

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

PRINTED: 05/29/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345168	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GREENVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2910 MACGREGOR DOWNS GREENVILLE, NC 27834		
(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, record review and staff interviews, the facility failed to transcribe a doctor's order to the Medication Administration Record (MAR) correctly resulting in the failure to follow the order for 1 of 12 (Resident #74) sampled residents. Findings include: Resident #74 was admitted to the facility on 2/5/04 with cumulative diagnoses of anemia, hypertension and Alzheimer's disease. Resident #74's quarterly Minimum Data Set (MDS) dated 4/4/12 indicated that Resident #74 had short and long term memory problems and was severely impaired in daily decision making. Resident #74 was totally dependent on two people for toilet use and bed mobility. Resident #74 was always incontinent of bowel and bladder. In an observation of medication administration on 5/16/12 at 8:30 AM, Nurse #1 was observed administering sorbitol (a medication to help prevent constipation) 15 milliliters (ml) by mouth to Resident #74. Nurse #1 stated this medication was provided once each day to Resident #74. Medication reconciliation of Resident #74's Active Orders from 5/1/12 to 5/31/12 showed an order for sorbitol 70% solution by mouth once daily everyday; Give 15ml by mouth twice a day for	F 281	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F281 The Medication Administration Record for resident #74 was updated on 5/16/2012 by the Charge Nurse. The responsible party and the attending physician were notified by the Unit Manager on 5/16/2012 of the administered doses of Sorbitol. No new orders were received. No negative outcomes noted. An audit of all resident medication administration records was completed by the Director of Nursing Services, Assistant Director of Nursing, Director of Clinical Education, Unit Managers, and Treatment Nurses by 5/31/2012 to ensure written medication orders correlated with times designated on the medication administration record. Any resident medication administration record found to be affected had their attending physician and responsible party notified and their medication record updated.	6/19/12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE

Executive Director

(X6) DATE

6/6/12

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 281	Continued From page 1 constipation. A review of the May 2012 MAR showed that Resident #74 was receiving sorbitol only once each day even though the order clearly written on the MAR stated the medication was to be given twice each day.	F 281	All facility licensed nurses will be educated by the Director of Clinical Education regarding the medication administration process by 6/14/2012. The Director of Nursing Services, Assistant Director of Nursing Services, Director of Clinical Education and/or the Unit Managers will audit all newly admitted orders to ensure written orders correlate with times assigned to medications. This audit will be conducted daily, five days per week for four weeks, then three times per week for four weeks, then once weekly for four weeks. The results of this audit will be reviewed by and brought to the Quality Assessment and Assurance Committee Meeting by the Director of Nursing Services. Any issues or trends identified will be addressed by the Quality Assurance Committee as they arise and the plan will be revised as needed to ensure continued compliance.	
	In an interview on 5/16/12 at 9:30 AM with Nurse #1, she stated that she had given the medication everyday. On review of the MAR she read the order and stated the medication should have been given twice each day. She stated the scheduled time next to the medication was for 8:00 AM but that there was no scheduled time provided for the second dose of the sorbitol. She indicated that by the signatures on the MAR the sorbitol had only been given once each day instead of twice as ordered. In an interview on 5/17/12 at 10:25 AM with Nurse #1, she indicated that the MAR's were auto-cycled (not re-entered every month). She stated the second dose of sorbitol was missed due to the failure of the nurses to read down to the end of the order. In an interview on 5/17/12 at 11:52 AM with the Nurse Educator, she stated that the nurse administering medications should have read the order all the way through and should not have based medication administration strictly by the administration time written on the MAR. She indicated that the order had not been keyed into the computer correctly which resulted in Resident #74 not receiving her medication as ordered. In an interview on 5/17/12 at 11:57 AM with the			

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F 281	Continued From page 2 Director of Nursing (DON), she stated it was her expectation that the nurses would read the complete order and administer the medications as ordered. In an interview on 5/17/12 at 2:30 PM with the 3-11 Nurse Supervisor, she indicated that she had keyed in Resident #74's order for sorbitol incorrectly which had caused the error to occur. She stated that the narrative portion of the order and the administration times were keyed separately. She indicated that instead of keying in twice each day as ordered she had keyed in every day. She stated that by not giving the sorbitol as ordered, Resident #74 could have become constipated or developed a bowel obstruction.	F 281			
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to ensure a gastrostomy tube was checked for placement prior to medication administration for 1 (Resident #95) of 1 residents with a gastrostomy tube observed during medication pass. Findings	F 322	F322 Resident #95 was assessed by the Director of Nursing Services on 05/16/2012. Nurse #4 was immediately inserviced on the facility policy and procedure for enteral nutritional therapy and verbalized understanding. A skills validation was completed for nurse #4 by the Director of Clinical Education on 05/17/2012 to ensure the policy was followed. An inservice for all licensed nurses will be conducted regarding the policy and procedure for enteral nutritional therapy with specific emphasis on verification of placement prior to administration of medications. This inservicing will be completed by 6/14/2012.	6/14/12	

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F 322	Continued From page 3 Include: Review of the facility procedure #385, dated 2006, entitled ENTERAL NUTRITIONAL THERAPY under the section Procedure read in part: "#3. Remove plug from end of feeding tube, check position of tube, and attach barrel of syringe to end of tubing." During a medication pass observation on 05/16/12 at 8:20 AM, after Nurse #4 prepared medications to be administered via a gastrostomy tube for Resident #95, Nurse #4 went into the room and picked up a syringe from the bedside table and removed the plunger from the syringe, then removed the plug from the gastrostomy tube and placed the barrel of the syringe in the tube. Nurse #4 proceeded to pour approximately 30 milliliters of water down the tube followed by the prepared medications. In an interview with Nurse #4 on 05/16/12 at 11:00 AM, Nurse #4 said she usually checked the gastrostomy tube for placement or residual. (Procedure done by inserting the barrel of the syringe with the plunger into the tubing and pulling the plunger out to check for stomach contents for tube placement.) Nurse #4 said she did not check Resident #95's gastrostomy tube for placement prior to the administration of medication because she had been nervous. During an interview with the Director of Nurses (DON) on 05/17/12 at 12:30 PM, she said it was her expectation each nurse would check a gastrostomy tube placement by listening with a stethoscope or checking for residual prior to medication administration.	F 322	The Director of Nursing Services, Assistant Director of Nursing Services, Director of Clinical Education, and/or Unit Managers will conduct random observation audits of nurses administering via gastric tubes to ensure compliance with the facility policy and procedure. This audit will be conducted three times per week for four weeks, then weekly for two months. The results of this audit will be reviewed by and brought to the Quality Assessment and Assurance Committee Meeting by the Director of Nursing Services. Any issues or trends identified will be addressed by the Quality Assessment and Assurance Committee as they arise and the plan will be revised as needed to ensure continued compliance.		

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F 329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and pharmacist and staff interviews, the facility failed to clarify an as needed (prn) Haldol order which resulted in a resident receiving Haldol twice daily for 1 of 10 (Resident #173) sampled residents whose medications were reviewed for unnecessary medications. Based on observations, record review, and staff interview, the facility also failed</p>	F 329	<p>F 329</p> <p>The responsible party and attending physician were notified of the administered doses of the Haldol for resident #173. An order was received by the charge nurse from the attending physician on 5/16/2012 changing the dose frequency to twice daily as needed.</p> <p>The responsible party and attending physician were notified of the administered doses of Ativan for resident # 27. New orders were received increasing the dose to 0.5mg twice daily.</p> <p>An audit of all medication related pharmacy recommendations was conducted by the Director of Nursing Services, Assistant Director of Nursing Services, Director of Clinical Education, Unit Managers, and Nursing Supervisors for the previous thirty days to ensure that there were no outstanding recommendations with needed follow up. No other residents were found to be affected. A Medication Administration Record to Medication Card audit was conducted by the Director of Nursing Services, Assistant Director of Nursing Services, Unit Managers, and Nursing Supervisor on 06/10/2012 to ensure that the ordered medication amount was the amount supplied and administered.</p>	6/14/12

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F 329	<p>Continued From page 5</p> <p>to prevent 1 (Resident #27) of 10 sampled residents reviewed for unnecessary medications from receiving an excessive dose of medication. Findings include:</p> <p>1. Resident #173 was admitted to the facility on 2/24/09 with cumulative diagnoses of dementia, anxiety disorder and psychotic disorder.</p> <p>Resident #173's Quarterly Minimum Data Set (MDS) dated 4/04/12 indicated that Resident #173 had short and long term memory problems and was moderately impaired in daily decision making. Resident #173 did not reject care or have any behavioral symptoms.</p> <p>Review of the Physician's Active Orders for April 2012 and May 2012 revealed an order for Haloperidol (Haldol) 0.5 milligrams (mg) by mouth twice each day. The start date for this order was 7/14/11.</p> <p>A review of the Medication Administration Records for March 2012 and April 2012 indicated that Haldol was administered twice each day. A review of the Medication Administration Record for May indicated the Haldol had been given twice each day through May 17.</p> <p>A review of the pharmacy recommendation from the consultant pharmacist, dated 3/21/12, indicated the pharmacist was aware of the twice daily Haldol order for Resident #173 and he was recommending the drug be discontinued due to duplicate antipsychotic therapy. It was noted at the bottom of the request that the physician had responded on 3/28/12 with "Haldol is only prn (as needed for) agitation." The recommendation was</p>	F 329	<p>The consultant pharmacists was educated by the Director of Nursing Services on ensuring the Executive Director, Medical Director, and Director of Nursing Services were made aware of outstanding recommendations with needed follow up. The Unit Managers, Assistant Director of Nursing Services and Director of Clinical Education were inserviced by the Director of Nursing Services on ensuring follow up on outstanding pharmacy recommendations. All facility licensed nurses will be educated by the Director of Clinical Education regarding the medication administration process by 6/14/2012.</p> <p>An audit of pharmacy recommendations for changes in medication administration frequency will be reviewed by the Director of Nursing Services or Assistant Director of Nursing Services, Director of Clinical Education, or Unit Managers weekly for two months to ensure that recommendations with changes in administration frequency are communicated and updated on the medication administration record. An audit of medication administration records will be conducted by the Director of Nursing Services or Assistant Director of</p>	

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F 329	<p>Continued From page 6</p> <p>signed by the physician. The response was received via fax by the facility on 03/29/12.</p> <p>It was noted that on 3/30/12, Nurse #2 had refaxed the 3/21/12 pharmacy recommendallon back to the physician for clarification. Nurse #2 indicated on the recommendation that she had "refaxed to physician for clarification. Patient is still on scheduled Haldol."</p> <p>During an observallon on 5/17/12 at 8:22 AM, Resident #173 was sitting in the dining room in a chair waiting calmly for breakfast.</p> <p>In an interview on 5/17/12 at 9:20 AM with Nurse #4, she stated Resident #173 wandered the hallways and was not lethargic.</p> <p>In an interview on 5/17/12 at 9:45 AM with Resident #173's physician's office nurse, she indicated that the physician stated Resident #173's Haldol was supposed to be as needed with a maximum dose of twice daily. She stated the physician did not want Resident #173's Haldol to be scheduled twice daily and expected it to be administered only as needed.</p> <p>In an interview on 5/17/12 at 10:30 AM with Nurse #2, she indicated that she was responsible for the pharmacist recommendallons. She stated that the process was for the consultant pharmacist to provide his recommendations to the facility. The recommendallons were then reviewed by the medical director, Director of Nursing (DON) and the Administrator. The recommendallons were then faxed to the physicians. Nurse #2 stated that the physicians would agree or disagree with the recommendallons or write a narrative note with</p>	F 329	<p>Nursing Services, Director of Clinical Education, or Unit Managers to ensure the prescribed drug amount correlates with the available amount on the medication cart. These audits will be conducted once per week for two months.</p> <p>The results of these audits will be reviewed by and brought to the Quality Assessment and Assurance Committee Meeting by the Director of Nursing Services. Any issues or trends identified will be addressed by the Quality Assessment and Assurance Committee as they arise and the plan will be revised as needed to ensure continued compliance.</p>		

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F 329	<p>Continued From page 7</p> <p>their own changes, sign it, and fax it back to the facility. She indicated that once signed by the physician and received by the facility, the recommendations were considered to be physician orders. She stated that if a clarification was needed, she would fax the recommendation back to the physician and make a notation in the resident's chart. She stated she followed-up on all medication clarifications within 1 week. Nurse #2 reported that she had been unable to locate any documentation as to the clarification for the Haldol order or provide any information that anyone had followed up on the request. She stated that she did not know what had happened.</p> <p>In an interview on 5/17/12 at 11:15 AM with the consultant pharmacist, he stated that he felt Resident #173 was being over medicated with the twice daily doses of Haldol. When questioned if he ever followed up directly with the physician, he responded that he depended upon nursing staff to follow-up on his recommendations and that he had not followed-up with the physician.</p> <p>In an interview on 5/17/12 at 11:52 AM with the Nurse Educator, she indicated that when a clarification of an order was needed the nurse would phone or fax the physician. She stated that the nursing staff was taught that if they had not received a response from the physician by 5:00 PM the day the fax was sent, they were to contact the physician's office the next morning and every following day until they received a response.</p> <p>In an interview on 5/17/12 at 11:57 AM with the DON, she stated that it was her expectation that the nurse in charge of the pharmacist recommendations would follow-up on any</p>	F 329		

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F 329	Continued From page 8 clarifications that were needed. She indicated that she also expected the consultant pharmacist to tell her if a clarification on a recommendation he had made had not been received.	F 329			
	<p>2. Resident #27 was readmitted to the facility on 04/27/12 with cumulative diagnoses of episodic mood disorder, senile dementia, anxiety, depressive disorder, peripheral neuropathy, cerebral vascular accident, and hypertension.</p> <p>A significant change Minimum Data Set (MDS) assessment completed on 05/04/12 documented Resident #27 as having had moderate cognitive impairment and no behaviors.</p> <p>A hospital discharge sheet, dated 04/27/12, for Resident #27 under Medications listed Lorazepam (Ativan) (medication to treat anxiety) 0.5 mg (milligrams) take 0.25 mg po daily.</p> <p>A physician's admission order sheet on Resident #27 dated 04/27/12, listed Ativan 0.25 mg po daily under the Medication and Treatment section.</p> <p>Review of Resident #27's Medication Administration Records (MAR's) for April 2012 and May 2012 listed Ativan (Lorazepam) Dose: 0.25 mg po daily. Boxes for 04/28/12 through 05/15/12 were initialed at 8:00 AM. (Initials in the blocks indicated medication was administered.)</p> <p>Review of a Controlled Drug Record for Resident #27 had handwritten Lorazepam (Ativan) 0.5 q (every) day prn (as necessary) anxiety and</p>				

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F 329	<p>Continued From page 9</p> <p>Indicated 60 tablets. From 04/28/12 until 05/15/12, it was noted 1 tablet was signed out for each day at 9:00 AM.</p> <p>On 05/16/12 at 9:45 AM, as Nurse #3 prepared medcations to be administered to Resident #27, the label on Resident #27's medication card read: TAKE 1 TABLET BY MOUTH TWICE DAILY HOLD IF DROWSY Ativan 0.5 mg. There were 10 small white pills observed in the slots on the card. Nurse #1 said the pharmacy usually cut the pills in half as the dosage on Resident #27's MAR was 0.25 mg. On further examination of the medication card, Nurse #1 said she would have to check with the pharmacy as the pills in the card were not halved and the dosage of the pills was 0.5mg. Nurse #3 said when Resident #27 came back from the hospital his previous medcations that were dispensed by a private pharmacy had been placed back into the medication cart and new medications had not been dispensed by the pharmacy. Nurse #3 said a copy of the admssion physclian's orders was faxed to the private pharmacy.</p> <p>In an interview with Nurse #2 on 05/16/12 at 10:47 AM, she said she had called the pharmacy that dispensed the medcation for Resident #27 and had been told they did not have 0.25 mg of Ativan in stock and the 0.5mg dosage pills were too small to cut as they would crumble. Nurse #2 said she had placed a call to Resident #27's physician to nollify him that Resident #27 had received the incorrect dosage of the medication from 04/27/12 until 05/15/12 and for clarification of the dosage order.</p> <p>At 11:25 AM on 05/16/12, in an interview Nurse</p>	F 329			

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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 329	<p>Continued From page 10</p> <p>#3 said she had signed out and administered 0.5 mg dosage to Resident #27 on ten occasions where she had signed the Controlled Drug Record and MAR for Resident #27.</p> <p>An observation of Resident #27 was made on 05/17/12 at 8:25 AM. Resident #27 was sitting in a wheelchair alert and verbally responsive. Resident #27 said he had slept well and felt good today.</p> <p>In another interview with Nurse #3 on 05/17/12 at 8:35 AM, Nurse #3 said Resident #27 had several changes in his Ativan order prior to his discharge to the hospital. Nurse #3 said since Resident #27's medications were filled by a private pharmacy, when he had been readmitted his medications were put back in the medication cart and the change in the dosage of Ativan should have clarified and the pharmacy and physician notified at that time. Nurse #3 said Resident #27's mental status varies day to day where he is more alert on some days. Nurse #3 said she had not thought there had been any changes in Resident #27's mental status since his readmission to the facility.</p> <p>During an interview with the Director of Nurses (DON) on 05/17/12 at 12:15 PM, she said her expectation was for each nurse to have read the entire medication entry on the MAR's and to have checked the dosage of the dispensed medication against what was ordered for each medication. The DON said the discrepancy should have been picked up when Resident #27 had been readmitted and the pharmacy notified immediately of the wrong dosage. The DON said medication error forms would be completed by</p>	F 329			

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

PRINTED: 05/29/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345168	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GREENVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2010 MAGGREGOR DOWNS GREENVILLE, NC 27834		
(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)	(X6) COMPLETION DATE	
F 329	Continued From page 11 the nurses who administered the incorrect dosage to Resident #27.	F 329			

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

RECEIVED
PRINTED: 06/01/2012
FORM APPROVED
OMB NO: 0938-0391
JUN 12 2 00 PM
CONSTRUCTION SERVICES
DATE SURVEY COMPLETED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345168	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - NEW 152 BED FACILITY - B. WING _____
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NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - GREENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2910 MACGREGOR DOWNS GREENVILLE, NC 27834
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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)	(X6) COMPLETE DATE
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K 076 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.</p> <p>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</p> <p>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 18.3.2.4</p> <p>This STANDARD is not met as evidenced by: 42 CFR 483.70 By observation on 5/31/12 at approximately noon the full and empty oxygen cylinders were stored together. If stored within the same enclosure, empty cylinders shall be segregated and designated (with signage) from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. [NFPA 99 4-3.5.2.2b(2)] (main oxygen storage on service hall)</p>	K 076	<p>K-076</p> <p><u>Criteria 1</u> This issue will be corrected by 6/17/2012. Additional metal storage racks have been ordered, and will be installed upon receipt.</p> <p><u>Criteria 2</u> The maintenance director, assistant maintenance director, and Executive Director will monitor oxygen storage for compliance on daily rounds.</p> <p><u>Criteria 3</u> The maintenance director will report any oxygen storage issues to the Executive Director for follow up. The Executive Director will ensure appropriate action is taken to ensure compliance.</p> <p><u>Criteria 4</u> The maintenance director will report any compliance issues in the monthly Quality Assurance (QA) Committee. The Committee will make recommendations as needed. The Executive Director is responsible for overall compliance.</p>	6/17
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 6/19/12
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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 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 15 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.