontinent of bowel and bladder and was dependent on staff for activities of daily living (ADLs) including personal hygiene.

Resident # 16 ' s care plan, updated on 1/6/12, indicated a problem with bowel and bladder incontinence and urinary tract infections (UTI), and established a goal the resident would have proper incontinence care as evidenced by no

- F:312

04/18/12

ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:

All certified nursing assistants have been re-educated on April 4th and 5th 2012 by the Director of Nursing concerning correct procedure and protocol for perineal care, all incontinent residents will have barrier cream applied after perineal care is provided and nail care will be provided on a daily basis with ADL care.

ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:

All certified nursing assistants have been re-educated on April 4th and 5th 2012 by the Director of Nursing concerning correct procedure and protocol for perineal care, all incontinent residents will have barrier cream applied after perineal care is provided and nail care will be provided on a daily basis with ADL care.

ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR:

Each certified nursing assistant will complete a competency on perineal care and nail care, which will be done during a resident's ADL care, by April 18, 2012. This observation will be done by the Director of Nursing, Clinical Service Nurse, and MDS Nurse.

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F 312	Continued From page 3 signs or symptoms of urinary tract infections or skin breakdown. Approaches included provide incontinence care promptly, washing appropriately front to back, and apply protective skin barrier with each incontinent care. On 3/21/12 8:42 am Nursing Assistant # 1 (NA # 1) was observed providing a bed bath for Resident # 16. Nursing Assistant # 2 (NA # 2) assisted with the bed bath by turning and positioning the resident. The resident was turned to the left side and was noted to be incontinent of bowel. NA # 1 cleaned the resident with disposable wipes, washing front to back to clean away the stool from the rectal area. The resident was then turned to the back, and perineal care continued. NA # 1 washed the urethra area back to front, the left groin area back to front, and the right groin area back to front, in a direction starting nearer the rectum, and ending above the urethral area, contrary to the accepted practice of washing front to back to prevent introduction of bacteria into the urethra. The resident was dried, and dressed in an adult brief. No protective skin barrier product was applied. During an interview on 3/21/12 at 9:00 am, NA # 1 stated the resident was washed back to front when perineal care was provided and indicated this was thought to be correct practice, and that barrier cream was not applied every time perineal care was provided, only when this NA saw a rash. During an interview on 3/21/12 at 9:05 am, NA# 2 stated perineal care should be provided washing front to back. On 3/21/12 at 12:20 pm the Director of Nursing	F 312	A QA form has been implemented called "The Peri Care Audit" which includes: Date, Resident Name, Employee Name, Pass/Fail, and Recommendations. A second QA form has been implemented called "ADL Care" which includes Date, Resident Initial, Nail Care Provided, Employee Name, Barrier Cream Applied. If any employee fails to demonstrate competency in any of these areas they will be removed from the assignment and will be unable to give direct care to any resident until the Director of Nursing re-educates the nursing assistant and they have exhibited competency in these areas before they are returned to an assignment. INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY: After every employee has passed their competency in each area, the Director of Nursing, Clinical Service Nurse, and MDS Nurse will conduct random QA's of peri care and personal care to ensure the certified nursing assistant's are following the facility's protocol. Two residents, three times a week for two months will be observed, then two residents, two times a week for one month, then one resident, one time a week for one month, and then as needed. This will be documented on the proper QA Forms developed.	

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F 312	Continued From page 4 (DON) stated it was her expectation for the care plan approaches to provide incontinence promptly, washing appropriately and apply protective skin barrier with each incontinence care, was washing the perineum front to back, or top to bottom and applying skin barrier cream every time they (NA) changed the resident. 1b. Record review revealed Resident # 16 was last admitted to the facility on 4/19/11 with a cumulative diagnosis of advanced dementia, diabetes mellitus, renal failure, hypertension, bradycardia, aphasia, dysphasia, anemia, hyperthyroidism and history of urinary tract infections. The last completed Minimum Data Set (MDS), dated 12/20/11 revealed the resident had long and short term memory loss, severe cognitive impairment, was incontinent of bowel and bladder and was dependent on staff for activities of daily living (ADLs) including personal hygiene. Resident # 16 ' s care plan, updated on 1/6/12, indicated the resident required total assistance for all ADLs and established a goal that the resident would be clean and well groomed as evidenced by visual inspection. Approaches included assist with shower or bath daily and check fingernails daily and clean if needed. On 3/21/12 at 8:42 am Nursing Assistant # 1 (NA # 1) was observed providing a bed bath for Resident # 16. Nursing Assistant # 2 (NA # 2) assisted with the bed bath by turning and	F 312	These audits will be taken to the QA Committee on a monthly basis by the Administrator for the Committee review. The QA Committee is responsible to ensure that correction is achieved and sustained.	

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F 312	Continued From page 5 positioning the resident. During the bath, both of the resident ' s hands were washed by NA # 1. The resident ' s nails were observed to be trimmed to extend approximately 1/8 inch beyond the end of each finger tip and the thumb, first and middle fingers of the right hand were observed to be soiled with dried, dark colored material under the nails. The nails were not cleaned and NA # 1 continued with the bed bath and washed the resident ' s thighs and lower legs next. During an interview on 3/21/12 at 9:15 am NA # 1 was asked if checking the fingernails and cleaning the fingernails if needed, was a routine and expected task to be completed with each bath or shower. NA # 1 stated cleaning under the nails was something that would normally be done. NA # 1 stated he did not see the dirt under the resident ' s fingernails. NA # 1 returned to the resident ' s hands and washed under the fingernails of the hands, cleaning away the dried, dark colored material under the thumb, first and middle fingers of the right hand with the corner of a washcloth. During an interview, on 3/21/12 at 12:20 pm the DON stated it was her expectation for the care plan approach to check fingernails daily and clean if needed, the nursing assistant who provided the AM care (morning care) or bath, would check the nails daily and clean if needed.	F 312		

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	345140	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	04/12/2012

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K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III protected construction, one story with a complete automatic sprinkler system. The facility utilizes a NC Special Locking System.	K 000	THIS FACILITY'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW.	
K 025 SS=E	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 the observations and staff interviews on 4/12/2012 the following item was observed as noncompliant, the specific findings include: There were unsealed penetrations in the rated smoke wall in the attic area leading to the "East" hallway as you enter that space from the access door in the dining room. CFR#: 42 CFR 483.70 (a)	K 025	• K 025 ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The unsealed penetrations in the raged smoke wall in the attic area leading to the East hallway as you enter the space from the access door in the dinning room have been sealed. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Any resident has the ability to be affected by the cited practice. The unsealed penetrations have been sealed. The attic for the other hall has been inspected to determine if other unsealed penetrations exist. None were found. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: The attic area has been inspected to determine if other unsealed penetrations exist. None were found.	4-12-12
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Adm (X6) DATE: 4-24-12

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.

In the future for any repairs or installations involving smoke walls the Maintenance Supervisor will inspect the walls to ensure that unsealed penetrations are not left. All penetrations will be sealed by the Maintenance Supervisor.

On a quarterly basis the Maintenance Supervisor will inspect all areas in the building for unsealed penetrations. If any found the Maintenance Supervisor will repair at that time and document on a log

INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY:

In the future for any repairs or installations involving smoke walls the Maintenance Supervisor will inspect the walls to ensure that unsealed penetrations are not left. All penetrations will be sealed by the Maintenance Supervisor.

The Administrator will present the Maintenance Supervisor log to the QA committee on a quarterly basis. If no issues after fourth quarter it will be monitored on an annual basis.

The QA committee will be responsible to ensure compliance is achieved and sustained.

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K 038	Continued From page 1 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: Based on the observations and staff interviews on 4/12/2012 the following item was observed as noncompliant, the specific findings include: The required exit from the dietary area leading to the outside near the managers office had a working dead bolt attached. This dead bolt did not work in unison with the other door hardware. This condition requires more than one motion to exit at that location. CFR#: 42 CFR 483.70 (a)	K 038	THIS FACILITY'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW. • K 038 ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The required exit from the dietary area leading to the outside near the managers office had a dead bolt which now all internal parts have been removed from dead bolt. Allowing this exit to be readily accessible at all times. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Any resident has the ability to be affected by the cited practice. The internal parts that were on the dead bolt have been removed allowing this exit to be readily accessible. The other exit doors in the facility have been inspected to determine if any other exits are not readily accessible. None were found.	4-12-12
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by:	K 052		

MCst

ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR:

On a quarterly basis the Maintenance Supervisor will inspect all doors and document on a log that all doors are readily accessible. If any found the Maintenance Supervisor will repair at that time and document on a log.

INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY:

The Maintenance Supervisor will be responsible for ensuring that all exit doors in the facility are readily accessible at all times.

The Administrator will present the Maintenance Supervisor log to the QA committee on a quarterly basis. If no issues after the fourth quarter it will be monitored on an annual basis.

The QA committee will be responsible to ensure compliance is achieved and sustained.

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BRIGHTMOOR NURSING CENTER	610 WEST FISHER STREET SALISBURY, NC 28145

(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
K 052	Continued From page 2 Based on the observations and staff interviews on 4/12/2012 the following item was observed as noncompliant, the specific findings include: The sampling tubes for the duct detector nearest to the boiler did not have its sampling tube holes in the direction of air flow. CFR#: 42 CFR 483.70 (a)	K 052	THIS FACILITY'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW. • K 052 ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The sampling tubes for the duct detector nearest the boiler have been changed and now have the sampling tube holes in the direction of air flow. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Any resident has the ability to be affected by the cited practice. The sampling tubes for the duct detector have been changed and the sampling tube holes are now in the direction of air flow. The building has been inspected to determine if any other sampling tubes for duct detectors are not in the direction of the air flow exist. None were found.	4-16-12

ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR:

The facility has been inspected to determine if other sampling tubes for duct detectors have the sampling tube holes in the direction of air flow exist. None were found.

The Maintenance Supervisor will inspect all sampling tubes for duct detectors on a quarterly basis to ensure all sampling tube holes are in the direction of air flow. If any found the Maintenance Supervisor will repair at time and document on a log.

INDICATE HOW THE FACILITY PLANS TO MONITOR ITS PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY:

The Maintenance Supervisor will be responsible for ensuring all sampling tubes for the duct detectors are in the direction of air flow.

The Administrator will present the Maintenance supervisor log to the QA committee on a quarterly basis. If no issues after fourth quarter it will be monitored on an annual basis.

The QA committee will be responsible to ensure compliance is achieved and sustained.