STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING ____ B. WING ____	C 11/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS *Amended 11/1/2012 The Division of Health Service Regulation (DHSR), Nursing Home Licensure and Certification Section conducted a recertification, complaint investigation and revisit survey on October 14 through 18, 2012 and on November 1, 2012. It was determined the facility had provided substandard quality of care at the Immediate Jeopardy level. A partial extended survey was conducted on 10/18/2012 and an exit conference was held with the facility on 11/1/2012. The SA determined the facility has Immediate Jeopardy at F221 and F323. The facility was notified of the Immediate Jeopardy at F323 on 10/23/2012. The facility provided a credible allegation on 10/24/2012 that was accepted by the SA on 10/24/2012. An on-site visit was performed on 11/01/12 for validation of the credible allegation for F 323. The Immediate Jeopardy at F 323 was abated on 10/24/2012. The Immediate Jeopardy began on April 1, 2012 and was removed on 10/24/2012. F 278 was amended this date with Resident #209 being removed from the citation because there was no deficient practice. Amended S/S F221 & 323 on 11/8/2012.	F 000		
F 221 SS=K	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	F 221	**1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice:** **Resident #18 was assessed by the Interdisciplinary Team which includes the Director of Nursing, Nursing Home Administrator, Resident Assessment Director, Coordinator, the Social Services Director, Director of Rehabilitation, Staff Development/ Risk Manager and Dietary Manager on 10/17/12 with pelvic belt discontinued and self- releasing Velcro alarming seat belt now in place. Resident placed on one to one observation as part of his plan of care on 10/17/12. The 1:1 supervision will be provided 24 hours per day and will continue until resident is discharged; experiences significant change in condition or Quality Assurance Committee and Attending physician determines 1:1 continuous observation is no longer necessary to maintain resident safety.**	12-5-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John Wall
TITLE: Administrator
(X6) DATE: 11-21-12

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 221	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to use a least restrictive restraint, did not develop a plan for reduction and elimination and did not monitor and evaluate the resident's response to the restraint for 1 (Resident #18) of 3 sampled residents on a physical restraint. The findings include: Immediate Jeopardy began on 04/01/2012 and was identified on 10/17/2012 at 6:20 PM. Immediate Jeopardy was removed on 10/18/2012 at 7:30 PM. when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level E (a pattern of no actual harm with potential for more than minimal harm that is not immediate jeopardy)*. Resident #18 was originally admitted to the facility on 07/13/11 and was re-admitted on 09/29/11 with multiple diagnoses including Hypertension, Bipolar Disorder, Hepatic Encephalopathy, and Traumatic Brain Injury. The admission Minimum Data Set (MDS) dated 07/20/11 indicated that Resident #18 had moderate cognitive impairment, had no physical restraint, ambulation did not occur during the entire 7 day period and needed limited assistance with transfer.	F 221	**1:1 observation is defined as continuous staff observation of resident. Resident will be observed at all times. The staff member assigned will notify charge nurse for relief for breaks and will not leave resident until staff member is present for relief. 1:1 observations will be documented on 1:1 flow sheet with behaviors recorded as observed. Behaviors observed that are determined to be potentially harmful will be reported to the charge nurse immediately.** **2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken:** **A. All residents with restraints have the potential to be affected by this alleged deficient practice. On 10/17/12 a complete restraint reduction assessment was completed on all residents with restraints by the Interdisciplinary Team to ensure least restrictive device in use. Interdisciplinary Team observed resident without restraints, through staff interviews and observations of effectiveness of restraint use. Care plan was amended in accordance with reduction. Responsible party was notified and in agreement with reduction, to include risks and benefits of the alternative plan.**	

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Continued From page 2

The significant change in status assessment dated 12/22/11 indicated that Resident #18 had memory and decision making problems, had a trunk restraint used in chair or out of bed, ambulation did not occur during the entire 7 day period and was dependent on the staff for transfers.

The care area assessments (CAAs) summary for physical restraints dated 12/22/11 indicated "resident was provided with lap belt to wheelchair in an effort to reduce injury related to falling. Resident noted with frequent falls during episodes of confusion/lethargy with elevated ammonia level. Resident slides/leans forward and falls from the chair. Provided with Geri chair during episodes of lethargy to maintain safety. Provided 1:1 supervision as indicated."

The physical restraint consent form dated 12/23/11 was reviewed. The form indicated the type of restraint used was pelvic restraint, the specific target behaviors were "unsafe transfers and positioning in chair "and the medical symptom was "encephalopathy".

The care plan with 12/28/11 as date of onset was reviewed. The care plan problem was "resident is very impulsive with movements and has no safety awareness placing him at risk for falls, unsteady, staggering gait and right knee buckles at times. Needs verbal cues to stay focused. Requires need for pelvic restraint and broda chair. Resident will sit self down on floor at times, will lie down to sleep on floor." The goal was "resident will be free of injury thru 12/28/12, will receive least restrictive most effective restraint through 03/28/12, will receive no injury or

F 221

3. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur:

A. Corporate Clinical Consultant who is a Registered Nurse in-serviced the Interdisciplinary team on 10/17/12 on the use of restraints to include facility policy on use of least restrictive device, monitoring, response to use of restraints and their effectiveness. In-service included policy content to include: Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination, care plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use and that Restraints shall be used in such a way as not to cause physical injury to the resident and to insure the least possible discomfort to the resident.

B. All nursing staff , to include Licensed Nurses and Certified Nursing Assistants, have been in-serviced on facility policy on use of restraints and proper placement on 10/18/12 by the Director of Nursing and Staff

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F 221	Continued From page 3 breakdown related to restraint thru 12/28/12." The approaches included "up to broda chair (tilting/reclining chair) as tolerated, pelvic restraint to broda chair, ensure pelvic restraint is properly placed/attached and functioning properly every shift and PRN (as needed), release during care rounds, supervised activities and PRN (as needed), frequent body audits for early identification of breakdown, weights to broda chair (added on 4/3/12), chair pad alarm to alert staff of unsafe movements (added on 9/11/12), low bed to wall and non skid socks when in bed (added on 10/1/12)." The "physical restraint elimination assessment" form was reviewed. The instruction on the form indicated that "restrained individual should be reviewed at least quarterly to determine whether or not they are candidate for restraint reduction, less restrictive restraining measures or total restraint elimination." Resident #18 was started on pelvic restraint on 12/23/11. The form did not indicate that Resident #18 was assessed for restraint reduction/elimination in March, 2012. On 6/5/12, Resident #18 was assessed for restraint reduction. The form revealed that the resident was not a candidate for restraint reduction or elimination program. The comments were "resident continued with impulsive behaviors, leaning down to pick up items, scoots/slides in chair, etc (etcetera) requiring pelvic restraint for safety." On 9/5/12, Resident #18 was again assessed for restraint reduction. The form indicated that the resident was a candidate for restraint reduction or elimination program but there was no action plan written. The comments were "continued with impulsive behavior- leans. Continue with broda /pelvic restraint." On	F 221	Development Coordinator and RN Supervisor who is an RN. Review of requirement to check restraints to include proper placement every 30 minutes and release and reposition every 2 hours and when needed and document completion every shift on the resident's Treatment Record. The use of physical restraints will be determined by the interdisciplinary team. The Director of Nursing in accordance with the recommendations of the interdisciplinary team will assure the use of least restrictive device. If emergency restraint is applied to assure safety of resident or others based on change in medical condition, the interdisciplinary team will convene to review restraint assessment and change in condition to assure use of least restrictive device within 24 hours of application of the device. Team will be available 7 days per week to participate in interdisciplinary review when necessary. C. All new nursing staff will receive training on facility policy on restraints and use of least restrictive device, monitoring, correct application, response to use of restraints and their effectiveness by	

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F 221	Continued From page 4 10/17/12 at 9:25 AM, MDS Nurse #1 was interviewed. She indicated that she had assessed Resident #18 for restraint reduction on 9/5/12 but he was not a candidate for reduction due to being impulsive. The latest quarterly MDS assessment dated 08/24/12 indicated that Resident #18 had severely impaired cognition, had a trunk restraint used in chair or out of bed, ambulation did not occur during the entire 7 day period and was dependent on the staff for transfers. The nurse's notes and the incident reports were reviewed. Resident #18 had several falls/accidents involving the use of the restraint. The nurse's notes and the incident report dated 12/8/11 at 11:50 AM indicated that Resident #18 was observed on the floor in his room lying on his stomach. On 12/12/11, there was doctor's order for the use of the lap belt to wheelchair. There was no assessment for a lesser restrictive device prior to using a lap belt. There were no lesser restrictive devices tried prior to using the lap belt aside from the alarms. The nurse's notes and the incident report dated 12/23/11 at 10:00 AM indicated that Resident #18 had released the lap belt and he was observed on the floor on the hallway. The doctor was informed and a new order for pelvic restraint in a broda chair was obtained. There was no assessment for a lesser restrictive device from lap belt to pelvic restraint. There were no lesser restrictive devices tried prior to using the lap belt and the pelvic restraint aside from the alarms.	F 221	**Registered Nurse/Staff Development during orientation.** **D. Directed in-services on the following topics will be completed for all staff** **1. Behavior Management** **2. Restraints** **Local ombudsman will complete training on 11-30-12 and management will video in-service. Director of Nursing and/or Staff Development Coordinator will complete training with staff members unable to attend on or before 12-5-12.** **4. Monitoring of corrective action to ensure the deficient practice will not reoccur:** **A. The interdisciplinary team (DON, NHA, Staff Development Coordinator, Social Services Director, Director of Rehab, Dietary manager and MDS) will review all residents with restraints weekly X 8 weeks then monthly X 3 then quarterly for continued use of least restrictive device, monitoring response to use of restraints and their effectiveness. Each patient who has orders of restraint will be reviewed by the team to assure effectiveness and safety of device in use, evaluate safety**	

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F 221	Continued From page 5 The nurse's notes and the incident report dated 1/9/12 at 11:45 AM, Resident #18 had a fall in the bathroom. He was observed in front of the broda chair with his legs in the air. The pelvic restraint was still tied to the chair. His pants and the pelvic restraint were down around his mid thigh to the knee area. He was tangled in his pants and the pelvic restraint. The only intervention was staff education. There was no assessment for the continued need/effectiveness of the restraint and did not assess the restraint as an accident hazard and the risk to the resident. The nurse's notes and the incident report dated 4/2/12 at 8:45 PM indicated that Resident #18 was observed in his room with the broda chair tipped over him. He was lying on the floor with the broda chair on top of him. The interventions were staff education and weights were added to the broda chair. Again, there was no assessment for the continued need/effectiveness of the restraint and did not assess the restraint as an accident hazard and the risk to the resident. The nurse's notes dated 6/10/12 at 11:35 AM indicated that Resident #18 placed himself in bed with the broda chair on top of him and the pelvic restraint was still attached. There was no intervention found after this incident. There was no assessment for the effectiveness of the restraint and did not assess the restraint as an accident hazard and the risk to the resident. The nurse's notes dated 8/12/12 at 3:00 PM indicated that Resident #18 was observed to get up with broda chair attached and lying in bed with the chair and pelvic restraint attached. There	F 221	**and determine potential for reduction to a lesser restrictive device. This review will include walking rounds to observe the patient, staff interviews and review of documentation related to the use of restraints. Resident review will be documented on interdisciplinary team notes within the resident's clinical record.** **B. Events involving accident, injury or potential harm related to the use of restraints will be reported to the Administrator immediately by way of cell phone. The administrator will evaluate the event to:** **Assure optimal safety and well- being of resident and determine if policy was adhered to, if policy was not adhered to, the Administrator will evaluate the event to determine further necessary actions to assure continued compliance.**	

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F 221	Continued From page 6 was no intervention put in place after the incident and there was no assessment for the continued need/effectiveness of the restraint and the risk for accident hazard to the resident. The nurse's notes and the incident reports dated 9/7/12 at 8:15 PM revealed that Resident #18 was found tipped over in the broda chair with the pelvic restraint in place. The interventions were staff education and weights added to the broda chair. There was no record that staff education was provided and there was no additional weights added to the broda chair. There was no assessment for the effectiveness of the restraint and the risk for accident hazard to the resident. On 10/17/12 at 9:25 AM, MDS nurse #1 was interviewed. She stated that the pelvic restraint was to prevent falls/injury. She added that the resident was very impulsive and his ammonia level was high. On 10/17/12 at 11:15 AM, administrative staff member #1 was interviewed. She stated that PBA (personal body alarm), bed pad alarm and lap belt were tried prior to pelvic restraint. She also stated that 1:1 supervision was provided the end of 2011 but not in 2012. She indicated that the pelvic restraint was used because he tried to get up and slid down. He also had falls and this had helped to prevent further falls. She thought that the pelvic restraint was the safest for Resident #18. She further stated that the facility had conducted a quarterly restraint reduction by taking the restraint off and by observing the resident. If he continued to get up, the use of restraint was continued.	F 221	**C. Result of Audits related to the use of restraints will be reported to the facility Quality Assurance Committee by the Nursing home Administrator. The Quality Assurance Committee consists of Director of Nursing, Medical Director, Nursing Home Administrator, Nurse Assessment Coordinator, Pharmacy Consultant, Social Services Director, and Dietary Manager monthly to review the need for continued intervention or amendment of plan.**	

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On 10/17/12 at 3:32 PM, therapist #2 was interviewed. She stated that the 10 lbs weights were added a few months ago to prevent him from tipping the broda chair over. She also stated therapy department does not recommend what type of restraints to use. She indicated that nursing decides what type of restraint to use. She also added that PBA, seat pad alarm, seat belt and Geri chair had been tried prior to pelvic restraint. She also added that the broda chair was used for positioning.

On 10/17/12 at 4:20 PM, Nurse Manager #1 was interviewed. She stated that she was new to the facility but she had observed the pelvic restraint of Resident #18 not correctly placed once. She immediately trained the nursing assistant on how to correctly apply the pelvic restraint. She stated that she did not remember the exact date and she did not have records of the training.

The Administrator was notified of the Immediate Jeopardy on 10/17/2012 at 6:20 PM. The facility provided a credible allegation of compliance on 10/18/2012 at 7:30 PM. The allegation of compliance indicated:

Credible Allegation of Compliance:

1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice:

Resident #18 was assessed by the Interdisciplinary Team which includes the Director of Nursing (DON), Nursing Home Administrator

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F 221	Continued From page 8 (NHA), Resident Assessment Director, Coordinator, the Social Services Director, Director of Rehabilitation, Staff Development/ Risk Manager and Dietary Manager on 10/17/12 with pelvic belt discontinued and self- releasing Velcro alarming seat belt now in place. Resident placed on one to one observation as part of his plan of care on 10/17/12. The 1:1 supervision will be provided 24 hours per day and will continue until resident is discharged; experiences significant change in condition or Quality Assurance Committee and attending physician determines 1:1 continuous observation is no longer necessary to maintain resident safety. 1:1 observation is defined as continuous staff observation of resident. Resident will be observed at all times. The staff member assigned will notify charge nurse for relief for breaks and will not leave resident until staff member is present for relief. 1:1 observations will be documented on 1:1 flow sheet with behaviors recorded as observed. Behaviors observed that are determined to be potentially harmful will be reported to the charge nurse immediately. All residents with restraints have the potential to be affected by this alleged deficient practice. On 10/17/12 a complete restraint reduction assessment was completed on all residents with restraints by the Interdisciplinary Team to ensure least restrictive device in use. There are 10 residents with restraints in the facility; all 10 residents were reviewed by the interdisciplinary team in a meeting called for this purpose. The team completed the facilities quarterly restraint reduction assessment in review	F 221		

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F 221	Continued From page 9 of least restrictive device use; review included observation of residents while restraints were removed for approximately 20 minutes each. 9 residents remained in designated device at this time; one resident was amended, in accordance with MD order obtained, to device of lesser restriction. Care plan was amended in accordance with reduction. Responsible party was notified and in agreement with reduction, to include risks and benefits of the alternative plan. Measure and Systemic Changes The Corporate Clinical Consultant who is a Registered Nurse in-serviced the Interdisciplinary team on 10/17/12 on the use of restraints to include facility policy on use of least restrictive device, monitoring, response to use of restraints and their effectiveness. In-service included policy content to include: Restrained individuals shall be reviewed regularly (at least quarterly) to determine whether they are candidates for restraint reduction, less restrictive methods of restraints, or total restraint elimination, care plans shall also include the measures taken to systematically reduce or eliminate the need for restraint use and that Restraints shall be used in such a way as not to cause physical injury to the resident and to insure the least possible discomfort to the resident. All assigned nursing staff, to include Licensed Nurses and Certified Nursing Assistants, will be in-serviced on facility policy on use of restraints and proper placement on 10/18/12 by the Director of Nursing and Staff Development Coordinator and RN Supervisor who is a Registered Nurse (RN). No nursing staff will	F 221		

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F 221	Continued From page 10 provide direct care until in-service attended. Currently, 26 direct care staff have been trained and are assigned to residents. 19 are scheduled for 3PM. in-service on Oct 18, 2012 then will be assigned to residents. 13 are scheduled for the 11pm in-service on Oct 18, 2012 and then will be assigned to residents. There are 87 in total. In-servicing is scheduled before each shift until all staff are re-in-serviced. Review of requirement to check restraints to include proper placement every 30 minutes and release and reposition every 2 hours and when needed and document completion every shift on the resident's Treatment Record. Part time licensed nursing staff, part time nursing Assistants and new hires will not be assigned to direct care until completion of this in-service. Training will be conducted by the Staff Development Coordinator or RN Supervisor. The Facility existing restraint policy has been added to the orientation program for all new nursing employees. The use of physical restraints will be determined by the interdisciplinary team. The Director of Nursing in accordance with the recommendations of the interdisciplinary team will assure the use of least restrictive device. If emergency restraint is applied to assure safety of resident or others based on change in medical condition, the interdisciplinary team will convene to review restraint assessment and change in condition to assure use of least restrictive device within 24 hours of application of the device. Team will be available 7 days per week to participate in interdisciplinary review when necessary.	F 221		

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All new hires will receive training on facility policy on restraints and use of least restrictive device, monitoring, correct application, response to use of restraints and their effectiveness by Registered Nurse/Staff Development

Monitoring

The interdisciplinary team (DON, NHA, Staff Development Coordinator, Social Services Director, Director of Rehabilitation, Dietary manager and Minimum Data Set (MDS) coordinator will review all residents with restraints weekly X 8 weeks then monthly X 3 months then quarterly for continued use of least restrictive device, monitoring response to use of restraints and their effectiveness. Each patient who has orders of restraint will be reviewed by the team to assure effectiveness and safety of device in use, evaluate safety and determine potential for reduction to a lesser restrictive device. This review will include walking rounds to observe the patient, staff interviews and review of documentation related to the use of restraints. Resident review will be documented on interdisciplinary team notes within the resident's clinical record.

Events involving accident, injury or potential harm related to the use of restraints will be reported to the Administrator immediately by way of cell phone. The administrator will evaluate the event to:

Assure optimal safety and well- being of resident and determine if policy was adhered to, if policy was not adhered to, the Administrator will evaluate the event to determine further necessary

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FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

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F 221	Continued From page 12 actions to assure continued compliance. Result of Audits related to the use of restraints will be reported to the facility Quality Assurance Committee by the Nursing home Administrator. The Quality Assurance Committee consists of Director of Nursing, Medical Director, Nursing Home Administrator, Nurse Assessment Coordinator, Pharmacy Consultant, Social Services Director, and Dietary Manager monthly to review the need for continued intervention or amendment of plan. The credible allegation was verified 10/18/2012 at 5:00 PM. as evidenced by staff interviews on in-service training received on restraints, proper placement of restraints, how to release restraints and when to release restraints. Also, the IDT team was interviewed on in-service training received on the use of least restrictive restraint, proper application of restraint, correct positioning of the restraint how to release restraints and when to release restraints. Resident #18 was observed to have no pelvic restraint and was on 1:1 observation by a staff member.	F 221		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on the reviews of policy and employee	F 226	**1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice:** **A. No residents identified.** **B. Certifications for all nursing assistants have been verified through HCPR (Health Care Personnel Registry) and maintained in personnel files. Audit completed on 11-8-12** **2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken:** **A. All residents who reside in the facility have the potential to be affected by this alleged deficient practice.**	~~11-9-12~~ gw 12-5-12

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F 226	Continued From page 13 records, and staff interview, the facility failed to verify the license of 1 of 2 nurses (Nurse #4) and certifications of 2 of 2 nurse aides (Nurse Aides # 7 & #8) prior to offering employment. The findings include: The facility's Abuse Prohibition Policy, dated August, 2009 read that "Human Resources Manager or designee, who assures that all pre-employment screenings are completed and reviewed prior to hire." Screening per federal and/or state regulations, all applicants/employees must complete and application and pass a (n): Abuse registry check, criminal background investigation, licensure and/or certification, and reference check (per policy). 1. On 10/18/12 a sample of new employee files were reviewed. It revealed that Nurse #4, was hired on 8/20/12. A copy of her license verification was in her personnel file and documented that on 8/21/12 at 11:16 am, the facility checked her status. On 10/18/12 at 1:35 pm the Administrative Staff #1 was interviewed. She stated that in August, she briefly performed some of the new employee screenings, when the staff who was normally responsible for the task, vacated her position, however she shared that she did not handle the pre-screening for any of the nurses. She shared that normally when staff has to verify a license; it was performed prior to the hire date. 2. On 10/18/12 a sample of new employee files	F 226	**3. Measures/systematic changes put in place to ensure that the deficient practice does not recur:** **A. Nurse #4 and Nurse Aides #7 and # 8 have licenses/certifications in good standing with NC Board of Nursing.** **B. 100% audit of all licensed nurses and CNA's to ensure that all have current updated licenses/certification completed by Human Resource office by11/8/2012.** **C. Human Resource/Business Office personnel were in-serviced by the Administrator on 11/1/2012 on facility policy for verification of licenses/certifications prior to employment.** **D. Upon review of applications of potential new nursing staff and prior to offering employment the Business Office/Human Resource will verify and print a copy of their current license and place copy in their personnel file.** **E. No nursing employee will be able to attend orientation until a copy of their license have been verified, printed and placed in personnel file.** **F. Facility maintains copy of license for nurse's within personnel file. Audit was completed by Human Resource office by 11-8-12. HCPR (Health Care Personnel Registry) was notified on 10-22-12.** **4. Monitoring of corrective action to ensure the deficient practice will not recur:** **A. Director of Nursing/Staff Development Coordinator/Administrator will audit 100% of all new nursing employees personnel file prior to orientation weekly x 4 weeks then monthly x 3 to ensure all license/certification have been verified.**	

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F 226	Continued From page 14 were reviewed. It revealed that Nurse Aide #7 was hired on 8/16/12. A copy of her nurse aide certification was in her personnel file and documented that on 8/20/12, it was verified. On 10/18/12 at 1:35 pm, the Administrative Staff #1 was interviewed. She stated that in August, she briefly performed some of the nurse aides pre-employment screenings, when the staff who was normally responsible for the task, vacated her position. She stated that when she must validate certifications, she always looked at the Nurse Aide Registry online, prior to any offer of employment. She offered that perhaps she might have viewed the certification and omitted printing it, before the employment began. 3. On 10/18/12 a sample of new employee files were reviewed. It revealed that Nurse Aide #8 was hired on 8/16/12. A copy of her nurse aide certification was in her personnel file and documented that on 8/20/12, it was verified. On 10/18/12 at 1:35 pm, the Administrative Staff #1 was interviewed. She stated that in August, she briefly performed some of the nurse aides pre-employment screenings, when the staff who was normally responsible for the task, vacated her position. She stated that when she must validate certifications, she always looked at the Nurse Aide Registry online, prior to any offer of employment. She offered that perhaps she might have viewed the certification and omitted printing it, before the employment began.	F 226	B. **Report of findings and subsequent disciplinary action, if applicable, will be reported to the facility Quality Assurance Committee consisting of Nursing Home Administrator, Director of Nursing, Medical Director, Unit Supervisors, SDC/ Risk Manager, MDS Nurse, Pharmacy Consultant, Wound Care Nurse, Social Services Director, and Dietary Manager monthly to review the need for continued intervention or amendment of plan.**	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the	F 278	**1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice:** **A. Resident #18 had a modification to his quarterly MDS from 8/24/2012 completed on 10/30/2012 to include days that resident ambulated by MDS/RN.**	gw 11-9-12 12-5-12

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F 278	Continued From page 15 resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to accurately assess residents on areas of ambulation (Resident # 18) and medications (Resident #17) for 2 of 22 sampled residents. The findings include:	F 278	Resident #17 had a modification to her quarterly MDS from 8/13/2012 completed on 10/30/2012 to include coding days of antidepressant and anticoagulation use by MDS/RN. **2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken:** A. All residents who reside in the facility have the potential to be affected by this alleged deficient practice. B. All MDS's have been reviewed by Interdisciplinary team to ensure accuracy of assessments. **3. Measures/systematic changes put in place to ensure that the deficient practice does not recur:** A. Corporate Resident Assessment Specialist/Registered Nurse in-serviced the MDS department on 10/30/2012 on proper coding of the MDS. B. Any new MDS nurse will receive training during the orientation period by Corporate Resident Assessment Specialist/Registered Nurse to ensure accurate coding of the MDS. **4. Monitoring of corrective action to ensure the deficient practice will not recur:** A. Director of Nursing/Staff Development Coordinator will audit 10 MDS weekly x 4 weeks then monthly x 3 to ensure all have accurate coding. B. Report of findings and subsequent disciplinary action, if applicable, will be reported to the facility Quality Assurance Committee consisting of Nursing Home Administrator, Director of Nursing, Medical Director, Unit Supervisors, SDC/ Risk Manager, MDS Nurse, Pharmacy Consultant, Wound Care Nurse, Social Services Director, and Dietary Manager monthly to review the need for continued intervention or amendment of plan.	

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F 278	Continued From page 16 1. Resident #18 was admitted to the facility on 7/13/11 and was re-admitted on 9/29/11. The quarterly MDS assessment dated 8/24/12 indicated that ambulation did not occur during the entire 7 day period. Review of the nursing restorative notes in August, 2012 revealed that Resident #18 was on restorative ambulation program 6 times per week. The notes revealed that Resident #18 had ambulated with the use of rolling walker 6 times a week. On 10/16/12 at 2:38 PM, restorative aide #1 was interviewed. He stated that Resident #18 ambulated at least 25 feet 6 times per week with 1 person assist. On 10/16/12 at 3:34 PM, Resident #18 was observed walking using a rolling walking with 1 person assist. On 10/17/12 at 8:10 AM, NA #1 was observed taking Resident #18 to the bathroom. Resident #18 was able to ambulate with 1 person assist. She stated that resident was able to ambulate but with unsteady gait. On 10/18/12 at 3:36 PM, MDS Nurse #1 was interviewed. She acknowledged that ambulation was not coded accurately on the MDS assessment. 2. Resident #17 was admitted to the facility on 4/18/11 and was re-admitted on 1/27/12. The quarterly MDS assessment dated 8/13/12 indicated that Resident #17 was not on	F 278		

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F 278	Continued From page 17 antidepressant and anticoagulant medications. Review of Resident #17's physician's orders revealed that she was on Trazodone (antidepressant) since 1/30/12 and on Coumadin (anticoagulant) since 7/16/12. On 8/4/12, Coumadin was changed to Pradaxa (anticoagulant). The MARs (Medication Administration Record) for July, 2012 and August, 2012 were reviewed. The MARs indicated that Resident #17 had received Trazodone and Coumadin in July, 2012 and Trazodone and Pradaxa in August, 2012 as ordered. On 10/18/12 at 11:45 AM, MDS Nurse #1 was interviewed. She agreed that the assessment for Resident #17 was not coded accurately for the use of the antidepressant and the anticoagulant medications.	F 278		
F 279 SS=B	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	F 279	**1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice:** **A. Resident #17 had her Care Plan updated on 10/30/2012 to include the use of anticoagulant medication by the Interdisciplinary team.** **Resident #209 had her Care Plan updated on 10/30/21012 to include the use of Psychotropic medication by the Interdisciplinary team.** **Resident #64 has an IDT note completed on 10/ 17 /2012 by the Social Worker to indicate that resident's long term plan is to remain in facility.**	gw 11-9-12 12-5-12

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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 medical record review and staff interviews, the facility failed to develop a care plan for two (2) of ten (10) residents reviewed for the appropriate use of medications (Resident #17, Resident #209) and failed to develop a care plan for discharge planning for one (1) of three (3) sampled residents who were reviewed for community discharge (Resident #64). Findings included:

1. Resident #17 was admitted to the facility on 4/18/11 and was re-admitted on 1/27/12. The significant change in status assessment dated 5/25/12 indicated that the resident was on anticoagulant medication and the care plan decision was to proceed to care plan. The quarterly MDS assessment dated 8/13/12 indicated that Resident #17 was not on anticoagulant medications.

The care plan for Resident #17 was reviewed. There was no care plan developed to address the use of the anticoagulant medication Pradaxa.

The MARs (Medication Administration Record) for July, 2012 and August, 2012 were reviewed. The MARs indicated that Resident #17 had received

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2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken:

A. All residents who reside in the facility have the potential to be affected by this alleged deficient practice.
B. All Care Plans have been reviewed by the Interdisciplinary team by 11/7/2012 to ensure all residents have comprehensive care plans.

3. Measures/systematic changes put in place to ensure that the deficient practice does not recur:

A. Corporate Resident Assessment Specialist/Registered Nurse in-serviced registered nurses responsible for the development and accuracy of care plans. Interdisciplinary Team was also include in the in-service on 10/30/2012 on the development of comprehensive care plans.
B. Any new MDS (RN) Interdisciplinary Team member will receive training during the orientation period by Corporate Resident Assessment Specialist/Registered Nurse on development and accuracy of care plans. Any new Interdisciplinary Team member will receive training during orientation on develop of comprehensive care plans. Training will be completed by Corporate Resident Assessment Specialist (RN).

4. Monitoring of corrective action to ensure the deficient practice will not recur:

A. Director of Nursing/Staff Development Coordinator will audit 10 Care Plans weekly x 4 weeks then monthly x 3 to ensure all have accurate comprehensive care plans.

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F 279	Continued From page 19 Trazodone and Coumadin in July, 2012 and Trazodone and Pradaxa in August, 2012 as ordered. On 10/18/12 at 10:45 AM, MDS Nurse #1 was interviewed. She stated that the care plan for the use of the anticoagulant medication was developed in May, 2012 but was discontinued in August, 2012 when the Coumadin was changed to Pradaxa. She further stated that it was an error because Pradaxa was also an anticoagulant medication. She further stated that she would initiate a care plan for Resident #17 to address the use of the anticoagulant medication. 2. Resident #209 was admitted on 8-21-12 with a diagnosis of Depressive disorder. On 10-16-12, a review of the physician orders dated 8-21-12 revealed that Resident #209 was to receive Ambien (a hypnotic medication) 5 milligrams (mg) as needed at bedtime and Zoloft (an antidepressant medication) 50mg every day. The September 2012 Medication Administration Record (MAR) revealed Resident #209 received the Zoloft and Ambien throughout the month of September. A review of the resident Care Plan (CP) dated 8-30-12 revealed no Psychotropic medication was addressed and no approaches and interventions were documented. On 10-17-12 at 3:45pm, an interview was conducted with Nurse #4 who was also the MDS coordinator. She reported that she was new to	F 279	**B.** **Report of findings and subsequent disciplinary action, if applicable, will be reported to the facility Quality Assurance Committee consisting of Nursing Home Administrator, Director of Nursing, Medical Director, Unit Supervisors, SDC/ Risk Manager, MDS Nurse, Pharmacy Consultant, Wound Care Nurse, Social Services Director, and Dietary Manager monthly to review the need for continued intervention or amendment of plan.**	

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F 279	Continued From page 20 this position and was still learning how the MDS process worked. She indicated that she had been unaware that the CP had to address psychotropic medication use along with approaches and interventions. On 10-25-12 at 10:00am, a telephone interview was conducted with Administrative staff #1. She indicated her expectations were for the Care Plan assessments to be accurate and be resident specific. 3. Resident #64 was admitted to the facility on 5/21/12. Cumulative diagnoses included: Diabetes Mellitus, chronic respiratory failure and chronic kidney disease with dialysis. An Admission Minimum Data Set (MDS) assessment dated 5/28/12 indicated Resident #64 was mildly impaired in cognition. Section Q titled "Participation in Assessment and Goal Setting" indicated Resident #64 participated in the assessment Resident # 64's overall goal was to expect to be discharged to the community. Care plans for Resident #64 dated 6/6/12 and 8/29/12 were reviewed. There was no care plan noted regarding potential discharge to community. On 5/22/2012, a Social Services Evaluation form revealed Resident #64 planned to be short term and return home. On 5/22/2012 at 2:15 PM., an interdisciplinary progress note indicated long term plans per resident was to go home.	F 279		

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F 279	Continued From page 21 On 6/18/2012 at 2:45 PM., an interdisciplinary progress note indicated long term plans were for Resident #64 to return to the community. On 7/10/12 at 2:00 PM., an interdisciplinary progress note stated discharge plans were pending per physician approval. On 10/16 12 at 3:10 PM., MDS Nurse #1 stated the Interdisciplinary Team (IDT) met weekly to discuss a resident ' s progress in therapy, the need for continued therapy/ nursing services and potential discharge from the facility. She stated that rehabilitation services and the Social Worker have discharge planning meetings with the resident and family. She reviewed the care plan for Resident #64 and indicated she did not find a discharge planning care plan. On 10/16/12 at 3:24 PM., Administrative staff #2 stated Resident #64 indicated on admission that she lived with her son and grandchildren and planned to return to the community. Administrative staff #2 said Resident #64's power of attorney (POA) was concerned about her returning home. She stated she met with Resident #64 and the POA on 8/17/2012. During that meeting, both resident and daughter agreed Resident #64 would remain in the facility. Administrative staff #2 revealed she had not documented in the medical record the progression of the discharge plans and the decision on 08/17/2012 for Resident #64 to remain in the facility.	F 279		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive	F 315	1. **Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice:** A. **Resident #33 had her indwelling catheter secured with a leg strap on 10/18/2012 by nurse.**	~~12-?-12~~ 12-5-12 gw

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F 315	Continued From page 22 assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to secure the indwelling catheter for 2 (Residents # 135 & #33) of 3 sampled residents with an indwelling catheter. The findings include: 1. Resident #33 was admitted to the facility on 8/3/12 and was re-admitted on 8/30/12 with multiple diagnoses including Pressure ulcer. The admission MDS (Minimum Data Set) assessment dated 9/6/12 indicated that Resident #33 had severe cognitive impairment, had a stage IV pressure ulcer and had an indwelling catheter. The care plan dated 9/12/12 was reviewed. One of the care plan problems was "at risk for UTI (urinary tract infection) related to Foley catheter in place." The care plan indicated that the indwelling catheter was used for the stage IV pressure ulcer on the sacrum/coccyx. The goal was "will remain free of UTI through next review and comfort and dignity will be maintained through next review 12/18/12." The approaches included "Foley catheter care every shift, empty drainage bag every shift, change Foley catheter	F 315	Resident #135 had her indwelling catheter secured with a leg strap on 10/18/2012 by nurse. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: A. All residents with indwelling catheters have the potential to be affected by this alleged deficient practice. B. All residents with indwelling catheter were assessed on 10/18/2012 to ensure that leg strap was in place by unit supervisors. 3. Measures/systematic changes put in place to ensure that the deficient practice does not recur: A. Director of Nursing/Staff Development Coordinator will in-service all nursing staff on facility policy on indwelling catheter by 11/7/2012. B. All new nursing staff will be in-serviced during orientation by the Staff Development Coordinator on facility policy for indwelling catheter. C. Education on policy regarding indwelling catheter included that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site. 4. Monitoring of corrective action to ensure the deficient practice will not recur: A. Director of Nursing/Staff Development Coordinator/Unit Coordinators will audit 5 residents with indwelling catheters weekly x 4 weeks then monthly x 3 to ensure indwelling catheters are secured per facility policy.	

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	345186	A. BUILDING ____ B. WING ____	C 11/01/2012

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F 315	Continued From page 23 as needed, assess for signs/symptoms of UTI, Foley catheter flushes with NS (normal saline) with MD order as needed, drainage bag should be lowered than the abdominal level to maintain patency." On 10/16/12 at 10:34 AM, Resident #33 was observed during the dressing change. The treatment nurse and Nurse Manager #2 were in the room to provide the dressing change. Resident #33 was in bed with the indwelling catheter in place. When the resident was turned to her side, it was observed that the indwelling catheter was not secured to her thigh. On 10/16/12 at 4:45 PM, Resident #33's indwelling catheter was observed with Nurse #6. The catheter was still not secured to her thigh. On 10/16/12 at 4:46 PM, Nurse #6 was interviewed. She stated that residents with an indwelling catheter should have a leg strap to secure the catheter tubing in place. She stated that she did not know why Resident #33 had no leg strap on but she would secure the tubing immediately. 2. Resident #135 was admitted to the facility on 2/14/12 and was re-admitted on 8/16/12 with multiple diagnoses including urinary retention. The quarterly MDS assessment dated 9/18/12 indicated that Resident #135's cognitive status was intact and had an indwelling catheter. The care plan dated 9/19/12 was reviewed. One of the care plan problems was "resident had 16	F 315	**B. Report of findings and subsequent disciplinary action, if applicable, will be reported to the facility Quality Assurance Committee consisting of Nursing Home Administrator, Director of Nursing, Medical Director, Unit Supervisors, SDC/ Risk Manager, MDS Nurse, Pharmacy Consultant, Wound Care Nurse, Social Services Director, and Dietary Manager monthly to review the need for continued intervention or amendment of plan.**	

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F 315	Continued From page 24 FR (French) Foley catheter in place secondary to urinary retention with more than 200 cc (cubic centimeter) post void residual, she is at risk for trauma, UTI and discomfort." The goal was "will be free of complications related to Foley catheter placement through 12/19/12." The approaches included " secure Foley catheter to leg, below bladder at all times, keep in Foley catheter bag when out of bed and in hallway, ensure Foley catheter tubing remain patent and not kinked and monitor for signs/symptoms of UTI." On 10/18/12 at 8:40 AM, Resident #135 was observed in bed. She had an indwelling catheter in place and the tubing was not secured to her leg/thigh. Interview with the resident revealed that a staff member had removed the leg strap days ago and did not put it back on. She did not know the name of the staff member and she did not know why the staff member removed it. On 10/18/12 at 11:50 AM, NA #1 was interviewed. She stated that she had seen the resident this morning with the catheter tubing not secured. She stated that she would inform the nurse about it. On 10/18/12 at 11:58 AM, Nurse Manager #3 was interviewed. She stated that she didn't know that Resident #135 had indwelling catheter. NA #1 was observed informing Nurse Manager #3 that Resident #135 needed a leg strap to secure her catheter tubing.	F 315		
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323	1. **Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice:**	12-5-12

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F 323	Continued From page 25 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interviews, the facility failed to evaluate the need for the restraint to prevent falls and did not identify and assess the use of the restraint as an accident hazard/risk to 1 (Resident #18) of 3 sampled residents with accidents. The findings include: Immediate Jeopardy began on 04/01/2012 and was identified on 10/23/2012 at 4:13 PM. Immediate Jeopardy was removed on 10/24/2012 when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level E (a pattern of no actual harm with potential for more than minimal harm that is not immediate jeopardy)*. Resident #18 was originally admitted to the facility on 07/13/11 and was re-admitted on 09/29/11 with multiple diagnoses including Hypertension, Bipolar Disorder, Hepatic Encephalopathy, and Traumatic Brain Injury. The admission Minimum Data Set (MDS) dated 07/20/11 indicated that Resident #18 had moderate cognitive impairment, had no physical	F 323	Resident #18 accident history was assessed by the Interdisciplinary Team which includes the Director of Nursing, Nursing Home Administrator, Resident Assessment Director, Coordinator, the Social Services Director, Director of Rehabilitation , Staff Development/ Risk Manager and Dietary Manager on 10/17/12 with pelvic belt discontinued and self- releasing Velcro alarming seat belt now in place. Resident placed on one to one observation as part of his plan of care on 10/17/12. Review of incident logs reveals no further falls as of 10/24/2012. The 1:1 supervision will be provided 24 hours per day and will continue until resident is discharged; experiences significant change in condition or Quality Assurance Committee and Attending physician determines 1:1 continuous observation is no longer necessary to maintain resident safety. 1:1 observation is defined as continuous staff observation of resident. Resident will be observed at all times. The staff member assigned will notify charge nurse for relief for breaks and will not leave resident until staff member is present for relief. 1:1 observations will be documented on 1:1 flow sheet with behaviors recorded as observed. Behaviors observed that are determined to be potentially harmful will be reported to the charge nurse immediately. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken:	

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F 323	Continued From page 26 restraint, ambulation did not occur during the entire 7 day period and needed limited assistance with transfer. The significant change in status assessment dated 12/22/11 indicated that Resident #18 had memory and decision making problems, had a trunk restraint used in chair or out of bed, ambulation did not occur during the entire 7 day period and was dependent on the staff for transfers. The care area assessments (CAAs) summary for falls dated 12/22/11 was reviewed. The summary indicated " will continue with care plan with continued staff support in an effort to reduce risk for injury related falling. Has been provided with 1:1 supervision as indicated, broda chair with pelvic restraint, low bed and chair/bed alarms to alert staff of unsafe movements. Will notify MD of status changes and provide support as indicated." The care plan with 12/28/11 as date of onset was reviewed. The care plan problem was " resident is very impulsive with movements and has no safety awareness placing him at risk for falls, unsteady, staggering gait and right knee buckles at times. Needs verbal cues to stay focused. Requires need for pelvic restraint and broda chair. Resident will sit self down on floor at times, will lie down to sleep on floor. " The goal was " resident will be free of injury thru 12/28/12, will receive least restrictive most effective restraint through 03/28/12, will receive no injury or breakdown related to restraint thru 12/28/12. " The approaches included " up to broda chair (tilting/reclining chair) as tolerated, pelvic restraint	F 323	A. All residents who sustain falls/accidents have the potential to be affected by this alleged deficient practice. B. On 10/24/12 a complete audit by the Interdisciplinary Team of all residents with falls/accidents in the last 30 days has been completed to ensure all residents have appropriate interventions in place to prevent reoccurrence and Care Plans have been amended to reflect current interventions. Audits were completed by review of Fall/Accident report, review of charts and updates to Care Plan. IDT note completed in each resident chart to support findings of audits. 3. Measures/systematic changes put in place to ensure that the deficient practice does not reoccur: A. The Corporate Clinical Nurse who is a Registered Nurse in-serviced the Interdisciplinary Team on 10/24/2012 on accident prevention and monitoring as it relates to providing an environment free from hazards that the facility has control over. B. All staff have been in-serviced on facility policy on Preventing accidents by providing an environment that is free from hazards over which the facility has control by the Director of Nursing / Staff Development Coordinator and RN Supervisor by 11/7/2012.	

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F 323	Continued From page 27 to broda chair, ensure pelvic restraint is properly placed/attached and functioning properly every shift and PRN (as needed), release during care rounds, supervised activities and PRN (as needed), frequent body audits for early identification of breakdown, weights to broda chair (added on 4/3/12), chair pad alarm to alert staff of unsafe movements (added on 9/11/12), low bed to wall and non skid socks when in bed (added on 10/1/12). " The latest quarterly MDS assessment dated 08/24/12 indicated that Resident #18 had severely impaired cognition, had a trunk restraint used in chair or out of bed, ambulation did not occur during the entire 7 day period and was dependent on the staff for transfers. The nurse's notes and the incident reports were reviewed. Resident #18 had several falls/accidents involving the use of the restraint. The notes and the report dated 12/8/11 at 11:50 AM indicated that Resident #18 was observed on the floor lying on his stomach next to his bed in front of the wheelchair. The immediate action taken were labs (laboratory) were ordered (ammonia level), staff education and frequent monitoring. On 12/12/11, there was a doctor's order for " lap belt to wheelchair, check and release on care rounds/PRN." On 10/17/12 at 11:15 AM, administrative staff #1 had provided in-service records. The in-service was conducted on 12/8/11 with the topics covered " Geri chair when resident is lethargic and unable to sit upright and wheelchair when resident is alert and able to sit upright and on 12/12/11, the topics were lap belt restraint while up in wheelchair and release restraint on care rounds/PRN activities."	F 323	**C.** All residents that have falls/accidents will be reviewed in the daily Interdisciplinary Team's morning meeting during regular business hours to ensure proper interventions have been put in place to prevent reoccurrence and Care Plans have been amended to reflect current interventions. **D.** All new hires will receive training on facility policy on preventing accidents by providing an environment that is free from hazards which facility has control by Registered Nurse/Staff Development during orientation. **E.** Directed in-service on the topic of falls will be completed for all staff on or before 12-5-12 utilizing DVD, Mobility and Safe Movement of the Elderly. Director of Nursing and/or Staff Development Coordinator will be completing in-service. DVD was purchased from NCHCFA. **4.** Monitoring of corrective action to ensure the deficient practice will not reoccur: **A.** The interdisciplinary team (DON, NHA, Staff Development Coordinator, Social Services Director, Director of Rehab, Dietary manager and MDS) will review all residents through incident reports, 24 hour reports, chart reviews who sustain falls/accidents daily in the morning meeting during regular business hours to ensure all have proper interventions in place and Care Plans have been amended.	

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F 323	Continued From page 28 There was no assessment for a lesser restrictive device prior to using a lap belt and there was no lesser restrictive device tried prior to using the lap belt aside from the alarms. The notes and the report dated 12/23/11 at 10:00 AM indicated the staff was called to the red hall nurse's station. Resident #18 was observed in sitting position with the lap belt released by him. The doctor was informed and a new order was received for pelvic restraint in broda chair due to poor safety awareness. A doctor's order dated 12/23/11 revealed " pelvic restraint in broda chair due to poor safety awareness; discontinue lap belt restraint to wheelchair, check every shift and release on care rounds, activities and PRN. The immediate action taken was broda chair. On 10/17/12 at 11:15 AM, administrative staff member #1 was interviewed. She stated that there was no in-service record on how to properly apply the restraint after the 12/23/11 incident. There was no assessment for a lesser restrictive device from lap belt to pelvic restraint and there were no lesser restrictive devices tried prior to using the lap belt and the pelvic restraint aside from the alarms. The notes and the report dated 1/9/12 at 11:45 AM indicated that Resident #18 had a fall in the bathroom. He was observed on his right side in front of the broda chair with his legs in the air. The pelvic restraint was still tied to the chair. His pants and the pelvic restraint were down around his mid thigh to the knee area. He was tangled in his pants and the pelvic restraint. After he was untangled, he stood up without assistance. Immediate action taken was staff education. On 10/17/12 at 11:15 AM, the administrative staff	F 323	B. Events involving accident, injury or potential harm will be reported to the Administrator immediately by way of cell phone. The administrator will evaluate the event to: Assure optimal safety and well- being of resident and Determine if policy was adhered to, if policy was not adhered to, the Administrator will evaluate the event to determine further necessary actions to assure continued compliance C. Tracking and audits will be completed by the Staff Development/RN or Director of Nursing on falls/accidents into the AHT Quality Assurance log daily. Result of Audits related to sustained falls/accidents will be reported to the facility Quality Assurance Committee by the Nursing home Administrator. The Quality Assurance Committee consists of Director of Nursing, Medical Director, Nursing Home Administrator, Nurse Assessment Coordinator, Pharmacy Consultant, Social Services Director, and Dietary Manager monthly to review the need for continued intervention or amendment of plan.	

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F 323	Continued From page 29 member #1 was interviewed. She stated that she could not find any training/staff education record for 1/9/12 incident. There was no assessment for the need/effectiveness of the restraint to prevent falls/accidents. There was no assessment to identify the restraint as an accident hazard to the resident. The notes dated 2/25/12 at 2:00 PM indicated that Resident #18 was combative and was taking off pelvic restraint. He was observed walking with very unsteady gait and was getting out of the broda chair multiple times. He was observed sitting on the floor, refusing to get up and he required 2 plus staff members to sit him back down. The pelvic restraint was put back on and will continue to monitor him. On 10/17/12 at 11:15 AM, interview with the administrative staff member #1 was conducted. She stated that she could not find an incident report for 2/25/12 incident and did not know what intervention was taken after the fall. There was no assessment for the need/effectiveness of the restraint to prevent falls/accidents. There was no assessment to identify the restraint as an accident hazard to the resident. The notes/report dated 3/29/12 at 8:30 PM revealed that Resident #18 was observed sitting in the grass in the courtyard. The report indicated that the restraint was in use at the time of the incident. The immediate action taken was 1:1 observation. On 10/17/12 at 11:15 AM, administrative staff member #1 was interviewed. She stated that 1:1 observation was not provided at that time instead the resident was frequently monitored by the staff. She did not explain why 1:1 was not provided. There was no assessment	F 323		

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F 323	Continued From page 30 for the need/effectiveness of the restraint to prevent falls/accidents. There was no assessment to identify the restraint as an accident hazard to the resident. The notes and the report dated 4/1/12 at 3:00 PM revealed that Resident #18 was found on the floor in his room. The nursing assistant stated that the resident had untied the pelvic restraint and had laid down on the floor. The staff assisted the resident back in broda chair with the restraint on. The immediate actions taken were frequent monitoring and reapplied pelvic restraint appropriately. On 10/17/12 at 11:15 AM, interview with the administrative staff #1 was conducted. She stated that the pelvic restraint was applied appropriately but was not able to explain how she knew that the restraint was correctly applied prior to the incident. She further stated that the resident was referred to therapy on 4/2/12. The nursing referral to therapy notes dated 4/2/12 read " Pt (patient) positioned appropriately in pelvic restraint in broda chair. May offer to ambulate with assist several times a day. " On 10/17/12 at 3:05 PM, NA # 2 was interviewed. She stated that she had observed Resident #18 on the floor on 4/1/12. He untied his restraint by pulling the strap at the back of the chair. She also added that she had observed the resident standing with the broda chair and pelvic restraint attached. She also had observed resident putting himself in bed with the broda chair and restraint attached. There was no in-service provided to the staff on how to apply the restraints properly after the fall. There was no assessment for the need/effectiveness of the restraint to prevent falls/accidents. There was no assessment to identify the restraint as an	F 323		

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F 323	Continued From page 31 accident hazard to the resident. The notes and the report dated 4/2/12 at 8:45 PM revealed that Resident #18 was observed on the floor in his room with the broda chair tipped over him. The physical restraint was in use at the time of the incident. When assessed, he was noted to be lying on the floor and the broda chair was on top of him. The immediate actions taken were staff education and weights were added to the broda chair. On 10/17/12 at 11:15 AM, administrative staff member #1 was interviewed. She stated that the staff members were in-serviced on 4/3/12 and the topics were weights added to the broda chair, monitor for incontinence and frequent toileting on care rounds and PRN. She further stated that the resident was referred to therapy. The nursing referral to therapy form dated 4/3/12 was reviewed. The form indicated that the therapist had placed 10 lbs (pounds) weight on each side of base of broda chair to reduce risk of tipping. On 10/17/12 at 8:15 AM, the weights on the resident's broda chair were checked. The weights were 5 lbs. on each side of the base of the broda chair and not 10 lbs as recommended by the therapist. On 10/18/12 at 2:15 PM, therapist #1 was interviewed. She stated that she was the therapist who recommended the 10 lbs weights on each side of the base of the broda chair to reduce the tipping. She also stated that she was the one who put the weights on the broda chair but unable to remember how many lbs. of weights she had used on each side of the broda chair. Again, there was no assessment for the need/effectiveness of the restraint to prevent falls/accidents. There was no assessment to	F 323		

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identify the restraint as an accident hazard to the resident.

The notes dated 6/10/12 at 11:35 AM, revealed that Resident # 18 placed himself in bed with the broda chair on top of him. On 10/17/12 at 11:15 AM, administrative staff member #1 was interviewed. She stated that she could not find an incident report for the 6/10/12 incident and she did not remember what immediate action was taken after the incident. On 10/17/12 at 9:43 AM, Nurse #2 was interviewed. She stated that she had seen Resident #18 in bed with the broda chair on top of him and was still attached to the pelvic restraint. He was lying on his stomach. She did not know how he did it but this behavior was common to him. He was also observed sitting on the commode attached to the pelvic restraint and the broda chair was against the wall. She added that the resident was on pelvic restraint because he tried to stand up and he was very unsteady. She also indicated that she had observed him to untie the pelvic restraint. She also reported that restraint was checked every shift if it was on but not checked for correct placement. Again, there was no assessment for the need/effectiveness of the restraint to prevent falls/accidents. There was no assessment to identify the restraint as an accident hazard to the resident.

The notes dated 8/12/12 at 3:00 PM indicated that Resident #18 was very combative, continued to get up with the chair attached, lying in bed with the chair attached, continued to get up walking, swinging at staff and cursing. Haldol (anti psychotic medication)IM (intramuscularly) was

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F 323	Continued From page 33 administered. On 10/17/12 at 11:15 AM, interview with the administrative staff member #1 was conducted. She stated that she could not find the incident report for the 8/12/12 incident and she did not remember what immediate action was taken. She reported that an in-service was conducted on 8/8/12 and 8/9/12 to ensure that he had socks/shoes when out of bed and toileting during care rounds. She also stated that the staff members were in-serviced on how to apply the restraints. On 10/17/12 at 8:55 AM, Nurse #3 was interviewed. She stated that Resident #18 had been found in bed with the broda chair and the pelvic restraint attached on several occasions. It happened on her shift and it was also reported to her by the other shift. She added that the resident was using the pelvic restraint because he tried to get up and he was very unsteady. She further stated that he tried to wiggle to get out of the pelvic restraint. Nurse #3 reported that she checked the restraint if it was on but not for proper placement. Again, there was no assessment for the need/effectiveness of the restraint to prevent falls/accidents. There was no assessment to identify the restraint as an accident hazard to the resident. The notes and the report dated 9/7/12 at 8:15 PM indicated that Resident #18 was found sitting in the broda chair at the nurse's station. The nurse and the nursing aide heard a loud noise and when they came out of the resident's room they found the resident tipped over in the broda chair. The pelvic restraint was still in place. The immediate action taken were staff education and weights added to wheelchair. On 10/17/12 at 11:15 AM, interview with the administrative staff	F 323		

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F 323	Continued From page 34 #1 was conducted. She stated that she could not find an in-service or staff education record for the 9/7/12 incident. She also stated that the weights were the same as what was recommended by the therapy department in April, 2012. Again, there was no assessment for the need/effectiveness of the restraint to prevent falls/accidents. There was no assessment to identify the restraint as an accident hazard to the resident. Review of the physician ' s orders for October, 2012 revealed that Resident #18 was on Haldol (antipsychotic) 5 mgs (milligram)three times a day for Bipolar Disorder, Klonopin (antianxiety) 1 mgs three times a day for Agitation and Trazodone (antidepressant) 100 mgs at bedtime for Depression. On 10/16/12 at 8:55 AM and 3:34 PM, Resident #18 was observed up in broda chair with pelvic restraint attached. The restorative aide was observed walking the resident using the gait belt. At 3:45 PM, interview with the restorative aide # 1 revealed that Resident #18 was able to ambulate but with unsteady gait. On 10/17/12 at 8:10 AM, NA #1 was interviewed. NA #1 was assigned to Resident #18. She stated that Resident #18 was using a pelvic restraint to prevent him from falling. He would stand up and walk and he was very unsteady. She stated that she had not received an in-service on how to properly apply restraints. On 10/17/12 at 9:25 AM, MDS nurse #1 was interviewed. She stated that the pelvic restraint was to prevent falls/injury. She added that the	F 323		

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F 323	Continued From page 35 resident was very impulsive and his ammonia level was high. She also indicated that the IDT (interdisciplinary team) would meet after the incident and discuss what interventions to put in place. She reported that the interventions were written in the incident report, in the care plan and in the kardex. On 10/17/12 at 11:15 AM, administrative staff member #1 was interviewed. She stated that PBA (personal body alarm), bed pad alarm and lap belt were tried prior to pelvic restraint. She also stated that 1:1 supervision was provided the end of 2011 but not in 2012. She indicated that the pelvic restraint was used because he tried to get up and slid down. He also had falls and the restraint had helped to prevent further falls. She thought that the pelvic restraint was the safest for Resident #18. On 10/17/12 at 3:32 PM, therapist #2 was interviewed. She stated that the 10 lbs weights were added a few months ago to prevent the resident from tipping the broda chair over. She also added that the broda chair was used for positioning. On 10/17/12 at 4:20 PM, Nurse Manager #1 was interviewed. She stated that she was new to the facility but she had observed the pelvic restraint of Resident #18 not correctly placed once. She immediately trained the nursing assistant on how to correctly apply the pelvic restraint. She stated that she did not remember the exact date and she did not have records of the training. The Administrator was notified of the Immediate	F 323		

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F 323	Continued From page 36 Jeopardy on 10/23/2012 at 4:13 PM. The facility provided a credible allegation of compliance on 10/24/2012 at 4:46 PM. The allegation of compliance indicated: Resident #18 accident history was assessed by the Interdisciplinary Team which includes the Director of Nursing, Nursing Home Administrator, Resident Assessment Director, Coordinator, the Social Services Director, Director of Rehabilitation , Staff Development/ Risk Manager and Dietary Manager on 10/17/12 with pelvic belt discontinued and self- releasing Velcro alarming seat belt now in place. Resident placed on one to one observation as part of his plan of care on 10/17/12. Review of incident logs reveals no further falls as of 10/24/2012. The 1:1 supervision will be provided 24 hours per day and will continue until resident is discharged; experiences significant change in condition or Quality Assurance Committee and Attending physician determines 1:1 continuous observation is no longer necessary to maintain resident safety. 1:1 observation is defined as continuous staff observation of resident. Resident will be observed at all times. The staff member assigned will notify charge nurse for relief for breaks and will not leave resident until staff member is present for relief. 1:1 observations will be documented on 1:1 flow sheet with behaviors recorded as observed. Behaviors observed that are determined to be potentially harmful will be reported to the charge nurse immediately. All residents who sustain falls/accidents have the potential to be affected by this alleged deficient practice.	F 323		

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F 323	Continued From page 37	F 323		

On 10/24/12 a complete audit by the Interdisciplinary Team of all residents with falls/accidents in the last 30 days has been completed to ensure all residents have appropriate interventions in place to prevent reoccurrence and Care Plans have been amended to reflect current interventions. Audits were completed by review of Fall/Accident report, review of charts and updates to Care Plan. IDT note was completed in each resident chart to support findings of audits.

Measures and systemic changes

A. The Corporate Clinical Nurse who is a Registered Nurse in-serviced the Interdisciplinary Team on 10/24/2012 on accident prevention and monitoring as it relates to providing an environment free from hazards that the facility has control over.

B. All assigned nursing staff, to include Licensed Nurses and Nursing Assistants, will be in-serviced on facility policy on Preventing accidents by providing an environment that is free from hazards over which the facility has control by the Director of Nursing and Staff Development Coordinator and RN Supervisor. At this time 75 out of 89 nursing staff have been in-serviced on preventing accidents. No nursing staff will provide direct care until in-service attended. The Facility existing policy on preventing accidents by providing an environment that is free from hazards which the facility has control has been added to the orientation program for all new nursing employees.

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F 323	Continued From page 38 C. All residents that have falls/accidents will be reviewed in the daily Interdisciplinary Team ' s morning meeting during regular business hours to ensure proper interventions have been put in place to prevent reoccurrence and Care Plans have been amended to reflect current interventions. D. All new hires will receive training on facility policy on preventing accidents by providing an environment that is free from hazards which facility has control by Registered Nurse/Staff Development during orientation. Monitoring A .The interdisciplinary team (DON, NHA, Staff Development Coordinator, Social Services Director, Director of Rehab, Dietary manager and MDS) will review all residents through incident reports, 24 hour reports, chart reviews who sustain falls/accidents daily in the morning meeting during regular business hours to ensure all have proper interventions in place and Care Plans have been amended. B. Events involving accident, injury or potential harm will be reported to the Administrator immediately by way of cell phone. The administrator will evaluate the event to: assure optimal safety and well- being of resident and determine if policy was adhered to, if policy was not adhered to, the Administrator will evaluate the event to determine further necessary actions to assure continued compliance. C. Tracking and audits will be completed by the	F 323		

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F 323	Continued From page 39 Staff Development/RN or Director of Nursing on falls/accidents into the AHT Quality Assurance log daily. Result of Audits related to sustained falls/accidents will be reported to the facility Quality Assurance Committee by the Nursing home Administrator. The Quality Assurance Committee consists of Director of Nursing, Medical Director, Nursing Home Administrator, Nurse Assessment Coordinator, Pharmacy Consultant, Social Services Director, and Dietary Manager monthly to review the need for continued intervention or amendment of plan. The credible allegation was verified 11/01/2012 at 3:00 PM. as evidenced by staff interviews on in-service training received on accidents. In-service training records were reviewed on preventing accidents by providing an environment that is free from hazards. In-service training of current facility staff was provided on 10/23/2012 and 10/24/2012. In-service training was done on 10/30/2012 for new employees and has been added to the orientation of new employees. Also, the IDT team was interviewed on in-service training received on accidents. A Quality Assurance Meeting was held on 10/25/2012. Minutes reviewed revealed F 221, F323, Immediate Jeopardy status and current PoC were reviewed. Resident #18 was not in the facility a the time of the validation. Resident was hospitalized 10/31/12.	F 323		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal	F 334	**1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice:** **A. Resident #17 received the influenza vaccine on 10/10/2012.** **Resident #130 received the influenza vaccine on 10/30/2012.**	~~11-9-12~~ gw 12-5-12

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F 334	Continued From page 40 representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes	F 334	**2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken:** **A. All residents who request the influenza vaccine have the potential to be affected by this alleged deficient practice.** **B. The current year 2012-2013 influenza consents were mailed out to all current residents/resident's legal representative in September 2012. 100% audit has been completed to ensure all resident's that have returned the consent have been given the influenza vaccine. Staff Development Coordinator monitored consents that were mailed back to the facility** **3. Measures/systematic changes put in place to ensure that the deficient practice does not recur:** **A. Corporate Clinical Consultant/RN in-serviced the Director of Nursing, Staff Development Coordinator/Unit Supervisors on facility policy "Influenza Vaccine" on 10/31/2012.** **B. Director of Nursing/Staff Development Coordinator/RN will in-serviced all licensed nursing staff on facility policy "Influenza Vaccine" by 11/7/2012.** **C. All new licensed nursing staff will in-serviced during orientation by the Staff Development Coordinator on facility policy Influenza Vaccine.** **4. Monitoring of corrective action to ensure the deficient practice will not recur:** **A. Director of Nursing/Staff Development Coordinator/Unit Coordinators will keep a running list of all residents who have been given the influenza vaccine during the current influenza season to ensure the influenza vaccine was administered when consent obtained.**	

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F 334	Continued From page 41 documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to offer and/or to administer the influenza vaccine to 2 (Resident # 17 & # 130) of 5 sampled residents during the period from 10/1/11 through 3/31/12. The findings include: The facility policy on Influenza Vaccine dated December, 2008 (revised date) was reviewed. The policy read in part "Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees who have direct contact with residents, unless vaccination is medically contraindicated or the resident or employee had already been immunized. Employees hired or residents admitted between	F 334	**B. Report of findings and subsequent disciplinary action, if applicable, will be reported to the facility Quality Assurance Committee consisting of Nursing Home Administrator, Director of Nursing, Medical Director, Unit Supervisors, SDC/ Risk Manager, MDS Nurse, Pharmacy Consultant, Wound Care Nurse, Social Services Director, and Dietary Manager monthly to review the need for continued intervention or amendment of plan.**	

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F 334	Continued From page 42 October 1st and March 31st shall be offered the vaccine within 5 working days of the employee's job assignment or the resident's admission to the facility. Prior to the vaccination, the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and the potential side effects of the influenza vaccine. Provision of such education shall be documented in the resident's/employee's medical record. For those who receive the vaccine, the date of vaccination, lot number, expiration date, person administering and the site of vaccination will be documented in the resident's/employee's medical record." 1. Resident # 17 was admitted to the facility on 4/18/11 and was discharged to home on 9/26/11. The resident was re-admitted back to the facility on 1/27/12 with multiple diagnoses including Diabetes Mellitus, Hypertension and Congestive Heart Failure. Review of the resident's immunization record revealed no documentation that she had received the influenza vaccine during the period from 10/1/11 through 3/31/12. The "Influenza Immunization Informed Consent" form was reviewed. The form was signed by the resident and witnessed by a staff member on 1/30/12. The form was giving the facility permission to administer the influenza vaccine. On 10/18/12 at 5:10 PM, the infection control nurse was interviewed. She stated that she could not find documentation that the influenza vaccine was administered to the resident during the period from 10/1/11 through 3/3/1/12. She did not provide an explanation why the vaccine was not	F 334		

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F 334	Continued From page 43 administered to the resident. 2. Resident #130 was admitted to the facility on 7/7/11 with multiple diagnoses including Congestive Heart Failure, Hypertension and Diabetes Mellitus. Review of the resident's immunization record revealed no documentation that she had received influenza vaccine during the period from 10/1/11 through 3/31/12. On 10/18/12 at 5:10 PM, the infection control nurse was interviewed. She stated that she could not find documentation that the influenza vaccine was offered to the resident/legal representative during the period of 10/1/11 through 3/31/12. She also could not find the Influenza Immunization Informed Consent form for the resident.	F 334		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:	F 356	1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice: A. No residents identified. B. Posted nursing staffing information will be completed by staffing coordinator and/or nursing supervisor whom is also responsible for completion. C. Posted staffing information is readily accessible to residents/visitors. D. Staffing information will be posted by staffing coordinator and or nursing management. 2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken: A. All residents who reside in the facility have the potential to be affected by this alleged deficient practice. 3. Measures/systematic changes put in place to ensure that the deficient practice does not recur:	~~11-9-12~~ 12-5-12

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F 356	Continued From page 44 o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interview, the facility failed to post accurate daily staff postings for 7 consecutive days. The findings include: On 10/14/12 at 5:00 pm, an initial tour of the facility was conducted. On the bulletin board on the 200 hall, near the nurse's station, were three daily staffing sheets for 10/12/12, 10/13/12 and 10/14/12. The staffing for 10/14/12 was at the bottom of the pile and was not readily visible to individuals passing by. It was noted on all of the staffing documents that the actual hours worked for staff was not recorded and the resident census included residents who resided in the rest home beds. On 10/15/12 at 5:25 pm, the daily staff posting lacked the actual hours worked for staff and continued to combine the rest home residents with the skilled nursing residents, for the census.	F 356	**A.** Corporate Clinical Consultant/RN in-serviced the Director of Nursing, Staff Development Coordinator/Unit Supervisors and staffing coordinator on facility policy for Posting Nurse Staffing Information on 10/30/2012. **B.** All new licensed nursing staff will in-serviced during orientation by the Staff Development Coordinator on facility policy Posting Nurse Staffing information. **4.** Monitoring of corrective action to ensure the deficient practice will not recur: **A.** Director of Nursing/Staff Development Coordinator/Unit Coordinators/Staffing Coordinator will audit posting nurse staffing information sheets for correct census (excluding rest home residents) number of staff and actual hours worked daily x 2 weeks then weekly x 4weeks then monthly x 3 months to ensure continued compliance.. **B.** Report of findings and subsequent disciplinary action, if applicable, will be reported to the facility Quality Assurance Committee consisting of Nursing Home Administrator, Director of Nursing, Medical Director, Unit Supervisors, SDC/ Risk Manager, MDS Nurse, Pharmacy Consultant, Wound Care Nurse, Social Services Director, and Dietary Manager monthly to review the need for continued intervention or amendment of plan.	

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F 356	Continued From page 45 On 10/16/12 at 5:25 pm and 10/17/12 at 9:25 am, the current daily staff posting continued to contain rest home residents in the census count and the actual hours worked were not listed on the staff posting. The Staffing Coordinator was interviewed on 10/18/12 at 8:56 am. She stated that she started completing the daily staff posting last month and that it was previously done by several employees. She shared that she had professional experience completing the document; therefore, she did not have any training before she took on the assignment. She then shared that when she recorded the information it was essential to capture the total number of nurse aides, license practical nurses (LPN) and RNs who do hands on patient care. Together, we reviewed the 10/18/12 staff posting. She pointed out that on today's posting; she listed the Director of Nursing, the Staff Development Coordinator (SDC) and 2nd shift Unit Nurse, under RN staff. She clarified that if the SDC nurse was administering immunizations then she was included under staff however she acknowledged that the SDC nurse was not scheduled to give shots for the 8 hours she credited her today. In addition, the Staffing Coordinator stated that today she was also working in the capacity of a nurse aide but had not calculated her hours into the formula for the daily nursing staff. When asked how she determined the resident census, the Staffing Coordinator commented that she received the resident census from the	F 356		

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	345186	A. BUILDING ______ B. WING ______	C 11/01/2012

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FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

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F 356	Continued From page 46 business office. She was aware that it contained residents in the rest home beds but did not know that she should exclude them on the daily posting form. She further stated that she completed the daily staff postings for the weekend on Fridays and left them at the nurse's station for the supervisor to post daily. The Staffing Coordinator returned on 10/18/12 at 11:45am with a modified daily staffing form that had corrective measures in place. On 10/19/12 at 12:48 pm, the Director of Nursing (D.O.N) was interviewed. The D.O.N stated that she has taken measures to inform her weekend nurse managers of their new duties to complete the daily nursing staffing and post the form daily.	F 356		
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. 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	F 431	1. **Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice:** A. **No residents identified.** B. **Identified outdated inhaler's have been discarded.** 2. **Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken:** A. **All residents who have medication orders for Inhalers have the potential to be affected by this alleged deficient practice.** B. **100% audit of all medication carts was completed by the Unit supervisors to ensure all Inhalers are dated appropriately on 10/31/2012.** 3. **Measures/systematic changes put in place to ensure that the deficient practice does not recur:**	~~11-9-12~~ 12-5-12

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F 431	Continued From page 47 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, staff interview and the facility policy for storage of Advair Diskus, the facility failed to date 2 Advair Diskus when opened on 1 (cart #6) of 6 medication carts. The findings were: An undated facility policy for the storage of Advair Diskus read in part, "Safely discard Advair Diskus 1 month after you remove it from the foil pouch, or after the dose indicator reads '0', whichever comes first." On 10/17/12 at 8:05 AM, 2 opened, undated Advair Diskus were observed on medication cart #6. During an interview on 10/17/12 at 8:05 AM, Nurse #1 indicated she did not date Advair Diskus when she opened them, and did not know how long they should be kept after opening.	F 431	A. Staff Development Coordinator/ (SDC)/Director of Nursing (DON) have in serviced all Nursing licensed staff on "Medication Storage Policy" 10/26/2012. B. All new licensed nurses will be in service on" Medication Storage Policy" in orientation by the Staff Development Coordinator/RN. 4. Monitoring of corrective action to ensure the deficient practice will not recur: A. DON/Unit Supervisor will audit 100% of medication carts, weekly x 4 weeks then monthly x 3 to ensure facility medication storage policy is being followed. B. Report of findings and subsequent disciplinary action, if applicable, will be reported to the facility Quality Assurance Committee consisting of Nursing Home Administrator, Director of Nursing, Medical Director, Unit Supervisors, SDC/ Risk Manager, MDS Nurse, Pharmacy Consultant, Wound Care Nurse, Social Services Director, and Dietary Manager monthly to review the need for continued intervention or amendment of plan.	

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F 431	Continued From page 48 During an interview on 10/18/12 at 2:20 PM, Administrative Staff #1 stated Advair Diskus was good for 1 month after opening, and she expected nurses to date Advair Diskus when opened.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (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.	F 441	**1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice:** **A. No residents identified. All glucometers are being cleaned/sanitized per facility policy.** **2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken:** **A. All residents who receives blood glucose test in the facility have the potential to be affected by this alleged deficient practice.** **3. Measures/systematic changes put in place to ensure that the deficient practice does not recur:** **A. Director of Nursing provided nurse #7 a one to one in-service on 10/17/2012 on facility policy for cleaning /sanitizing glucometers..**	12-5-12

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F 441	Continued From page 49	F 441		

Summary statement of deficiencies (F 441):

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and staff interviews, the facility failed to clean and disinfect a glucometer for one of five sampled residents receiving blood glucose monitoring, (Resident #55).

Resident #55 was admitted with a diagnosis of Diabetes Mellitus and was to receive fingersticks for blood glucose monitoring prior to meals.

The Centers for Disease Control (CDC) Prevention and Guidelines for Glucose Monitoring read in part: " Any time blood glucose monitoring equipment is shared between individuals; there is a risk of transmitting Viral Hepatitis and other blood borne pathogens. Decontaminate environmental surfaces, such as glucometers regularly and any time contamination with blood or body fluids occurs or is suspected. Glucose test meters approved for the use with more than one person must be cleaned and disinfected following disinfection guidelines. "

Review of the facility policy, provided by the manufacturer for the glucometers used in the facility was dated 10-14-12. The policy for cleaning shared glucometers is outlined as follows: Place a barrier between the device and

Provider's plan of correction (F 441):

B. Director of Nursing/Staff Development Coordinator in-serviced all licensed nursing staff on facility policy for cleaning/sanitizing glucometer on 10-26-12.

C. All licensed nurses will have successfully completed glucometer cleaning/sanitizing competencies by11/7/2012.

D. All new licensed nursing staff will in-serviced during orientation by the Staff Development Coordinator on facility policy for glucometer cleaning/sanitizing.

E. All staff will be in-serviced on topic of Infection Control. Representative from SPICE will be conducting in-service. Director of Nursing will complete in-service to staff unable to attend SPICE representative's class on or before 12-5-12. Training will be completed by representative from SPICE on 11-29-2012.

4. Monitoring of corrective action to ensure the deficient practice will not recur:

A. Director of Nursing/Staff Development Coordinator/Unit Coordinators/Staffing Coordinator will audit 10 staff

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F 441	Continued From page 50 the surface if the device is placed on the medication cart, wash or sanitize your hands, apply gloves, Obtain a blood specimen, check the specimen, discard the specimen, clean the glucometer with an approved product (Alcohol wipes are not approved), allow applicable drying time, discard your gloves and wash or sanitize your hands. An observation of a medication pass on 100 hall was completed on 10-16-12. Nurse # 7 was observed using a blood glucose monitor on Resident #55. She then discarded the glucose strip and removed her gloves. She began preparation for the following resident receiving a blood glucose test. Nurse #7 applied her gloves and placed a new glucose test strip in the glucometer. She failed to clean and disinfect the glucometer prior to moving to the next resident. Nurse #7 was stopped as she entered the resident ' s room to prevent cross contamination to the next resident. In an interview with Nurse #7 on 10-17-12 at 8:00 am, she revealed she had forgotten to clean the glucometer before moving to the next resident. In an interview with Administrative staff #1 on 10-17-12 at 8:20am, revealed her expectations for cleaning the glucometer were as the policy was written. This would include cleaning the glucometer between residents requiring fingersticks by using the provided Sani-wipes on each medication cart, waiting a two minute drying period then moving to the next resident.	F 441	**nurses performing blood glucose testing to ensure facility policy on cleaning glucometers adhered to weekly x 4 weeks then monthly x 3 months to ensure continued compliance Monitoring will occur on all three shifts and on weekends by audits/observations.** **B. Report of findings and subsequent disciplinary action, if applicable, will be reported to the facility Quality Assurance Committee consisting of Nursing Home Administrator, Director of Nursing, Medical Director, Unit Supervisors, SDC/ Risk Manager, MDS Nurse, Pharmacy Consultant, Wound Care Nurse, Social Services Director, and Dietary Manager monthly to review the need for continued intervention or amendment of plan.**	
F 499 SS=D	483.75(g) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS	F 499		

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F 499	Continued From page 51 The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure that all licensed nursing staff had a current, North Carolina nursing license on one (1) of ten (10) employees reviewed. Findings Include: A review of employee files revealed one (1), Nurse #5 had a Virginia nursing license and no current North Carolina nursing license. The Virginia nursing license was current with a North Carolina address of record and an expiration date of 4-30-13. The North Carolina Board of Nursing regulation for nurses with compact (Multi-state) licenses is as follows, " A nurse changing primary state of residence, from one party state to another party state, may continue to practice under the former home state license and multistate licensure privilege during the processing of the nurse's licensure application in the new home state for a period not to exceed 30 days." An employee file review revealed that Nurse #5 started working at the facility on 10-5-2010. Her Virginia license listed Kannapolis, North Carolina	F 499	**1. Corrective action(s) accomplished for those residents found to have been affected by the alleged deficient practice:** **A. No residents identified. All licensed nurses are licensed appropriately with the N.C Board of Nursing.** **B. Nurse #5 obtained a North Carolina Nursing License on 10/24/2012.** **C. All new licensed nursing staff will in-serviced during orientation by the Staff Development Coordinator on facility policy on obtaining a NC nursing license when moving from a multi-compact state.** **2. Identify other residents who have the potential to be affected by the same deficient practice and what corrective action taken:** **A. All residents who reside in the facility have the potential to be affected by this alleged deficient practice.** **B. 100% audit of all licensed nurses will be completed by the Director of Nursing/Staff Development Coordinator by 11/7/2012 to ensure all licensed nurses have current NC Nursing license.** **3. Measures/systematic changes put in place to ensure that the deficient practice does not recur:** **A. Business office/ Human Resource will be responsible for verifying N.C Nursing Licensure at the time of employment. In-service on credentialing of Nursing Service Personnel was completed on 11-1-12. Audits are completed by verifying nursing licensure prior to hire including expiration date. Documentation will be kept on N.C license audit tool.** **4. Monitoring of corrective action to ensure the deficient practice will not recur:**	11-9-12 12-5-12

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F 499	Continued From page 52 as her address of record. In an interview on 10-18-12 at 6:15pm, Administrative staff #1 stated her expectation was that all nursing licenses be verified for current state licensure prior to employment. On 10-22-12 at 8:00am, a telephone interview was conducted with Nurse #5. She revealed that she had not been aware that she had to transfer her Virginia nursing license to a North Carolina license once her primary address was established as North Carolina.	F 499	A. Director of Nursing/Staff Development Coordinator/Unit Coordinators/Human Resource will audit all new licensed nurses weekly x 6 then monthly x 3 to ensure continued compliance with policy. Audits will verify license nurses with compact license are in compliance with North Carolina Board of Nursing statutes B. Report of findings and subsequent disciplinary action, if applicable, will be reported to the facility Quality Assurance Committee consisting of Nursing Home Administrator, Director of Nursing, Medical Director, Unit Supervisors, SDC/ Risk Manager, MDS Nurse, Pharmacy Consultant, Wound Care Nurse, Social Services Director, and Dietary Manager monthly to review the need for continued intervention or amendment of plan.	

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K 000	INITIAL COMMENTS 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. The deficiencies determined during the survey are as follows:	K 000	DEC 07 2012	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The janitor closet located behind the kitchen, accessible from outside has holes in the walls that were not repaired and maintained in goood condition. 42 CFR 483.70(a)	K 012	**1. Corrective action(s) accomplished to correct the deficient practice:** **A. Janitor closet located behind the kitchen will have holes in walls repaired on or before completion date. Repairs will be completed by facility Maintenance Director.** **2. Identify other life safety issues having the potential to affect residents by the same deficient practice:** **A. Facility will inspect all janitor's closets weekly x4 then monthly to assure maintained in good condition. Inspection will be completed by Maintenance Director and/or Administrator. Inspections will be documented on janitor's closet audit tool.** **3. Measures will be put into place or what systemic change facility will make to ensure that the deficient practice does not recur.**	1-2-13
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
John Wall	Administrator	12-3-12

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 000	INITIAL COMMENTS 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. The deficiencies determined during the survey are as follows:	K 000		
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The janitor closet located behind the kitchen, accessible from outside has holes in the walls that were not repaired and maintained in goood condition. 42 CFR 483.70(a)	K 012		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from	K 029	**1. Corrective action(s) accomplished to correct the deficient practice:** **A. The corridor door to the laundry room will have needed repairs completed to ensure it is sealed and closes properly.**	1-2-13

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

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GW 12-3-12

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K 029	Continued From page 1 other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The corridor door to the laundry room did not close and seal. There is an excessive gap at to top of the door. 2) The corridor door to the mechanical/chemical room in the kitchen was not self closing. 42 CFR 483.70(a)	K 029	A. Facility will inspect all janitor's closets weekly x4 then monthly to assure maintained in good condition. Inspections will be completed by Maintenance Director and/or Administrator. Inspections will be documented on janitor's closet audit tool. B. Any identified non-compliance concerns will be reported to Administrator. Concerns will be corrected in a timely manner. 4. Corrective action will be monitored at our monthly Quality Assurance Meeting. Report of findings will be reported to our QA committee to review for continued intervention or amendment of plan.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by:	K 052		

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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
K 029	Continued From page 1 other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The corridor door to the laundry room did not close and seal. There is an excessive gap at to top of the door. 2) The corridor door to the mechanical/chemical room in the kitchen was not self closing. 42 CFR 483.70(a)	K 029	**B. Corridor door in the kitchen had self closure installed.** **C. Repairs will be completed on or before completion date.** **D. Repairs will be completed by facility Maintenance Director.** **2. Identify other life safety issues having the potential to affect residents by the same deficient practice:** **A. Facility will inspect all doors weekly x4 then monthly to assure they are sealed and close properly according to life safety code standards. Inspections will be completed by Maintenance Director and/or Administrator. Inspections will be documented on door inspection audit tool.**	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by:	K 052	**3. Measures will be put into place or what systemic change facility will make to ensure that the deficient practice does not recur.** **A. Facility will inspect all doors weekly x4 then monthly to assure they are sealed and close properly according to life safety code standards. Inspections will be completed by Maintenance Director and/or Administrator. Inspections will be documented on door inspection audit tool.**	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

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K 029	Continued From page 1 other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The corridor door to the laundry room did not close and seal. There is an excessive gap at to top of the door. 2) The corridor door to the mechanical/chemical room in the kitchen was not self closing. 42 CFR 483.70(a)	K 029		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by:	K 052	1. Corrective action(s) accomplished to correct the deficient practice: A. Repairs have been completed to fire alarm system to assure fire/smoke door hold open devices and exit doors will not re-energize with the fire alarm control panel in active trouble alarm. B. Repairs were completed on 11-20-12 by Simplex Grinnell. 2. Identify other life safety issues having the potential to affect residents by the same deficient practice:	1-2-13

gw
12-3-12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 2 Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The fire alarm system was non-compliant, specific findings include, during testing of the facility fire alarm system the alarm was initiated and the audible alarms were silenced at the Fire Alarm Control Panel (FACP) the fire/smoke doors hold open devices and exit doors would re-energized with the fire alarm control panel (FACP) in active trouble alarm. 42 CFR 483.70(a)	K 052	**B. Any identified non-compliance concerns will be reported to Administrator. Concerns will be corrected in a timely manner.** **C. Maintenance Director has been provided education on the following topic: K029 42 CFR 483.70 (a). Education was provided by Administrator.** **D. Education was completed on 11-30-12** **4. Corrective action will be monitored at our monthly Quality Assurance Meeting. Report of finding will be report to our QA committee to review for continued intervention or amendment of plan.**	
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The smoke duct detectors located in the HVAC unit in the kitchen was not maintained clean and in good operating condition. 42 CFR 483.70(a)	K 054		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in	K 056		

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	345186	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 052	Continued From page 2 Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The fire alarm system was non-compliant, specific findings include, during testing of the facility fire alarm system the alarm was initiated and the audible alarms were silenced at the Fire Alarm Control Panel (FACP) the fire/smoke doors hold open devices and exit doors would re-energized with the fire alarm control panel (FACP) in active trouble alarm.	K 052	**A. Facility will inspect/test fire alarm system weekly x4 then monthly to assure maintenance and testing comply with applicable requirements of NFPA 70 and 72. Inspections/test will be completed by Maintenance Director. Outcome of inspections/test will be documented on fire alarm system audit tool.** **3. Measures will be put into place or what systemic change facility will make to ensure that the deficient practice does not recur:**	
K 054 SS=D	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The smoke duct detectors located in the HVAC unit in the kitchen was not maintained clean and in good operating condition.	K 054	**A. Facility will inspect/test fire alarm system weekly x4 then monthly to assure maintenance and testing comply with applicable requirements of NFPA 70 and 72. Inspections/test will be completed by Maintenance Director. Outcome of inspections/test will be documented on fire alarm system audit tool.** **B. Any identified non-compliance concerns will be reported to Administrator. Concerns will be corrected in a timely manner.**	
K 056 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in	K 056	**4. Corrective action will be monitored at our monthly Quality Assurance Meeting. Report of findings will be reported to our QA committee to review for continued intervention or amendment of plan.**	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

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K 052	Continued From page 2 Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The fire alarm system was non-compliant, specific findings include, during testing of the facility fire alarm system the alarm was initiated and the audible alarms were silenced at the Fire Alarm Control Panel (FACP) the fire/smoke doors hold open devices and exit doors would re-energized with the fire alarm control panel (FACP) in active trouble alarm. 42 CFR 483.70(a)	K 052		
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The smoke duct detectors located in the HVAC unit in the kitchen was not maintained clean and in good operating condition. 42 CFR 483.70(a)	K 054	1. Corrective action(s) accomplished to correct the deficient practice: A. Smoke duct detector's located in HVAC unit in the kitchen has been cleaned and being maintained in good operating condition. 2. Identify other life safety issues having the potential to affect residents by the same deficient practice: A. Facility will inspect smoke duct detectors located in HVAC unit in the kitchen weekly x4 then monthly to assure clean and in good operating condition in accordance with life safety code standard 42 CFR 483.70 (a). Inspections will be completed by Maintenance Director and/or Administrator. Outcome of inspections will be documented on smoke duct detector (kitchen) audit form.	1-2-13
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in	K 056		

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	345186	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	11/19/2012

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K 052	Continued From page 2 Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The fire alarm system was non-compliant, specific findings include, during testing of the facility fire alarm system the alarm was initiated and the audible alarms were silenced at the Fire Alarm Control Panel (FACP) the fire/smoke doors hold open devices and exit doors would re-energized with the fire alarm control panel (FACP) in active trouble alarm.	K 052		
K 054 SS=D	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The smoke duct detectors located in the HVAC unit in the kitchen was not maintained clean and in good operating condition.	K 054		
K 056 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in	K 056	1. Corrective action(s) accomplished to correct the deficient practice: A. Sprinklers will have been installed under exterior canopies outside both exits door going to parking lot and exit door next to room #125. B. Sprinklers will be installed by qualified outside vendor	1-2-13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING 02 - BUILDING 02 B. WING	11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

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K 052	Continued From page 2 was noted. 1) The fire alarm system was non-compliant, specific findings include, during testing of the facility fire alarm system the alarm was initiated and the audible alarms were silenced at the Fire Alarm Control Panel (FACP) the fire/smoke doors hold open devices and exit doors would re-energized with the fire alarm control panel (FACP) in active trouble alarm.	K 052		
K 054 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The smoke duct detector installed in the first HVAC in the mechanical room on 200 hall was installed 180 degrees out of alignment.	K 054		
K 056 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of	K 056	**1. Corrective action(s) accomplished to correct the deficient practice:** **A. Showers on 200 hall will have sprinkler coverage via installation of additional sprinklers. Repairs/installation of additional sprinklers will be completed on or before completion date.**	1-2-13

JW
12-3-12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345186	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

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K 056	Continued From page 3 accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) (Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in depth per NFPA 13 section 5-13.8.1.) Location front entrance outside both exit doors and canopy outside the exit door located next to room 125. 42 CFR 483.70(a)	K 056	**2. Identify other life safety issues having the potential to affect residents by the same deficient practice:** **A. Facility will inspect all exterior roof and canopies weekly x4 then monthly to assure compliance with NFPA 13 section 5-13.8.1. Inspection will be completed by Maintenance Director and/or Administrator. Inspection will be documented on exterior roof and canopy audit tool.** **3. Measures will be put into place or what systemic change facility will make to ensure that the deficient practice does not recur:** **A. Facility will inspect all exterior roof and canopies weekly x4 then monthly to assure compliance with NFPA 13 section 5-13.8.1. Inspection will be completed by Maintenance Director and/or Administrator. Inspection will be documented on exterior roof and canopy audit tool.** **B. Any identified non-compliance concerns will be reported to administrator. Concerns will be corrected in a timely manner.**	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The facility's cooking system was not protected in accordance with NFPA 96 - Ventilation Control and Fire Protection of Commercial Cooking Operations. Specific findings include; the deep fryer was	K 069		

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	345186	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	11/19/2012

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K 056	Continued From page 3 accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) (Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in depth per NFPA 13 section 5-13.8.1.) Location front entrance outside both exit doors and canopy outside the exit door located next to room 125. 42 CFR 483.70(a)	K 056		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The facility's cooking system was not protected in accordance with NFPA 96 - Ventilation Control and Fire Protection of Commercial Cooking Operations. Specific findings include; the deep fryer was	K 069	**1. Corrective action(s) accomplished to correct the deficient practice:** **A. Deep fryer has been removed from dietary kitchen.** **2. Identify other life safety issues having the potential to affect residents by the same deficient practice:**	1-2-13

JW 12-3-12

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	345186	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/19/2012

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K 056	Continued From page 3 accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) (Sprinklers shall be installed under exterior roofs or canoples exceeding 4 ft (1.2 m) in depth per NFPA 13 section 5-13.8.1.) Location front entrance outside both exit doors and canopy outside the exit door located next to room 125. 42 CFR 483.70(a)	K 056	3. Measures will be put into place or what systemic change facility will make to ensure that the deficient practice does not recur: A. Facility will inspect smoke duct detectors located in HVAC unit in the kitchen weekly x4 then monthly to assure clean and in good operating condition in accordance with life safety code standard 42 CFR 483.70 (a). Inspections will be completed by Maintenance Director and/or Administrator. Outcome of inspections will be documented on smoke duct detector (kitchen) audit form. B. Any identified non-compliance concerns will be reported to Administrator. Concerns will be corrected in a timely manner. 4. Corrective action will be monitored at our monthly Quality Assurance Meeting. Report of findings will be reported to our QA committee to review for continued intervention or amendment of plan.	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The facility's cooking system was not protected in accordance with NFPA 96 - Ventilation Control and Fire Protection of Commercial Cooking Operations. Specific findings include; the deep fryer was	K 069		

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K 069	Continued From page 4 located next to a gas stove top without the required splash guard in the dietary kitchen. 42 CFR 483.70(a)	K 069	4. Corrective action will be monitored at our monthly Quality Assurance Meeting. Report of findings will be reported to our QA committee to review for continued intervention or amendment of plan.	
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) In front of the exit door in in corridor on 400 hall and in the corridor in front of the exit door next to the maintained office there was storage on the exit corridors. (soiled linen barrels) 42 CFR 483.70(a)	K 072		

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K 069	Continued From page 4 located next to a gas stove top without the required splash guard in the dietary kitchen. 42 CFR 483.70(a)	K 069	4. Corrective action will be monitored at our monthly Quality Assurance Meeting. Report of findings will be reported to our QA committee to review for continued intervention or amendment of plan.	
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) In front of the exit door in in corridor on 400 hall and in the corridor in front of the exit door next to the maintained office there was storage on the exit corridors. (soiled linen barrels) 42 CFR 483.70(a)	K 072		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 069	Continued From page 4 located next to a gas stove top without the required splash guard in the dietary kitchen. 42 CFR 483.70(a)	K 069	A. Inspections of dietary kitchen will be completed weekly x4 then monthly to assure facility's cooking system is protected in accordance with NFPA 96- Ventilation Control and Fire Protection of Commercial Cooking Operations. Inspections will be completed by Dietary Supervisor and/or Administrator. Inspections will be documented on Dietary Cooking System audit form.	
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) In front of the exit door in in corridor on 400 hall and in the corridor in front of the exit door next to the maintained office there was storage on the exit corridors. (soiled linen barrels) 42 CFR 483.70(a)	K 072	3. Measures will be put into place or what systemic change facility will make to ensure that the deficient practice does not recur: A. Inspection of dietary kitchen will be completed weekly x then monthly to assure facility's cooking system is protected in accordance with NFPA 96- Ventilation Control and Fire Protection of Commercial Cooking Operations. Inspections will be completed by Dietary Supervisor and/or Administrator. Inspections will be documented on Dietary Cooking System audit form. B. Dietary Supervisor has received education on the following topic: Facility's cooking system is protected in accordance with NFPA 96-Ventilation Control and Fire Protection of Commercial Cooking Operations. Training will be completed by Administrator. Training was completed on 11-30-12.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 069	Continued From page 4 located next to a gas stove top without the required splash guard in the dietary kitchen. 42 CFR 483.70(a)	K 069		
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) In front of the exit door in in corridor on 400 hall and in the corridor in front of the exit door next to the maintained office there was storage on the exit corridors. (soiled linen barrels) 42 CFR 483.70(a)	K 072	**1. Corrective action(s) accomplished to correct the deficient practice:** **A. All cooridors within facility are being maintained free of all obstructions and impediments in case of fire or emergency.** **2. Identify other life safety issues having the potential to affect residents by the same deficient practice:** **A. Facility will inspect all cooridors daily x30 days then weekly x4 then monthly to assure compliance with maintaining means of egress free of all obstructions or impediments. Inspections will be completed by Maintenance Director, Administrator and/or Nursing Supervisor's. Inspections will be documented on maintaining egress free of obstructions or impediments audit tool.** **3. Measures will be put into place or what systemic change facility will make to ensure that the deficient practice does not recur:**	1-2-13

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12-3-12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING 02 - BUILDING 02 B. WING ______	11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 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. The deficiencies determined during the survey are as follows:	K 000	C. Any indentified non-compliance concerns will be reported to Administrator. Concerns will be corrected in a timely manner. 4. Corrective action will be monitored at our monthly Quality Assurance Meeting. Report of findings will be reported to our QA committee to review for continued intervention or amendment of plan.	
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The sheetrock in the attic area above the corridors that is part of the one hour fire rated corridor was not maintained in good condition. There were hole in the top layer of sheetrock in the attic area that was not repaired, 200 hall. 42 CFR 483.70(a)	K 012		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system	K 029		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING 02 - BUILDING 02 B. WING	11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The sheetrock in the attic area above the corridors that is part of the one hour fire rated corridor was not maintained in good condition. There were hole in the top layer of sheetrock in the attic area that was not repaired, 200 hall. 42 CFR 483.70(a)	K 012	B. Facility staff will receive education on the following topic: Keeping cooridor's clear at all times. Education will be completed by Administrator and/or Staff Development Coordinator. Education will be completed on or before completion date. C. Any identified non-compliance concerns will be reported to Administrator. Concerns will be corrected in a timely manner. 4. Corrective action will be monitored at our monthly Quality Assurance Meeting. Report of findings will be reported to our QA committee to review for continued intervention or amendment of plan.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system	K 029		

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

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING 02 - BUILDING 02 B. WING	11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 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. The deficiencies determined during the survey are as follows:	K 000		
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The sheetrock in the attic area above the corridors that is part of the one hour fire rated corridor was not maintained in good condition. There were hole in the top layer of sheetrock in the attic area that was not repaired, 200 hall. 42 CFR 483.70(a)	K 012	1. **Corrective action(s) accomplished to correct the deficient practice:** A. **The top layer of sheetrock in the attic area above corridor's on 200 hall will have needed repairs completed to maintain in good condition. Repairs will be completed on or before completion date. Repairs will be completed by facility Maintenance Director.** 2. **Identify other life Safety issues having potential to affect residents by the same deficient practice:** A. **Facility will inspect attic area above corridor on 200 hall monthly post completion of needed repairs to assure being maintained in good condition and in compliance with Life Safety Code Standard. Inspections will be completed by Maintenance Director. Outcome of inspections will be documented on attic area above corridor 200 hall audit tool.**	1-2-13
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: John Wall
TITLE: Administrator
(X6) DATE: 12-3-12

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.

RF

PRINTED: 11/20/2012
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING 02 - BUILDING 02 B. WING ______	11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 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. The deficiencies determined during the survey are as follows:	K 000		
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The sheetrock in the attic area above the corridors that is part of the one hour fire rated corridor was not maintained in good condition. There were hole in the top layer of sheetrock in the attic area that was not repaired, 200 hall. 42 CFR 483.70(a)	K 012		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system	K 029	**1. Corrective action(s) accomplished to correct the deficient practice:** **A. Self closures have been installed to chemical rooms located on 200 hall. Self closures were installed by facility Maintenance Director.**	1-2-13

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

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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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING 02 - BUILDING 02 B. WING ______	11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 029	Continued From page 1 option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The chemical room corridors located on 200 hall were not self closing. 42 CFR 483.70(a)	K 029	3. Measures will be put into place or what systemic change facility will make to ensure that the deficient practice does not recur: A. Facility will inspect attic area above corridor on 200 hall monthly post completion of needed repairs to assure being maintained in good condition and in compliance with Life Safety Code Standard. Inspections will be completed by Maintenance Director. Outcome of inspections will be documented on attic area above corridor 200 hall audit tool. B. Any indentified non-compliance concerns will be reported to Administrator. Concerns will be corrected in a timely manner.	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following	K 052	4. Correction action will be monitored at our monthly Quality Assurance Meeting. Report of findings will be reported to our QA committee to review for continued intervention or amendment of plan.	

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FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

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K 029	Continued From page 1 option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The chemical room corridors located on 200 hall were not self closing. 42 CFR 483.70(a)	K 029	2. Identify other life safety issues having the potential to affect residents by the same deficient practice: A. Facility will inspect all chemical room doors weekly x4 then monthly to ensure self closures are present and working properly according to Life Safety Code Standard. Inspections will be completed by Maintenance Director and/or Administrator. Outcome of inspections will be documented on door inspection audit tool. 3. Measures will be put into place or what systemic change facility will make to ensure that the deficient practice does not recur:	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following	K 052	A. Facility will inspect all chemical room doors weekly x4 then monthly to ensure self closures are present and working properly according to Life Safety Code Standard. Inspections will be completed by Maintenance Director and/or Administrator. Outcome of inspections will be documented on door inspection audit tool. B. Any identified non-compliance concerns will be reported to Administrator. Concerns will be corrected in a timely manner.	

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K 029	Continued From page 1 option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The chemical room corridors located on 200 hall were not self closing. 42 CFR 483.70(a)	K 029		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following	K 052	1. Corrective action(s) accomplished to correct the deficient practice: A. Repairs have been completed to fire alarm system to assure fire/smoke door hold open devices and exit doors will not re-energize with the fire alarm control panel in active trouble alarm. B. Repairs were completed on 11-20-12 by Simplex Grinnell. 2. Identify other life safety issues having the potential to affect residents by the same deficient practice:	1-2-13

JW
12-3-12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 052	Continued From page 2 was noted. 1) The fire alarm system was non-compliant, specific findings include, during testing of the facility fire alarm system the alarm was initiated and the audible alarms were silenced at the Fire Alarm Control Panel (FACP) the fire/smoke doors hold open devices and exit doors would re-energized with the fire alarm control panel (FACP) in active trouble alarm.	K 052	4. Corrective action will be monitored at our monthly Quality Assurance Meeting. Report of findings will be reported to our QA committee to review for continued intervention or amendment of plan.	
K 054 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The smoke duct detector installed in the first HVAC in the mechanical room on 200 hall was installed 180 degrees out of alignment.	K 054		
K 056 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of	K 056		

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FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 052	Continued From page 2 was noted. 1) The fire alarm system was non-compliant, specific findings include, during testing of the facility fire alarm system the alarm was initiated and the audible alarms were silenced at the Fire Alarm Control Panel (FACP) the fire/smoke doors hold open devices and exit doors would re-energized with the fire alarm control panel (FACP) in active trouble alarm. 42 CFR 483.70(a)	K 052	A. Facility will inspect/test fire alarm system weekly x4 then monthly to assure maintenance and testing comply with applicable requirements of NFPA 70 and 72. Inspections/test will be completed by Maintenance Director. Outcome of inspections/test will be documented on fire alarm system audit tool.	
K 054 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The smoke duct detector installed in the first HVAC in the mechanical room on 200 hall was installed 180 degrees out of alignment. 42 CFR 483.70(a)	K 054	3. Measures will be put into place or what systemic change facility will make to ensure that the deficient practice does not recur: A. Facility will inspect/test fire alarm system weekly x4 then monthly to assure maintenance and testing comply with applicable requirements of NFPA 70 and 72. Inspections/test will be completed by Maintenance Director. Outcome of inspections/test will be documented on fire alarm system audit tool. B. Any identified non-compliance concerns will be reported to Administrator. Concerns will be corrected in a timely manner.	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of	K 056	4. Corrective action will be monitored at our monthly Quality Assurance Meeting. Report of findings will be reported to our QA committee to review for continued intervention or amendment of plan.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING 02 - BUILDING 02 B. WING ________	11/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

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K 052	Continued From page 2 was noted. 1) The fire alarm system was non-compliant, specific findings include, during testing of the facility fire alarm system the alarm was initiated and the audible alarms were silenced at the Fire Alarm Control Panel (FACP) the fire/smoke doors hold open devices and exit doors would re-energized with the fire alarm control panel (FACP) in active trouble alarm. 42 CFR 483.70(a)	K 052		
K 054 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The smoke duct detector installed in the first HVAC in the mechanical room on 200 hall was installed 180 degrees out of alignment. 42 CFR 483.70(a)	K 054	**1. Corrective action(s) accomplished to correct the deficient practice:** **A. Smoke duct detector in the first HVAC in the mechanical room on 200 hall has been corrected by Simplex Grinnell on 11-20-12.** **2. Identify other life safety issues having the potential to affect residents by the same deficient practice.** **A. Facility will inspect smoke duct detector installed in the first HVAC in the mechanical room on 200 hall weekly x4 then monthly to assure smoke duct detector is maintained in accordance with Life Safety Code Standard. Inspections will be completed by Maintenance Director. Outcome of inspections will be documented on smoke duct detector (200 hall) audit tool.**	1-2-13
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of	K 056		

JW
12-3-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING 02 - BUILDING 02 B. WING	11/19/2012

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FIVE OAKS MANOR	413 WINECOFF SCHOOL ROAD CONCORD, NC 28027

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K 056	Continued From page 3 Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) There are showers in the 200 hall resident rooms that were not protected with sprinkler coverage. Facility is equipped with mag lock equipped door that requires the facility to be have 100% sprinkler coverage. 42 CFR 483.70(a)	K 056	**3. Measures will be put into place or what systemic change facility will make to ensure that the deficient practice does not recur:** **A. Facility will inspect smoke duct detector installed in the first HVAC in the mechanical room on 200 hall weekly x4 then monthly to assure smoke duct detector is maintained in accordance with Life Safety Code Standard. Inspections will be completed by Maintenance Director. Outcome of inspections will be documented on smoke duct detector (200 hall) audit form.** **B. Any identified non-compliance concerns will be reported to Administrator. Concerns will be corrected in a timely manner.** **4. Corrective action will be monitored at our monthly Quality Assurance meeting. Report of findings will be reported to our QA committee to review for continued interventions or amendment of plan.**	
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The smoke damper located in the smoke wall in the attic area on 200 hall did not close upon activation of the fire alarm system.	K 104		

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K 056	Continued From page 3 Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) There are showers in the 200 hall resident rooms that were not protected with sprinkler coverage. Facility is equipped with mag lock equipped door that requires the facility to be have 100% sprinkler coverage. 42 CFR 483.70(a)	K 056	**B.** Installation of sprinklers will be completed by qualified outside vendor. **2.** Identify other life safety issues having the potential to affect residents by the same deficient practice: **A.** Facility will inspect all showers on 200 hall weekly x4 then monthly to assure sprinkler coverage is properly maintained in accordance with NFPA 25, standard for the inspection, testing, and maintenance of Water-Based Fire Protection System. Inspections will be completed by Maintenance Director and/or Administrator. Outcome of inspections will be documented on showers (200 hall) sprinkler coverage audit tool.	
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The smoke damper located in the smoke wall in the attic area on 200 hall did not close upon activation of the fire alarm system.	K 104	**3.** Measures will be put into place or what systemic change facility will make to ensure that the deficient practice does not recur: **A.** Facility will inspect all showers on 200 hall weekly x4 then monthly to assure sprinkler coverage is properly maintained in accordance with NFPA 25, standard for the inspection, testing, and maintenance of Water-based Fire Protection System. Inspections will be completed by Maintenance Director and/or Administrator.	

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K 056	Continued From page 3 Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) There are showers in the 200 hall resident rooms that were not protected with sprinkler coverage. Facility is equipped with mag lock equipped door that requires the facility to be have 100% sprinkler coverage. 42 CFR 483.70(a)	K 056		
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The smoke damper located in the smoke wall in the attic area on 200 hall did not close upon activation of the fire alarm system.	K 104	**1. Corrective action(s) accomplished to correct the deficient practice:** **A. Smoke damper located in the smoke wall in the attic area on 200 hall will have needed repairs completed and/or replacement on or before completion date.** **B. Repairs will be completed by qualified outside vendor.** **2. Identify other life safety issues having the potential to affect residents by the same deficient practice:**	1-2-13

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12-3-12

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345186	A. BUILDING 02 - BUILDING 02 B. WING	11/19/2012

NAME OF PROVIDER OR SUPPLIER: FIVE OAKS MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE: 413 WINECOFF SCHOOL ROAD, CONCORD, NC 28027

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K 104	Continued From page 4 42 CFR 483.70(a)	K 104	A. Facility will inspect smoke damper located in the smoke wall in the attic area on 200 hall to assure it closes properly upon activation of the fire alarm system. Maintenance Director will complete inspections weekly x4 then monthly. Outcome of inspections will be documented on smoke damper attic area (200 hall) audit tool.	
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The exhaust fans in the resident bathrooms 223, 221 and other resident bathroom on the hall did not operate when checked. 2) The exhaust fan in the soiled utility room 200 had did not operate when checked. 42 CFR 483.70(a)	K 147	3. Measures will be put in or what systemic change facility will make to ensure that the deficient practice does not recur: A. Facility will inspect smoke damper located in the smoke wall in the attic area on 200 hall to assure it closes properly upon activation of the fire alarm system. Maintenance Director will completed inspections weekly x4 then monthly. Outcome of inspections will be documented on smoke damper attic area (200 hall) audit tool. B. Any identified non-compliance concerns will be reported to Administrator. Concerns will be corrected in a timely manner. 4. Corrective action will be monitored at our Quality Assurance monthly meeting. Report of findings will be reported to our QA committee to review for continued intervention or amendment of plan.	

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K 104	Continued From page 4 42 CFR 483.70(a)	K 104	Outcome of inspections will be documented on showers (200 hall) sprinkler coverage audit tool.	
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The exhaust fans in the resident bathrooms 223, 221 and other resident bathroom on the hall did not operate when checked. 2) The exhaust fan in the soiled utility room 200 had did not operate when checked. 42 CFR 483.70(a)	K 147	B. Any identified non-compliance concerns will be reported to Administrator. Concerns will be corrected in a timely manner. 4. Corrective action will be monitored at our Quality Assurance monthly meeting. Reported of findings will be reported to our QA committee to review for continued intervention or amendment of plan.	

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K 104	Continued From page 4 42 CFR 483.70(a)	K 104		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The exhaust fans in the resident bathrooms 223, 221 and other resident bathroom on the hall did not operate when checked. 2) The exhaust fan in the soiled utility room 200 had did not operate when checked. 42 CFR 483.70(a)	K 147	**1. Corrective action(s) accomplished to correct the deficient practice:** **A. Exhaust fans in resident bathrooms #223, #221 and any other resident bathrooms which do not operate properly will be replaced.** **B. Exhaust fan in the soiled utility room 200 hall will be replaced.** **C. Replacement of exhaust fans will be completed by Maintenance Director on or before completion date.** **2. Identify other life safety issues having the potential to affect residents by the same deficient practice:** **A. Facility will inspect weekly x4 then monthly, all exhaust fans located on 200 hall to assure operating properly and in compliance according to Life Safety Code Standard. Inspections will be completed by Maintenance Director. Outcome of inspections will be documented on exhaust fans 200 hall audit tool.** **3. Measures will be put into place or what systemic change facility will make to ensure that the deficient practice does not recur:**	1-2-13

JW
12-3-12

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K 104	Continued From page 4 42 CFR 483.70(a) .	K 104	A. Facility will inspect weekly x4 then monthly, all exhaust fans located on 200 hall to assure operating properly and in compliance according to Life Safety Code Standard. Inspections will be completed by Maintenance Director. Outcome of inspections will be documented on exhaust fans 200 hall audit tool. B. Any identified non-compliance concerns will be reported to Administrator. Concerns will be corrected in a timely manner. 4. Corrective action will be monitored at our Quality Assurance monthly meeting. Report of findings will be reported to our QA committee to review for continued intervention or amendment of plan.	
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation on Monday 11/19/12 at approximately 11:00 AM onward the following was noted. 1) The exhaust fans in the resident bathrooms 223, 221 and other resident bathroom on the hall did not operate when checked. 2) The exhaust fan in the soiled utility room 200 had did not operate when checked. 42 CFR 483.70(a)	K 147		