STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345036	A. BUILDING _____ B. WING _____	08/23/2012

SEP 18 2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
W R WINSLOW MEMORIAL HOME	1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909

(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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a care plan to monitor the dialysis access site for 1 (Resident #58) of 1 resident receiving dialysis. Findings include: Resident #58 was admitted to the facility on 11/16/11. Cumulative diagnoses included end stage renal disease, hypertension and diabetes mellitus. Review of Resident 58 ' s quarterly Minimum	F 279	WR Winslow Memorial Home submits this Plan of Correction (PoC) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this PoC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services (CMS), the State of North Carolina or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. If the Provider meets the jurisdictional requirements, the Provider may be filing a request for an appeal before the U.S. Department of Health and Human Services Departmental Appeals Board to challenge the alleged deficiency cited in the HCFA-2567. Initially the Provider may exercise its limited rights to challenge the deficiency under the North Carolina Informal Dispute Resolution (IDR) process. **F279** On 8-22-12, a Care Plan was developed for Resident #58and placed on the chart and staff was in-serviced on how to assess the dialysis residents. Physician orders were written and transcribed to the medication administration record for documentation of dialysis access site.	09/20/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dawn Williams	Administrator	9-13-12

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 279	Continued From page 1 Data Set (MDS) assessment, dated 07/24/12, indicated the resident was alert and oriented, had no short or long term memory problems; and was capable of making decisions about her daily care. The assessment revealed Resident #58 was independent with bed mobility, transfers, walking in room and corridor, eating and toileting; required supervision with per hygiene and bathing; and, required extensive assistance with dressing. Resident # 58 was assessed to be receiving dialysis. Review of the Resident #58's care plan, updated 07/30/12, revealed no information on the care plan to monitor the resident ' s dialysis access site. An interview, on 08/22/12 at 5:00 PM, was conducted with the Director of Nursing (DON). The DON stated her expectations were that the nurses should be monitoring the dressing, the bruit, and the thrill of an access site for a resident on dialysis. An interview, on 08/23/12 at 12:15 PM, was conducted with Nurse #4 and she confirmed the care plan for Resident #58 had not included monitoring of the resident ' s dialysis shunt. Nurse #4 indicated during the survey there was a discussion related to checking the dialysis shunt for resident ' s receiving dialysis. She relayed that the residents on dialysis care plans were being reviewed to include the monitoring of the dialysis shunt.	F 279	Additional measures put into place to assure the same alleged deficient practice does not recur are as follows: An audit was completed of all other dialysis residents to ensure appropriate care plans were in place and physician orders were written and transcribed to the medication records for documentation of dialysis access sites. All licensed staff will be in-serviced on care plans, assessing and observing the dialysis access site for residents receiving dialysis. The Director of Nursing or designee will conduct random audits of all dialysis residents to ensure care plans are in place and licensed staff are monitoring and observing the dialysis resident's access site for bruit, thrill, bleeding, and signs of infection. These audits will be completed times three weeks, then monthly times three months. The results of these audits and any negative findings will be taken to the Quality Assessment Performance Improvement for review times 3 meetings and appropriate interventions will be implemented as needed	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 2	F 309		

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observations, record review and staff interviews, the facility failed to monitor the dialysis access site for 1 (Resident #58) of 1 resident receiving dialysis.
Findings include:

Resident #58 was admitted to the facility on 11/16/11. Cumulative diagnoses included end stage renal disease, hypertension and diabetes mellitus.

Review of Resident 58 ' s quarterly Minimum Data Set (MDS) assessment, dated 07/24/12, indicated the resident was alert and oriented, had no short or long term memory problems; and was capable of making decisions about her daily care. The assessment revealed Resident #58 was independent with bed mobility, transfers, walking in room and corridor, eating and toileting; required supervision with per hygiene and bathing; and, required extensive assistance with dressing. Resident # 58 was assessed to be receiving dialysis.

Review of the resident's care plan, updated on 07/30/12, revealed no information regarding the

F309

09/20/12

On 8-22-12, a communication record with the dialysis center and physicians' order was written and transcribed to the resident's medication administration record for Resident #58. The staff was in-serviced on how to monitor and observe the access site for dialysis residents.

Additional measures put into place to assure the same alleged deficient practice does not recur are as follows: An audit was completed of all other dialysis residents to ensure appropriate physician orders were written and transcribed to the medication records for documentation of monitoring and observing the dialysis access sites and a communication record in place for each resident.

All licensed staff will be in-serviced on monitoring and observing the dialysis access site for residents receiving dialysis and how to use the dialysis communication record.

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F 309	Continued From page 3 resident's dialysis access site. On 08/21/12 at 4:22 PM, during an interview with Resident #58, an observation was made of a dressing on the resident's right upper arm. The resident identified the dressing area as the area used when she went for dialysis three days a week. Review of the Medication Administration Record and the Treatment Administration Record for August 1-29, 2012 revealed no documentation for monitoring Resident #58's dialysis access site. Review of the Nursing Notes for August 1-29, 2012 revealed no documentation for monitoring Resident 58's dialysis access site. An interview, on 08/22/12 at 2:15 PM, was conducted with Nurse #3. Nurse #3 indicated Resident #58 returned from dialysis on the evening shift and that she had a dressing on her (right) arm for 24 hours. The nurse stated that the resident does have her blood sugar checked when she returned from dialysis. When asked if there were any measures needed when a resident on dialysis returned from dialysis, she indicated the nurses would need to be checking on the dressing. When asked about the bruit and thrill at the access site, the nurse indicated the resident had a dressing in place and that would make it difficult to assess. An interview, on 08/22/12 at 2:51 PM, was conducted with Nurse #2. Nurse #2 relayed when Resident #58 returned from dialysis she would have a dressing on her right arm for 24 hours and the nurses would observe the dressing site for	F 309	The Director of Nursing or designee will conduct random audits of all dialysis residents to ensure communication records are in place and in use and licensed staff are monitoring and observing the dialysis resident's access site for bruit, thrill, bleeding, and signs of infection. These audits will be completed times three weeks, then monthly times three months. The results of these audits and any negative findings will be taken to the Quality Assessment Performance Improvement for review times 3 meetings and appropriate interventions will be implemented as needed	

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F 309	Continued From page 4 bleeding and that an accucheck (blood sugar check) would also be done. The nurse indicated if the resident would complain of a headache or was dizzy, the staff would take the resident ' s blood pressure at that time. When asked if there were any other observations made, she indicated the resident was alert and oriented and would be able to let the nurses know if anything was wrong. An interview, on 08/29/12 at 5:00 PM, was conducted with the Director of Nursing (DON). The DON stated her expectations were that the nurses should be checking the dressing, the bruit, and the thrill for a resident on dialysis.	F 309		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based upon observations, staff interviews and record reviews the facility failed to do the following: 1. Maintain dish machine temperatures at or above 150 degrees fahrenheit for the wash cycle and at or above 180 degrees fahrenheit for the rinse cycle, 2. Label and date opened food products and 3. Maintain milk temperatures at or below 41 degrees fahrenheit.	F 371	F371 1. Repair services for the dish machine were called into the company on August 20, 2012, notifying them of the machine was not maintaining temperatures at or above 150 degrees Fahrenheit for the wash cycle and at or above 180 degrees Fahrenheit for the rinse cycle. The repairman worked on the machine August 21 & 22, 2012 after which the wash cycle and rinse cycle temperatures all reached at least the minimum standard. Repair service requests were called again on August 23, 2012 after noticing the rinse cycle not reaching minimum standard temperatures. He performed repairs on the machine on August 23, 2012 after which temperatures once again reached at least minimum standard temperatures.	09/20/12

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F 371	Continued From page 5 Findings include: 1. An initial kitchen tour was conducted with the Dietary Manager (DM) on 8/20/12 at 1:22 pm revealed the dish machine had a set of dishes running through the machine. The wash cycle temperature reading was 145 degrees. An observation on 8/23/12 at 8:31 am revealed a set of meal trays was running through the dish machine. The rinse cycle temperature reading was 158 degrees fahrenheit and the rinse cycle temperature reading was 120 degrees fahrenheit. An interview with Dietary Aide #1 on 8/23/12 at 8:34 am revealed the dish machine was in operation this morning and had reached 180 degrees fahrenheit for the rinse cycle. An observation on 8/23/12 at 8:36 am revealed the same set of meal trays were placed through the dish machine on a second occasion. The wash cycle temperature reading was 150 degrees fahrenheit and the rinse cycle temperature reading was 129 degrees fahrenheit. A record review of the facility dish machine temperature logs was conducted from March 2012 to August 2012. The following was found: 1. The temperature log sheet indicated to record temperatures once during each meal period. The temperature requirements were indicated to be 160 degrees fahrenheit for the wash cycle and 180 degrees fahrenheit for the rinse cycle. 2. The August temperature log revealed wash	F 371	Additional measures put into place to assure the same alleged deficient practice does not recur are as follows: Additional repairs performed on September 10 and 11 after which machine maintained temperatures according to standards. A new dish machine was ordered for purchase due to multiple repairs of old machine. An in-service on monitoring the wash and rinse cycle temperatures was conducted by the Dietary Manager for all Dietary Staff beginning August 24, 2012 regarding the importance of temperatures being at a certain degree, the expectation of monitoring them and what to do if the temperatures do not meet minimum standards. The Dietary Aide putting the dishes in the machine will monitor and log the temperatures daily. Any temperatures not at the minimum standards will be reported to the Dietary Manager and Maintenance Department for repair. The Dietary Management or designee will view the log daily and randomly monitor the dish machine twice a week times three weeks, then monthly. Any temperatures not at the minimum standards will be reported to the Maintenance Department for repair. Random monitoring audits will be conducted once a week times three weeks then monthly times three months by the Administrator or designee to ensure temperature logs are being maintained and that dish machine temperatures are at least reaching the minimum standards.	

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F 371	Continued From page 6 cycle temperatures at 123, 125, 130, 140 and 150 degrees fahrenheit throughout the month. There were five days undocumented for dish temperatures. 3. The July temperature log revealed the wash cycle temperatures at 125 and 140 degrees most days. There was a rinse cycle temperature at 160 degree fahrenheit for nine days. There were also nine days undocumented for dish temperatures. There was no final rinse temperatures recorded. 4. There was no June temperature logs produced. 5. The May temperature log revealed there were ten days undocumented for dish temperatures. There were no final rinse temperatures documented. 6. The April temperature log revealed two days undocumented. There were no final rinse temperatures documented. 7. The March temperature log revealed there was two days of wash temperatures at 140 degrees fahrenheit. There were seven days without dish temperature documentation. There were no final rinse temperatures documented. 8. Throughout March to August 2012 there were multiple meal periods without temperature documentation. An interview with the DM on 8/23/12 at 8:57 am revealed he had an outside repair service look at the dish machine two days ago and the element	F 371	The results of these audits and any negative findings will be taken to the Quality Assessment Performance Improvement for review times 3 meetings and appropriate interventions will be implemented as needed. 2. The food that was found opened and not labeled with the date opened was discarded. Additional measures put into place to assure the same alleged deficient practice does not recur are as follows: All food items were checked for proper labeling and discarded as needed. An in-service on labeling stored opened food with the date opened was conducted by the Dietary Manager beginning August 24, 2012 regarding the importance of labeling and the expectation of labeling all opened stored food. An Opening and Closing Audit/Checklist will be completed daily by the Dietary Supervisor or designee for any items opened and not dated. Any opened food items not labeled will be discarded.	

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F 371	Continued From page 7 was not working. He had it replaced. He would expect the dish machine to be 160 degrees fahrenheit wash cycle and above 180 degrees fahrenheit for rinse cycle due to it was a high temperature dish machine. 2. An initial kitchen tour was conducted with the DM on 8/20/12 at 1:30 pm revealed there were two opened bags of diced chicken, 1 opened bag of hot dogs and 1 opened bag of bread sticks in the walk-in freezer. These food items did not have food open dates on them. At 1:35 pm there was an opened bag of noodles and pasta in the dry storage room. These food items did not a have an open food date on them. An interview with the Assistant Dining Manager on 8/22/12 at 3:31 pm revealed that they label and date opened food and discard food after three days. She was not aware of the need to label and date opened frozen food items. Typically they use all frozen food at once when opened. An interview with the DM on 8/23/12 at 8:57 am revealed he would want all food labeled as soon as it was opened. The food would be discarded after 3 days. 3. A kitchen observation on 8/21/12 at 4:45 pm revealed the meal tray line service had begun. There was a tub of beverages in ice next to serving line. These beverages were being placed on the meal trays. At 4:46 pm a carton of milk was obtained from the tub. The milk temperature was obtained by the	F 371	The Dietary Management or designee will view the log daily and randomly monitor the area of stored food for correct labeling twice a week times three weeks then monthly times three months. A monitoring of these audits will be conducted once a week times three weeks then monthly times three months by the Administrator or designee to ensure food items stored and opened are properly labeled. The results of these audits and any negative findings will be taken to the Quality Assessment Performance Improvement for review times 3 meetings and appropriate interventions will be implemented as needed. 3. The milk on the tray line and in the walk in refrigerator that did not meet the temperature of 41 degrees Fahrenheit or below was discarded. Additional measures put into place to assure the same alleged deficient practice does not recur are as follows: All cold foods and milk were checked for proper temperature and discarded as needed. An in-service on maintaining cold food items at 41 degrees or below was conducted by the Dietary Manager beginning August 24, 2012 regarding the importance of maintaining temperature of 41 degrees Fahrenheit or below for milk and the expectations of monitoring and recording the temperature.	

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F 371	Continued From page 8 DM. The milk temperature registered at 43 degrees fahrenheit. The meal tray line continued with plating the milk and other beverages from the tub. At 4:50 pm the DM grabbed a carton of milk from the walk-in refrigerator. He obtained a milk temperature of 42 degrees fahrenheit. At 4:51 pm the DM placed more ice in the tub of beverages. At 4:51 pm the meal tray line continued with the plating of milk and other beverages from the tub. There was milk preplated prior to the milk initial temperature reading remaining on the meal tray cart and tray line. At 5:04 pm, after surveyor intervention, the DM had the milk removed off the tray line and meal cart. An interview with the DM on 8/23/12 at 8:57 am revealed he would expect the milk temperatures to ideally be 38 degrees fahrenheit because the milk would cool down when on the serving line.	F 371	Dietary aides will obtain temperatures of cold food and milk on the tray line during each meal and will log the results. The Dietary Manager or designee will monitor the log daily and randomly take temperatures of cold food and milk on the tray line and in the walk in refrigerator twice a week times 3 weeks then monthly. Any cold food item or milk noted to be higher than 41 degrees will be immediately discarded. Audits will be conducted once a week times three weeks then monthly times three months by the Administrator or designee to ensure cold food items and milk on the tray line and in the walk in refrigerator are 41 degrees Fahrenheit or below. The results of these audits and any negative findings will be taken to the Quality Assessment Performance Improvement for review times 3 meetings and appropriate interventions will be implemented as needed.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	**F431** On 8-23-12, in-servicing began with licensed staff who failed to securely store medication in 2 0f 6 medication carts during the medication pass. The policy was also reviewed..	09/20/12

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F 431	Continued From page 9 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, policy review, and staff interviews, the facility failed to securely store medication in 2 of 6 medication carts during medication pass. Findings include: 1. The facility policy titled Medication Storage, undated, read in part: "all medication and prescription biologicals shall be stored in locked carts or med rooms." A tour of the 100 hall on 8/22/12 at 8:17AM	F 431	Additional measures put into place to assure the same alleged deficient practice does not recur are as follows: An audit was completed of all other medication carts to ensure appropriate storage of medications. All licensed staff will be in-serviced on proper storage of medication during medication pass and the facility policy. The Director of Nursing or designee will conduct random audits of all medication carts to ensure proper storage of medications during and after medication passes. These audits will be completed times three weeks, then monthly times three months. The results of these audits and any negative findings will be taken to the Quality Assessment Performance Improvement for review times 3 meetings and appropriate interventions will be implemented as needed	

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F 431	Continued From page 10	F 431		

revealed a medication cart left unattended outside room 103. Observation revealed two vials of Novolog 70/30 insulin, two vials of Lantus insulin, one vial of Humulin R insulin, and one vial of Humalog insulin were stored on top of the medication cart in a plastic tray.

Observation on 8/22/12 at 8:22 AM revealed Nurse #1 prepared eight medications for resident #54. The nurse entered the resident's room and administered the medications. The insulin vials remained on top of the medication cart during the medication administration.

Observation on 8/22/12 at 8:35 AM revealed Nurse #1 prepared eleven medications for resident #85. The nurse entered the resident's room and administered the medications. The insulin vials remained on top of the medication cart during the medication administration. Observation revealed a resident in the hallway near the medication cart.

Observation on 8/22/12 at 8:48 AM revealed Nurse #1 prepared nine medications for resident #170. The nurse entered the resident's room and administered the medications. The insulin vials remained on top of the medication cart during the medication administration.

Observation on 8/22/12 at 9:04AM revealed the medication cart was left unattended on the 100 hall with the insulin vials stored on top of the cart.

Observation on 8/22/12 at 9:23AM revealed the medication cart was left unattended on the 100 hall with the insulin vials stored on top of the cart.

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	345036	A. BUILDING _____ B. WING _____	08/23/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
W R WINSLOW MEMORIAL HOME	1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909

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F 431	Continued From page 11	F 431		

Observation on 8/22/12 at 9:48 AM revealed the medication cart was left unattended on the 400 hall with the insulin vials stored on top of the cart.

In an interview on 8/22/12 at 9:55 AM, nurse #1 stated he was trained when hired and worked with the nurses on the floor before passing medications by himself. The pharmacy conducted periodic medication pass observations. The facility policy was to keep medications in the cart and not to leave them on top of the cart unattended. He usually kept the insulin in a drawer of the cart and returned it to the refrigerator when medication pass was finished. The nurse stated "I just forgot today." Nurse #1 removed the insulin vials from the top of the cart and returned them to the medication room refrigerator.

In an interview on 8/23/12 at 12:48PM, the Director of Nursing stated the staff was trained upon hire by the Staff Development Coordinator. After training, the new nurses worked with nurse mentors or preceptors for one month. Medication pass audits were conducted at least monthly by the pharmacist and administrative nursing staff. Her expectation was for the staff to store medications securely during medication pass.

2. Observation on 8-23-12 at 8:10am during the am medication pass on 800 hall, revealed an open container storing approximately 8-10 bottles of insulin were left unattended on top of the medication cart.

Observation on 8-23-12 at 8:30am, 9:00am and 9:30 am revealed the insulin tray still unattended on the top of the medication cart.

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F 431	Continued From page 12 An interview was conducted on 8-23-12 at 10:00am with Nurse #3 concerning storage of insulin during medication pass. She stated the insulin was kept in the refrigerator until time for medication pass then each nurse removed the insulin for their perspective residents. When asked where the insulin was stored during the medication pass, she stated that the container of insulin bottles usually remained on the top of the medication cart throughout the medication pass. She reported that she had never thought about the fact that she was leaving a medication unattended for a resident or other person to have access to. During an interview on 8-23-12 at 11:20am, the Director of Nursing (DON) stated that her expectation was that the insulin would be secured during the medication pass like all other medications.	F 431		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based upon observations and staff and family interviews the facility failed to position call bell equipment in reach of residents on 3 of 8 halls in the facility. Findings Include:	F 463	**F463** On 8-23-12, call bell equipment was positioned in the residents' reach in rooms 305, 503, and 709. Additional measures put into place to assure the same alleged deficient practice does not recur are as follows: All residents' call bell equipment was check and positioned to ensure appropriate positioning and in reach of residents.	09/20/12

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F 463	Continued From page 13 A family interview for a Resident in room 305 on 8/20/12 at 2:00 pm revealed that the Resident ' s call bell light was not in reach. An interview and observation on 8/21/12 at 3:33 pm with a Family Member of the Resident in room 305 revealed the call bell had been on the dresser before 3:00 pm today. The Resident was observed lying in his bed. The Resident was unable to reach his call bell upon command. The Family Member revealed she had visited the Resident on another occasion and saw that the call bell was hooked on its on cord next to the wall. The call bell was out-of-reach of the Resident in that position. An observation in room 503 on 8/21/12 at 3:49 pm revealed the call bell light was lying across the dresser. The Resident was sitting in a recliner chair. The recliner chair was located in front of the dresser. The back of the recliner was facing the dresser. The call bell light was out-of-reach to the Resident. An observation in room 709 on 8/21/12 at 4:01 pm the call bell was wrapped around the bottom rail leg on the floor. The Resident was seated in a recliner chair across from the bed. The call bell was out-of-reach to the Resident. An interview with Nursing Assistant (NA) #1 on 8/22/12 at 3:48 pm that call bells were to be placed at each Resident side. If the Resident was out-of- bed the call bell would be placed over their lap. NA #1 would usually pin it Residents instead of wrapping cord around the rail. An interview with NA #2 on 8/23/12 at 9:40 am	F 463	All facility employees of Winslow Memorial will be in-serviced on proper positioning of call bell equipment for residents and the facility policy. The Administrator, Director of Nursing or designee will conduct random audits of all call bell equipment to ensure proper placement for each resident. These audits will be completed times three weeks, then monthly times three months. The results of these audits and any negative findings will be taken to the Quality Assessment Performance Improvement for review times 3 meetings and appropriate interventions will be implemented as needed	

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F 463	Continued From page 14	F 463		

revealed she would place call bells in reach of Residents. If the Resident was out-of- bed would place the call bell next to them.

An interview with the Director of Nursing on 8/23/12 at 10:22 am revealed there was one Resident identified that preferred to have their call bell on the bell railing at all times. This Resident resided in another room on hall 300. The NA ' s were trained at orientation for call bells. The NA ' s have a Care Assistant that would help guide them during training and to ensure that all areas were covered, which included call bells. She would want call bells placed next to Residents or in their lap.

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

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	345036	A. BUILDING 04 - W.R WINSLOW MEMORIA B. WING OCT 17 2012	09/26/2012

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the New 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. Facility is using Delayed Egress system . The deficiencies determined during the survey are as follows:	K 000		
K 051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, 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 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, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observation and staff interview at 10:00 am, the following item was observed as	K 051	K51 On September 26, 2012, Edwards Electronics was notified of the alarm not sounding and strobes not functioning in certain areas. They performed their maintenance check and found that there was a loose wire in the fire alarm panel. The wiring was fixed, the system was tested and the alarm sounded and the strobes functioned in the areas where they previously did not. The alarm system will be tested once a week and evaluated by facility Maintenance personnel to ensure the alarm is sounding and the strobes are flashing. This will be done for 3 months and then monthly. The results of the tests will be reported to the facility QA Committee. The Committee will then determine the need and frequency of further monitoring.	11/10/12

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

Donna Williams | Administrator | 10-10-12

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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K 051	Continued From page 1 noncomplaint, specific findings include: there was no horn/strobe notification when fire alarm system was tested.	K 051		
K 069 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 18.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observation and staff interview at 10:00 am, the following item was observed as noncomplaint, specific findings include: 1. deep fat fryer was not under extinguishing system. 2. fryer needs splash guard on left side of fryer. 3. kitchen had neg. air pressure keeping door to corridor from closing.	K 069	K69 The deep fat fryer was placed in a position where it would be under the extinguishing system. An area on the floor was marked for proper placement of the fryer. Dietary staff was in-serviced on the need and reason for proper placement under the extinguishing system. The Dietary Manager or designee will monitor the position of the fryer three times a week for 3 months. The Maintenance Director or designee will monitor the position of the fryer twice a week for 3 months. The results of the monitoring will be reported to the facility QA Committee. The Committee will then determine the need and frequency of further monitoring.	11/10/12
K 144 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observation and staff interview at 10:00	K 144	A splash guard was installed on the left side of the fryer. Electric Motor Rewind company evaluated the negative air pressure in the kitchen preventing the door to the corridor from closing. Adjustments were made to the air flow in the service area (a vent fan was found not functioning) of the facility and a stronger door closure was installed on the corridor door. The door now closes properly.	

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K 144	Continued From page 2 am, the following item was observed as noncomplaint, specific findings include: generator did not crank and transfer with in 10 seconds on test. 42 CFR 483.70(a)	K 144	The door will be monitored weekly for 3 months by the Maintenance Director or designee to ensure proper functioning. The results of the monitoring will be reported to the facility QA Committee. The Committee will then determine the need and frequency of further monitoring. K144 Detroit Diesel came to evaluate the generator on October 2, 2012. They adjusted the generator and needed to consult with the generator monitoring company. Detroit Diesel evaluated and did some further adjustments on October 4, 2012. The facility Maintenance Director and Administrator tested the generator and it cranked and transferred in 9 seconds on 2 tests and 6.5 seconds on another test. The Maintenance Director or designee will test the generator twice a week for 3 months to monitor if the generator cranks and transfers within 10 seconds. The results of the monitoring will be reported to the facility QA Committee. The Committee will then determine the need and frequency of further monitoring.	11/10/12