| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345284 | A. BUILDING _____ B. WING _____ | C 06/21/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE OAKS | 901 BETHESDA RD WINSTON SALEM, NC 27103 |

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| F 164 SS=D | 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS<br><br>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews and record reviews, the facility failed to provide privacy for 2 of 3 residents during wound care(Resident #39 and #257). The findings included: | F 164 | **The statements made on this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies.**<br><br>**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 Plan of Correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.**<br><br>**483.10 (e), 483.75(I)(4) Personal Privacy/Confidentiality of Records**<br>**F Tag # 164**<br>**This requirement will be met as follows:**<br>**The facility has taken corrective action for the residents affected by this practice by:**<br>• Observation of Resident #39 & #257 on 06/22/12 has revealed that privacy has been maintained with wound treatment and care.<br>• Wound nurse was counseled and educated by DON on July 13, 2012.<br>• Observations of care on July 9, 2012 by SDC indicated privacy was provided by wound care nurse.<br>**The facility will take corrective action for those residents having the potential to affected by the same deficient practice:**<br>• Alert and oriented residents were interviewed on July 11-13, 2012 for any issues with privacy concerns during treatment and care.<br>• Residents expressed no concerns regarding privacy on these dates. | 07-13-12 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan Hallett — TITLE: Administrator — (X6) DATE: 07-13-12

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 164 | Continued From page 1<br><br>During an observation on 6/20/12 at 12:41PM, the wound care nurse(WCN) entered Resident #39 ' s room. Resident #39 was lying in bed under a blanket fully clothed. The privacy curtain was pulled all the way back to the wall and the blinds were open to the facility patio where 3 residents and staff were seated. The nurse pulled the blanket down to the resident ' s brief and the shirt up to the shoulder area exposing the resident ' s entire back to the view of the window. The windows in resident room were at seated wheelchair height.<br><br>The nurse was questioned about the facility practices for ensuring privacy during wound care. Nurse confirmed that the privacy curtain should have been pulled around the resident and the blind should have been closed before doing the wound care.<br><br>During an interview on 6/21/12 at 9:10AM, the Director of Nursing, Administrator both indicated that the expectation was that staff closed the resident ' s door, privacy curtain and blinds before any care was provided to ensure privacy.<br><br>During an interview on 6/21/12 at 12:23PM, the Staff Development Coordinator indicated the expectation would be that all staff followed the proper procedures for ensuring privacy during any type of care in accordance with facility policy.<br><br>2. During an observation on 6/20/12 at 12:50PM, wound care nurse entered Resident #257 ' s room. Resident# 257 was seated in a wheelchair. The privacy curtain was pulled back toward the wall and the blinds were open. Staff and residents | F 164 | **The following measures/systemic changes will be put in place to ensure that the deficient practice does not occur:**<br>• All nursing staff to include C N As and staff nurses were in-serviced by SDC by July 13, 2012 regarding providing privacy while administering personal care and treatments.<br>• Any in-house staff who did not receive in-service training will not be allowed to work until training is completed.<br>• This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.<br><br>**The facility will monitor its performance to ensure that solutions are achieved and sustained. The facility will evaluate the plan's effectiveness by:**<br>• Using the QA Survey Auditing Tool, privacy will be monitored by observing care and treatments on 2 residents daily Monday through Friday for two weeks then weekly for two months by SDC, Nurse Manager, or designee.<br>• Any immediate concerns will be brought to the DON or Administrator for appropriate action.<br>• Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. The Committee members will include at a minimum: Administrator, DON, SDC, Support Nurse, MDS nurses, Social Services, Dietary and other clinical team members as needed. | |

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| F 164 | Continued From page 2<br>were seated in the patio area in view of the resident window. The nurse was providing wound care to resident ' s heel. The windows in resident room were at seated wheelchair height.<br><br>The nurse was questioned about the facility practices for ensuring privacy during wound care. Nurse confirmed that the privacy curtain should have been pulled around the resident and the blind should have been closed before doing the wound care.<br><br>During an interview on 6/21/12 at 9:10AM, the Director of Nursing, Administrator both indicated that the expectation was that staff closed the resident ' s door, privacy curtain and blinds before any care was provided to ensure privacy.<br><br>During an interview on 6/21/12 at 12:23PM, the Staff Development Coordinator indicated the expectation would be that all staff followed the proper procedures for ensuring privacy during any type of care in accordance with facility policy. | F 164 | | |
| F 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced | F 371 | **483.35 (i) Food Procedure, Store/Prepare/Serve-Sanitary**<br>**F Tag # 371**<br>**This requirement will be met as follows:**<br>**The facility has taken corrective action for the residents affected by this practice by:**<br>• There were no residents identified in the 2567.<br>• All items identified as out of date or damaged were disposed of immediately. Other items identified were corrected by properly packaging and/or labeling with identifying information and a clear "use by date". Effected insulated domes and bottoms were removed from service. Storage rack for domes/bottoms was cleaned.<br>**The facility will take corrective action for those residents having the potential to affected by the same deficient practice:**<br>• All residents have the potential to be affected by this alleged practice. | 07-13-12 |

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| F 371 | Continued From page 3<br>by:<br>Based on observations, staff interviews, and record review, the facility failed to 1) remove 3 dented cans from the kitchen's dry-storage area, 2) failed to ensure food items in the one of one walk-in refrigerator were labeled when taken out of the original container and were discarded past the expiration date, and 3) failed to air-dry dome lids/insulated bottoms and stock them on a clean cart and clean racks.<br><br>Findings include:<br><br>During the initial tour of the kitchen's dry-storage area on 6/18/12 at 11:01 a.m., the following canned foods were damaged with significant dents at their rims and/or seals: 1 can of mandarins oranges, 1 can of pasta sauce, and 1 can of three-bean salad. They were observed stocked among and intermingled with undamaged canned products ready for resident use.<br><br>During the kitchen tour on 6/18/12 at 11:10 a.m., the following items were observed in one of one walk-in refrigerator: 1 bag of ravioli, 1 bag of frozen dinner rolls, 1 bag of hot dogs, a half deli-roll ham dated "use by 6/5/12," 1 large container of mustard dated "use by 5/8/12," 1 large container of Thousand Island dressing dated "use by 6/4/12" (as identified by the director of food services) that were unlabeled and expired.<br><br>During an interview on 6/20/12, the dietary manager indicated that the dietary aides were responsible for ensuring that foods are labelled | F 371 | **The following measures/systemic changes will be put in place to ensure that the deficient practice does not occur:**<br>• All cans will be inspected for damage on receipt and further inspection will occur per audit process. The kitchen manger will monitor for compliance.<br>• Ravioli, frozen dinner rolls, hot dogs, deli ham, mustard, salad dressing and like products will be labeled with identification of contents.<br>• All foods will be used or disposed on or before expiration date.<br>• Insulated dome lids and insulated bottoms will be allowed to air dry and will be inspected for food debris prior to stacking. Storage racks for these items will be cleaned daily.<br>• Long term plans include purchasing new storage racks.<br>• An audit process will be implemented to ensure compliance. An in-service developed and approved by the Registered Dietitian/CDM will be presented by the CDM beginning July 9-13, 2012 for all Food Service staff including the Kitchen Manager, Kitchen Supervisors, Cooks and Dietary Aids.<br>• This information has been integrated into the standard orientation training and will be included in the Kitchen survey that is conducted by the Regional Food Service Manager or designee.<br>• Any dietary staff who did not receive in-service training will not be allowed to work until training is completed. | |

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| F 371 | Continued From page 4<br>and dated as to when they are opened and when they should be used by before they are returned to the refrigerator/freezer.<br><br>During kitchen observation on 6/18/12 at 11:10 a.m., 31 domed lids and 45 insulated bottoms were observed stacked on top of each other, wet or with food debris.<br><br>During tray line observation on 6/20/12, at 11:08 a.m., 20 domed lids were observed wet or with food particles on them, and 22 domed lids were observed on the drying rack with food particles (the lids were identified by the dietay manager as clean and ready to be used. The rack the domed lids were on and the cart had dried-up black and yellow matter on them.<br><br>During an interview on 6/20/12 at 11:12 a.m. with the dietary manger, she indicated that the expectation is that the dietary aides who stack the dishes should check all the dishes for left-over food debris before stacking items on drying racks or in the drying area. The person assigned to check the stock or has retrieved food should label and date the foods before returning them to the refrigerator or freezer. Staff (7 staff members on duty between breakfast and lunch) have been informed and in-serviced on the expectations of the kitchen.<br><br>During an interview on 6/21/12 on 9:10 a.m., the administrator indicated that the expectation was that the dietary manager ensures that all sanitary conditions in the kitchen are maintained, that foods are labeled and dated, that dishes was cleaned and dried without food and debris, and that any broken dishes should be discarded. | F 371 | **The facility will monitor its performance to ensure that solutions are achieved and sustained. The facility will evaluate the plan's effectiveness by:**<br>**This requirement will be met as follows:**<br>• Using the QA Survey Auditing Tool, compliance will be monitored by inspection for dented cans, proper labeling, dating, and expiration of items, and that lids/insulated bottoms are dry/free of food debris. Audits will be conducted four times weekly for two weeks then weekly for two months by Dietary Manager or designee.<br>• Any immediate concerns will be brought to the Dietary Manager, DON or Administrator for appropriate action.<br>• Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. The Committee members will include at a minimum: Administrator, DON, SDC, Support Nurse, MDS nurses, Social Services, Dietary and other clinical team members as needed. | |

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| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | F 441 | **483.65 Infection Control, Prevent Spread, Linens**<br>**F Tag # 441**<br>**This requirement will be met as follows:**<br>**The facility has taken corrective action for the residents affected by this practice by:**<br>• Resident #39 has had no ill effect and all wounds are documented without signs and symptoms of infection. Resident #257 is no longer a resident in the facility.<br>• Wound Care Nurse was counseled and educated by DON on wound care procedure and infection control on July 13, 2012. Observations of wound care on July 9, 2012 by SDC for technique to ensure compliance with all infection control practices during treatments.<br>**The facility will take corrective action for those residents having the potential to affected by the same deficient practice:**<br>• All residents have the potential to be affected by this alleged practice. Residents with wounds were assessed on July 13, 2012 by the Nurse Practioner with Physicians Eldercare and have no signs or symptoms of infection. | 07-13-12 |

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| F 441 | Continued From page 6<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, staff interview and record review, the facility failed to the facility failed to wash hands before, and after wound care, the facility failed to clean environmental surfaces and equipment before and after wound care was provided for 2 of 3 sampled residents receiving wound care(Resident #39 and #257).<br><br>The findings included:<br><br>Review of the policy titled " General guidelines for Dressing Procedures " dated 3/10 read in part: section: General guidelines for infection control included #1 observe(standard) universal precautions or other infection control standards as approved appropriate committee. 2. wash hands before and after all procedures. Wear gloves when appropriate and 7. thoroughly clean all equipment used and return to appropriate storage area. Hand hygiene procedures dated 3/1/04, read in part; wash hands before performing dressing care or touching wounds of any kind, after handling used dressings and after handling items potentially contaminated with any resident ' s blood, secretions or excretions. Section noted gloves: if gloves are worn for a procedure, hand hygiene is to be completed before putting on gloves and after removal and deposit of gloves in appropriate container. The use of gloves does not replace hand hygiene.<br><br>1. During an observation on 6/20/12 at 12:41PM, the wound care nurse(WCN) pulled the treatment cart to the side of the resident room door before entering. Nurse did not use the hand sanitizer | F 441 | <u>The following measures/systemic changes will be put in place to ensure that the deficient practice does not occur:</u><br>• An in-service was provided for all nurses and wound care C N A II on dressing change technique, and infection control. Training included use of gloves, hand washing, preparation of a clean surface for dressing material and equipment, positioning of the resident so wound surface remain free from contaminated surfaces during treatment procedure. In-services were conducted by SDC and completed by July 13, 2012.<br>• Any in-house nursing staff or wound care C N A IIs who did not receive in-service training will not be allowed to work until training is completed.<br>• This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.<br>• SDC will conduct and complete a Nurses Skills Check List to include wound and skin care demonstration on orientation and annually. C N A II who provide wound care will also have to demonstrate competency on orientation and annually. Any identified concerns with infection control technique will be reported to the DON for appropriate action and follow up. | |

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| F 441 | Continued From page 7<br>located on the side of the nursing cart, nor did the nurse wash her hands before entering Resident #39 room. Nurse removed Resident #39 treatment supplies from the cart and placed the supplies on the tray table. Nurse #1 did not clean the surface area before placing the supplies on the tray table. Nurse reached into her pocket which had several other items and pulled out a pair of black gloves. Nurse removed the bandage from the resident ' s back, the area was sprayed with the anti-septic spray, removed a pair of scissors from her pocket to cut the dressing, applied the hydrocolloid gel to the dressing and put the scissors back in her pocket. The gloves broke during the treatment and the hydrocolloid gel was on the nurse hand when the gloves broke. The dressing was placed on the tray table while the nurse replaced the broken gloves. Nurse did not use any hand sanitizer or wash hands before or after completing the treatment. Nurse exited Resident #39 room returned the 1st cart to treatment room proceeded to next resident and did not wash hands. Nurse went from room to room without washing hands.<br><br>During an observation on 6/20/12 at 12:50PM, wound care nurse entered Resident #257 ' s room. Resident# 257 was seated in a wheelchair. Nurse pulled treatment cart in front of resident #257 room. Nurse did not use the hand sanitizer located at the side of the cart nor did she wash her hands before initiating treatment to Resident #257. The nurse retrieved the needed supplies for the treatment and placed it on an un-cleaned tray table. Nurse reached into her pockets and put on a clean set of clear gloves and pulled the dressing from the resident's left heel. The heel of the resident was rested on the foot pedal with the | F 441 | **The facility will monitor its performance to ensure that solutions are achieved and sustained. The facility will evaluate the plan's effectiveness by:**<br>• Using the QA Survey Auditing Tool, wound care will be monitored by observing care and treatments on 2 residents daily Monday through Friday for two weeks then weekly for two months by SDC or Nurse Manager or designee.<br>• Any immediate concerns will be brought to the DON or Administrator for appropriate action.<br>• Compliance will be monitored and ongoing auditing program reviewed at the Weekly Quality of Life Meeting. The Committee members will include at a minimum: Administrator, DON, SDC, Support Nurse, MDS nurses, Social Services, Dietary and other clinical team members as needed. | |

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| F 441 | Continued From page 8<br>wound exposed with white edges and some slough in the center. and placed the heel back on the foot pedal that had dripping antiseptic spray on it. She obtain scissors from her pocket that she did not clean, a flash light and sharpie marker. She cut the santyl gauze with the scissors obtained from the pocket in 6 slits and dated. Nurse# placed the scissors back into her pocket without cleaning them.<br><br>Nurse confirmed that she placed the opened wound heel on the foot pedal of the wheelchair. She added that she would normally perform the treatment with the resident in the bed, but she was up in the wheelchair so went ahead and did the treatment in the position the resident was in. She did not clean the surface of the tray table before putting the treatment supplies on it and retrieved the scissors, marker and pen light from her pocket and did not clean the scissors before and after the care. She indicated she was unaware of the need to clean the surfaces or the scissors before treatment was provided.<br><br>During an interview on 6/21/12 at 9:10AM, the Director of Nursing and Administrator indicated the expectation would be that staff should wash their hands and/or used the hand sanitizer in between glove and dressing changes. DON indicated that the resident area should have been cleaned before treatment supplies was put on the surface. The nurse should clean the scissors before and after use when treating an open wound. DON and Administrator further stated that all staff should follow the infection control protocol for hand washing, disinfecting of surfaces and equipment used during wound care. | F 441 | | |

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| F 441 | Continued From page 9<br><br>During an interview on 6/21/12 at 12:23PM, the Staff Development Coordinator(SDC) indicated the expectation would be that all staff follow the facility policy/procedures for hand washing and infection control during wound care. | F 441 | | |

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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 |
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| K 000 | INITIAL COMMENTS<br><br>Surveyor: 02249<br>This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III(211) construction, one story, with a complete automatic sprinkler system.<br><br>The deficiencies determined during the survey are as follows: | K 000 | NFPA 101 Life Safety Code Standard<br>Tag # K 012<br>This requirement will be met as follows:<br>The facility has taken corrective action for the residents affected by this practice by:<br><br>The following was repaired to the smoke resisting roof/ceiling :<br>• Sealed the pipe penetrations in phone equipment room ceiling<br>• Holes fixed in ceiling of mechanical room beside room 300<br>• Holes fixed in ceiling of toilet beside 200 hall clerical station<br>• Holes fixed in ceiling of toilet near front entrance main nurses' station | 31<br>8-24-12 |
| K 012<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 02249<br>Based on observation, on July 12, 2012 at approximately 9:00am onward, the smoke resisting roof/ceiling is non compliant in the facility due to the following:<br><br>1. unsealed pipe penetrations in phone equipment room ceiling.<br><br>2. holes in ceiling of mechanical room beside room 300.<br><br>3. holes in ceiling of toilet beside 200 hall clerical station.<br><br>4. holes in ceiling of toilet near front entrance | K 012 | The facility will identify other life safety issues having the potential to affect residents by the same deficient practice:<br>• Assess all areas for holes or penetrations to the smoke resisting roof/ceiling<br>• Repair areas as needed<br><br>The following measures/systemic changes will be put in place to ensure that the deficient practice does not recur:<br>• Assess all areas for holes or penetrations to the smoke resisting roof/ceiling<br>• Repair areas as needed<br><br>The facility will monitor its performance to ensure that solutions are achieved and sustained. The facility will evaluate the plan's effectiveness by:<br>• Maintenance Director will monitor for compliance monthly for the smoke resisting roof/ceiling to meet standard during preventative maintenance rounds.<br>• Corrective action taken if not compliant.<br>• Report will be made to the Quality Assurance Committee on a monthly basis for next 2 months.. | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Susan Hollett | Administrator | 07-25-12 |

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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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345284 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/12/2012 |

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| K 012 | Continued From page 1<br>main nurse's station.<br><br>42 CFR 483.70(a) | K 012 | NFPA 101 Life Safety Code Standard<br>Tag # K 015<br>This requirement will be met as follows:<br>The facility has taken corrective action for the residents affected by this practice by:<br><br>The following was repaired:<br>• Ceiling re-painted in the medication preparation room at station 3.<br><br>The facility will identify other life safety issues having the potential to affect residents by the same deficient practice:<br>• All medication preparation rooms assessed for flaking paint and painted if needed.<br>• Other areas within facility assessed for flaking pain and painted if needed.<br>The following measures/systemic changes will be put in place to ensure that the deficient practice does not recur:<br>• All medication preparation rooms assessed for flaking paint and painted if needed.<br>• Other areas within facility assessed for flaking pain and painted if needed.<br>The facility will monitor its performance to ensure that solutions are achieved and sustained. The facility will evaluate the plan's effectiveness by:<br><br>• Maintenance Director will monitor for compliance by assessing areas monthly for compliance during preventative maintenance rounds.<br>• Corrective action taken if not compliant.<br>• Report will be made to the Quality Assurance Committee on a monthly basis for next 2 months. | 31<br>8-14-12 |
| K 015<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings, has a flame spread rating of Class A or Class B. (In fully sprinklered buildings, flame spread rating of Class A, Class B, or Class C may be continued in use within rooms separated in accordance with 19.3.6 from the access corridors.) 19.3.3.1, 19.3.3.2<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 02249<br>Based on observation, on July 12, 2012 at approximately 9:00am onward, there is flaking paint on the ceiling in the medication preparation room at station #3. | K 015 | | |
| K 051<br>SS=D | 42 CFR 483.70(a)<br>NFPA 101 LIFE SAFETY CODE STANDARD<br><br>A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of | K 051 | | |

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|---|---|---|---|
| | 345284 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 07/12/2012 |

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| K 051 | Continued From page 2<br>nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 02249<br>Based on observation, on July 12, 2012 at approximately 9:00am onward, the audible trouble signal did not resound with the main power breaker off to the fire alarm control panel after acknowledgement of signal by utilizing the trouble silence switch and then activating the control panel reset switch with the breaker remaining in the off position. | K 051 | NFPA 101 Life Safety Code Standard<br>Tag # K 051<br>This requirement will be met as follows:<br>The facility has taken corrective action for the residents affected by this practice by:<br>• The audible trouble signal repaired to sound.<br><br>The facility will identify other life safety issues having the potential to affect residents by the same deficient practice:<br>• Alarm will sound.<br>The following measures/systemic changes will be put in place to ensure that the deficient practice does not recur:<br>• Facility will continue required inspections related to the fire panel.<br>The facility will monitor its performance to ensure that solutions are achieved and sustained. The facility will evaluate the plan's effectiveness by:<br>• Maintenance Director will monitor for compliance by assessing audible trouble signal standard during monthly preventative maintenance rounds.<br>• Corrective action taken if not compliant.<br>• Report will be made to the Quality Assurance Committee on a monthly basis for next 2 months. | 31<br>8-24-12 |
| K 061<br>SS=D | 42 CFR 483.70(a)<br>NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 | K 061 | NFPA 101 Life Safety Code Standard<br>Tag # K 061<br>This requirement will be met as follows:<br>The facility has taken corrective action for the residents affected by this practice by:<br>• Audible tamper switch signal has a local alarm that sounds when valves are closed on the dry-pipe sprinkler riser located on 400 hall. | 31<br>8-24-12 |

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| K 061 | Continued From page 3<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 02249<br>Based on observation, on July 12, 2012 at approximately 9:00am onward, the audible tamper switch signal can be permanently silenced with the valve in the closed position - main valve for dry-pipe sprinkler riser located on 400 hall.<br><br>42 CFR 483.70(a) | K 061 | <u>The facility will identify other life safety issues having the potential to affect residents by the same deficient practice</u>:<br>• A local alarm will sound when valves are closed.<br><u>The following measures/systemic changes will be put in place to ensure that the deficient practice does not recur:</u><br>• Facility will continue required inspections related to the fire panel.<br><u>The facility will monitor its performance to ensure that solutions are achieved and sustained. The facility will evaluate the plan's effectiveness by:</u><br>• Maintenance Director will monitor for compliance by assessing local alarm sound standard during preventative maintenance rounds.<br>• Corrective action taken if not compliant.<br>• Report will be made to the Quality Assurance Committee on a monthly basis for next 2 months. | |
| K 062 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 02249<br>Based on observation, on July 12, 2012 at approximately 9:00am onward, the sprinkler system is not maintain in accordance with NFPA 25 due to the following:<br><br>1. there is paint on the heat sensitive element of sprinkler in the janitor's closet beside room 309.<br><br>2. there is paint on the heat sensitive element of sprinkler in the kitchen dishwash area.<br><br>3. the sprinkler inspection report dated 4/10/2012 by Simplex-Grinnell revealed the following deficiencies with no documents to demonstrate | K 062 | **NFPA 101 Life Safety Code Standard**<br>**Tag # K 62**<br>**This requirement will be met as follows:**<br><u>The facility has taken corrective action for the residents affected by this practice by:</u><br>• Paint removed from the heat sensitive element of the sprinkler head or replaced in janitor's closet beside room 309 and in the kitchen dishwash area.<br>• Items revealed on inspection report dated 04/10/12 will be resolved.<br><u>The facility will identify other life safety issues having the potential to affect residents by the same deficient practice</u>:<br>• All the heat sensitive element of the sprinkler heads throughout the facility assessed for compliance.<br>• Post indicator valve and valve below ground pit has audible signal when valves are closed.<br>• Water motor gong function tests by sprinkler company. | 8-24-12 |

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| K 062 | Continued From page 4<br>corrective action:<br><br>a. Post indicator valve did not sound an audible signal with the valve closed.<br><br>b. valves in below ground pit did not sound an audible alarm with the valves closed.<br><br>c. water motor gong did not function test by sprinkler company.<br><br>42 CFR 483.70(a) | K 062 | <u>The following measures/systemic changes will be put in place to ensure that the deficient practice does not recur:</u><br>• All the heat sensitive element of the sprinkler heads throughout the facility assessed for compliance.<br>• Post indicator valve and valve below ground pit has audible signal when valves are closed.<br>• Water motor gong function tests by sprinkler company.<br><br><u>The facility will monitor its performance to ensure that solutions are achieved and sustained. The facility will evaluate the plan's effectiveness by:</u> | |
| K 072<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>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<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 02249<br>Based on observation, on July 12, 2012 at approximately 9:00am onward, the means of egress is obstructed by furnishings and other objects in the following areas:<br><br>1. corridor in front of restorative care sunroom.<br><br>2. corridor area near business manager office - 400 hall area.<br><br>42 CFR 483.70(a) | K 072 | • Maintenance Director will monitor for compliance monthly by assessing that sprinkler heads meet standard during preventative maintenance rounds.<br>• Maintenance Director will assure that facility has documentation to demonstrate follow-up of inspection reports.<br>• Corrective action taken if not compliant.<br>• Report will be made to the Quality Assurance Committee on a monthly basis for next 2 months.<br><br>**NFPA 101 Life Safety Code Standard**<br>**Tag # K 072**<br>**This requirement will be met as follows:**<br><u>The facility has taken corrective action for the residents affected by this practice by:</u><br>• Furnishings and other objects removed from egress in corridor of restorative care sunroom and corridor of Business Office Manager.<br><u>The facility will identify other life safety issues having the potential to affect residents by the same deficient practice</u>:<br>• All means of egress assessed for obstruction and objects removed as needed.<br><u>The following measures/systemic changes will be put in place to ensure that the deficient practice does not recur:</u><br>• All means of egress assessed for obstruction and objects removed as needed. | 31<br>8-24-12 |
| K 076 | NFPA 101 LIFE SAFETY CODE STANDARD | K 076 | | |

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| K 076 SS=D | Continued From page 5<br><br>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.<br><br>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.<br><br>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 02249<br>Based on observation, on July 12, 2012 at approximately 9:00am onward, there is an unsupported oxygen cylinder on the countertop; in the medication preparation room near room 507.<br><br>42 CFR 483.70(a) | K 076 | <u>The facility will monitor its performance to ensure that solutions are achieved and sustained. The facility will evaluate the plan's effectiveness by:</u><br>• Maintenance Director will monitor for compliance by assessing obstruction of egress during preventative maintenance rounds.<br>• Corrective action taken if not compliant.<br>• Report will be made to the Quality Assurance Committee on a monthly basis for next 2 months.<br><br>NFPA 101 Life Safety Code Standard<br>Tag # K 076<br>This requirement will be met as follows:<br><u>The facility has taken corrective action for the residents affected by this practice by:</u><br>• Unsupported oxygen cylinder secured in the medication preparation room near room 507.<br><u>The facility will identify other life safety issues having the potential to affect residents by the same deficient practice:</u><br>• All oxygen cylinders assessed for proper storage.<br><u>The following measures/systemic changes will be put in place to ensure that the deficient practice does not recur:</u><br>• All oxygen cylinders assessed for proper storage. | 31<br>8-24-12 |
| K 147 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 02249<br>Based on observation, on July 12, 2012 at approximately 9:00am onward, electrical wiring and equipment is not in accordance with NFPA | K 147 | <u>The facility will monitor its performance to ensure that solutions are achieved and sustained. The facility will evaluate the plan's effectiveness by:</u><br>• Maintenance Director will monitor for compliance of oxygen cylinder storage during preventative maintenance rounds.<br>• Corrective action taken if not compliant.<br>• Report will be made to the Quality Assurance Committee on a monthly basis for next 2 months. | |

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| K 147 | Continued From page 6<br>70 due to the following:<br><br>1. liquid-tight flexible condult is disconnected from fitting on food disposal in dishwash area of kitchen.<br><br>2. no thirty minute load test documented for emergency generator from January through June 2012.<br><br>3. broken ground fault interrupter receptacle in central bath near room 200.<br><br>4. emergency power system required greater than ten seconds to restore power during loss of normal power to the automatic transfer switch of the essential electrical system. Approximately sixteen seconds elapsed prior to restoral of power.<br><br>5. generator power light did not function on the annunciator panel located behind the main nurse's station - during loss of normal power to the automatic transfer switch of the essential electrical system.<br><br>6. exposed incandescent light fixture above shelf in storage room - across hall from central bath on 400 hall.<br><br>42 CFR 483.70(a) | K 147 | NFPA 101 Life Safety Code Standard<br>Tag # K 147<br>This requirement will be met as follows:<br>The facility has taken corrective action for the residents affected by this practice by:<br>• Liquid-tight flexible conduit reconnected on fitting of food disposal in dishwasher area of kitchen<br>• Thirty minute load test documented July 30, 2012.<br>• Broken ground faulty interrupter receptacle in central bath near room 200 repaired.<br>• Emergency power system restores power within 10 seconds or less.<br>• Generator power light now functions on annunciator panel behind main nurse's station.<br>• Incandescent light fixture fixed above shelf in storage room across hall from central bath on 400 hall.<br>The facility will identify other life safety issues having the potential to affect residents by the same deficient practice:<br>• All electrical fittings/wiring assessed.<br>• Thirty minute load tests conducted monthly.<br>• All ground fault receptacles assessed for broken areas.<br>• Emergency power system checked monthly to assure power is restored to facility within 10 seconds or less.<br>• Generator power light checked for continued appropriate functioning.<br>• All incandescent light fixtures assessed for exposure. | 31<br>8-24-12 |

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| K 147 | Continued From page 6<br>70 due to the following:<br><br>1. liquid-tight flexible conduit is disconnected from fitting on food disposal in dishwash area of kitchen.<br><br>2. no thirty minute load test documented for emergency generator from January through June 2012.<br><br>3. broken ground fault interrupter receptacle in central bath near room 200.<br><br>4. emergency power system required greater than ten seconds to restore power during loss of normal power to the automatic transfer switch of the essential electrical system. Approximately sixteen seconds elapsed prior to restoral of power.<br><br>5. generator power light did not function on the annunciator panel located behind the main nurse's station - during loss of normal power to the automatic transfer switch of the essential electrical system.<br><br>6. exposed incandescent light fixture above shelf in storage room - across hall from central bath on 400 hall.<br><br>42 CFR 483.70(a) | K 147 | <u>The following measures/systemic changes will be put in place to ensure that the deficient practice does not recur:</u><br>• All electrical fittings/wiring assessed.<br>• Thirty minute load tests conducted monthly.<br>• All ground fault receptacles assessed for broken areas.<br>• Emergency power system checked monthly to assure power is restored to facility within 10 seconds or less.<br>• Generator power light checked for continued appropriate functioning.<br>• All incandescent light fixtures assessed for exposure.<br><br><u>The facility will monitor its performance to ensure that solutions are achieved and sustained. The facility will evaluate the plan's effectiveness by:</u><br>• Maintenance Director will monitor for compliance of electrical fittings, appropriate load test documentation, ground fault receptacles, appropriate timing of emergency power restoration, functioning of generator power light, and light fixtures.<br>• Corrective action taken if not compliant.<br>• Report will be made to the Quality Assurance Committee on a monthly basis for next 2 months. | |