STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345140	A. BUILDING _____ B. WING _____	C 01/17/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Amended 2567 Based on additional information that was provided by the facility, tags F329 and F428 will be deleted on the 2567. There is no need to respond to these two tags.	F 000	THIS FACILITY'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, and staff interviews the facility failed to follow the care plan for range of motion for one of ten sampled residents requiring range of motion. Resident # 2 The findings were: Resident #2 was admitted to the facility on 10/7/10 with diagnoses of Stroke, hemiplegia on the dominant side and aphasia. Review of a progress note by occupational therapy, dated 2/24/12 revealed Resident #2 was to be provided " daily hand hygiene & (and) ROM (range of motion) as tolerated & allowed by pt (patient) ... will cont (continue) to receive hand hygiene/ROM from nursing. " Review of the Minimum Data Set (MDS), an Annual, dated 7/3/12 revealed Resident #2 had	F 282	• F:282 ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #2 has been reassessed by physical therapy along with all other residents to ensure that no resident has experienced a change in their Range of Motion without proper interventions. This was done to help each resident maintain the highest practicable physical, mental, and psychosocial well being as determined by the resident plan of care. Beginning 01-18-13, the facility Administrator, DON, Clinical Service Supervisor, MDS nurse, and Rehab Director reassessed every resident in the facility to determine if any decrease or increase in ROM/limitation has occurred. Each contracture assessment was reviewed as well to determine if any change in ROM was noted upon completion of their contracture assessment. If any decrease in ROM or increase in limitation was noted a referral was given to therapy at that time.	01-18-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Debra Williams	Adm	2-18-13

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 282	Continued From page 1 limitations in ROM of the upper and lower extremities on both sides of her body. This MDS documented total assistance was required by staff for turning, transferring, eating and personal hygiene. There were no behaviors for rejection of care by staff recorded for Resident #2. Review of the care plan dated 12/19/12 revealed a problem in activity of daily living (ADLs) related to limited ROM to bilateral shoulders, wrist and fingers. This problem included Resident #2 was at risk for contractures and pain. The goal for this problem included adl needs would be anticipated and met by staff. The approaches included nursing staff was to perform ROM during care, bathing, repositioning and dressing. Observations on 1/16/13 at 2:06 PM of staff providing Resident #2 a shower revealed neither aide #1 nor aide #2 provided range of motion to the resident ' s hands. During this observation, the aides had not provided ROM as they bathed Resident #2. Interview with aides #1 and #2 during the bath revealed they were not aware ROM was supposed to be done during care. Aide #1 stated she knew how to provide care for Resident #2 by following an aide during training. If she had questions about the resident, she would ask the nurse. Neither aide referred to the care plan for Resident #2. Interview with nurse #1 on 1/17/13 at 7:45 AM revealed the nurse does not do ROM for Resident #2 and she was not aware the aides were to provide ROM during care. Interview with aide #3 on 1/17/13 at 10:55 AM revealed she provided ROM during a bed bath.	F 282	Around October, 2012 the facility Administrator, in response to an identified problem through the facility's QA process, initiated a procedure whereby the MDS Coordinator would be the person responsible to complete all quarterly assessments, which included the Contracture Assessment. This was initiated due to inconsistency noted on the assessments completed by the Charge Nurses. Starting in November and December of 2012, all quarterly assessments were completed by the MDS nurse. Beginning 01-18-2013 any change noted in a resident's assessment, especially in their ROM, will be brought to the weekly QA Meeting and to the weekly interdisciplinary team meeting at which the Rehab Director is present. Discussion concerning the change will be conducted by the members present and if decided by the interdisciplinary team or the quality assurance committee that interventions are necessary, a referral will be made to therapy, other consultants and/or other interventions as deemed appropriate will be instituted. Resident #2 did not experience a decline in ROM or an increase in limitations. Her R OM and limitations were static from a year before; what appeared to be a decrease in ROM and increase in limitations of her fingers, hips and knees were	

inaccuracies in completion of the contracture assessment and/or documentation of such by charge nurses. However, Resident #2 is now receiving physical therapy for her fingers.

Resident care plans have been reviewed with CNAs so that they understand the components of the care plan that they are expected to do.

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

Any resident has the potential to be affected by this alleged deficient practice.

Beginning 01-18-2013 any change noted in a residents assessment, especially in their ROM, will be brought to the weekly QA Meeting and to the weekly interdisciplinary team meeting at which the Rehab Director is present. Discussion concerning the change will be conducted by the members present and if decided by the interdisciplinary team or the quality assurance committee that interventions are necessary, a referral will be made to therapy or other consultants and/or other interventions as deemed appropriate will be instituted.

On 1-18-13 an in-service was provided to all certified nursing assistants by the Rehab Director and Clinical Services Supervisor concerning ROM/exercise during baths and ADL's to help residents maintain the highest practicable physical, mental, and psychosocial well being. The Range of Motion Nursing Care policy has also been included in the orientation packet for all new hires and all new hires will be oriented to the facility's ROM/Exercise program during orientation.

The care plans for all residents have been reviewed with the CNAs so that the CNAs are familiar with the components that they are expected to perform. The CNAs have been in-serviced on 01-18-13 in how to perform ROM during ADLs.

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

An in-service for all certified nursing assistants was conducted on 01-18-13 concerning ROM/exercises during baths and ADL's. In addition to the in-service the Range of Motion Nursing Care policy has been included in the orientation packet and all new hires (CNAs) who will receive orientation on how to perform ROM during ADLs and the facility's expectations for performance of ROM for all residents. The MDS nurse will continue completing all quarterly assessments to include the Contracture Assessment and any changes noted will be brought to the interdisciplinary team weekly and the weekly quality assurance committee meeting where the Rehab Director is present. Any change noted by the MDS Nurse when completing the assessments will be discussed at these meetings and appropriate referrals will be made to the therapy department or other consultants as may be necessary. Other interventions as deemed necessary by either or both committees will be implemented.

A log has been developed by nursing listing all residents with a need for ROM exercises to be completed by CNAs. The Clinical Services Supervisor and/or DON will conduct weekly QA audits to determine if the CNAs are performing ROM for those residents on the log requiring ROM with ADLs. This QA will be done weekly for two months and then every other week for one month and then monthly. Results of the QA will be reported to the QA Committee weekly.

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

The QA Committee will review the Contracture assessments completed by the MDS nurse weekly and will evaluate if appropriate referrals or interventions were made and/or implemented. The QA Committee will review the facility's progress weekly for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions.

The QA Committee will review the Contracture log weekly and the QA audits completed by the Clinical Services Supervisor and DON to ensure that the plan of care is followed for those residents having ROM care planned in their plan of care.

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F 282	Continued From page 2 Aide #3 was asked what ROM was provided and she replied " flex ankles, knees, upper leg (the hip), shoulder, elbow and wrist. " When asked if ROM was provided to the fingers on either hand she replied " no. " Interview on 1/17/13 at 2:58 PM with aide #4 revealed she did not do ROM on 3-11 shift. This staff member stated " I think restorative does that. " Interview with Administrative nursing staff member #1 on 1/17/13 at 3:15 PM revealed she would expect the nursing staff to follow the care plan. Resident #2 would have ROM performed by the aides who worked on the floor.	F 282	• F:318 ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #2 has been reassessed by physical therapy along with all other residents to ensure that no resident has experienced a change in their Range of Motion without proper interventions. This was done to help each resident maintain the highest practicable physical, mental, and psychosocial well being as determined by the resident plan of care.	01-18-13
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review, staff interviews and facility policy review the facility failed to put measures in place to prevent a decline in range of motion for one of ten sampled residents with contractures requiring range of motion. Resident # 2 The findings included:	F 318	Resident #2 did not experience a decline in ROM or an increase in limitations. Her ROM and limitations were static from a year before; what appeared to be a decrease in ROM and increase in limitations of her fingers, hips and knees were inaccuracies in completion of the contracture assessment and/or documentation of such by charge nurses. However, Resident #2 is now receiving physical therapy for her fingers. Beginning 01-18-13, the facility Administrator, DON, Clinical Service Supervisor, MDS nurse, and Rehab Director reassessed every resident in the facility to determine if any decrease or increase in ROM/limitation has occurred. Each contracture assessment was reviewed as well to determine if any change in	

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F 318	Continued From page 3 Review of the facility ' s policy titled " Range of Motion Nursing Care, " that was not dated, revealed " During ADLs (activities of daily living) including bathing, dressing, grooming and ambulation residents joints will be taken through the range of motion as tolerated by the resident each time a specific ADL is performed by the Certified Nursing Assistants and/or Charge Nurse. Both passive and active (as tolerated by the resident) range of motion will be completed. In addition the following measures will be used to maintain joint ROM (range of motion); f. Assisting residents with their routine range of motion exercises " Resident #2 was admitted to the facility on 10/7/10 with diagnoses of Stroke, hemiplegia on the dominant side and aphasia. Review of a progress note by occupational therapy, dated 2/24/12 revealed Resident #2 was to be provided " daily hand hygiene & (and) ROM (range of motion) as tolerated & allowed by pt (patient). Will cont (continue) to receive hand hygiene/ROM from nursing. " Review of the annual Minimum Data Set (MDS), dated 7/3/12 revealed Resident #2 had limitations in ROM of the upper and lower extremities on both sides of her body. This MDS documented total assistance was required by staff for turning, transferring, eating and personal hygiene. There were no recorded behaviors for Resident #2 for rejection of care by staff. Review of the Care Area Assessments for the annual MDS revealed the area of contractures and/or range of motion was not addressed as part of the care area of	F 318	ROM was noted upon completion of their contracture assessment. If any decrease in ROM or increase in limitation was noted a referral was given to therapy at that time. Around October, 2012 the facility Administrator, in response to an identified problem through the facility's QA process, initiated a procedure whereby the MDS Coordinator would be the person responsible to complete all quarterly assessments, which included the Contracture Assessment. This was initiated due to inconsistency noted on the assessments completed by the Charge Nurses. Starting in November and December of 2012, all quarterly assessments were completed by the MDS nurse. Beginning 01-18-2013 any change noted in a resident's assessment, especially in their ROM, will be brought to the weekly QA Meeting and to the weekly interdisciplinary team meeting at which the Rehab Director is present. Discussion concerning the change will be conducted by the members present and if decided by the interdisciplinary team or the quality assurance committee that interventions are necessary, a referral will be made to therapy, other consultants and/or other interventions as deemed appropriate will be instituted.	

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F 318	Continued From page 4 ADLs. Comparison of the quarterly Contracture Assessments dated 9/24/12 and 12/15/12 revealed declines in ROM of both hands occurred from 9/24/12 to 12/15/12. These assessments were made by the nurse who completed the MDS. The fingers of the right hand had changed from minimal to severe flexion contracture. The fingers of the left hand changed from minimal to moderate flexion. Further changes were documented to the flexion of hips and knees. Those changes were from no contractures to minimal contractures. Review of the care plan dated 12/19/12 revealed a problem in activity of daily living (ADLs) related to limited ROM to bilateral shoulders, wrist and fingers. This problem included Resident #2 was at risk for contractures and pain. The goal for this problem included ADL needs would be anticipated and met by staff. The approaches included nursing staff was to perform ROM during care, bathing, repositioning and dressing. Interview on 1/15/13 at 10:24 AM with the therapy manager revealed Resident #2 had been discharged from occupational therapy 2/24/12. After discharge, the nursing would provide maintenance ROM to prevent contractures. The aides on the floor were to do ROM and apply hand rolls as the resident would allow. There were no specific plan guidelines for ROM, that is, how many repetitions, how often and to which specific body parts. Observations on 1/16/13 at 2:06 PM of staff providing Resident #2 a shower revealed neither	F 318	ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Any resident has the potential to be affected by this alleged deficient practice. Beginning 01-18-2013 any change noted in a residents assessment, especially in their ROM, will be brought to the weekly QA Meeting and to the weekly interdisciplinary team meeting at which the Rehab Director is present. Discussion concerning the change will be conducted by the members present and if decided by the interdisciplinary team or the quality assurance committee that interventions are necessary, a referral will be made to therapy or other consultants and/or other interventions as deemed appropriate will be instituted. On 1-18-13 an in-service was provided to all certified nursing assistants by the Rehab Director and Clinical Services Supervisor concerning ROM/exercise during baths and ADL's to help residents maintain the highest practicable physical, mental, and psychosocial well being. The Range of Motion Nursing Care policy has also been included in the orientation packet for all new hires and all new hires will be oriented to the facility's ROM/Exercise program during orientation.	

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F 318	Continued From page 5 aide #1 nor aide #2 provided range of motion to the resident ' s hands. Observations of the bath revealed the fingers were not separated, hands opened to stretch open the bent fingers, joints of the fingers were not moved and the wrists were not moved. The arms were slightly lifted to wash underneath, legs were moved to bathe the front perineum and the resident was turned side to side for bathing of the back and buttocks. Resident #2 was totally dependent on staff for turning and moving of extremities. During this observation, the aides had not provided ROM as they bathed Resident #2. Nurse #1 came to the shower room to dry Resident #2 ' s hands and place wash cloths in her hands. Nurse #1 did not provide ROM to the hands. Interview with aides #1 and #2 during the bath revealed they were not aware ROM was supposed to be done during care. Interview with nurse #1 on 1/17/13 at 7:45 AM revealed the nurse did not do ROM for Resident #2. Further explanation provided by nurse #1 revealed the nurses wiped between the fingers and palm and placed a washcloth hand roll in both hands. Nurse #1 was not aware the aides were to do ROM during care. Interview with aide #3 on 1/17/13 at 10:55 AM revealed she provided ROM during a bed bath. Aide #3 was asked what ROM was provided and she replied " flex ankles, knees, upper leg (the hip), shoulder, elbow and wrist. " When asked if ROM was provided to the fingers on either hand she replied " no. " Interview with Administrative nurse #2 on 1/17/13 at 11:08 AM revealed she had performed the	F 318	ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: An in-service for all certified nursing assistants was conducted on 01-18-13 concerning ROM/exercises during baths and ADL's. In addition to the in-service the Range of Motion Nursing Care policy has been included in the orientation packet and all new hires (CNAs) will receive orientation on how to perform ROM during ADLs and the facility's expectations for performance of ROM for all residents. The MDS nurse will continue completing all quarterly assessments to include the Contracture Assessment and any changes noted will be brought to the interdisciplinary team weekly and the weekly quality assurance committee meeting where the Rehab Director is present. Any change noted by the MDS Nurse when completing the assessments will be discussed at these meetings and appropriate referrals will be made to the therapy department or other consultants as may be necessary. Other interventions as deemed necessary by either or both committees will be implemented.	

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F 318	Continued From page 6 contracture assessments on 9/24/12 and 12/15/12. This nurse revealed she did hands on assessments by asking the resident to open her hands and placing her finger inside Resident #2 ' s palm and extending the fingers. The question was asked of administrative nurse #2 what would be done when a resident was found with worsening contractures. She responded it would be discussed in morning meetings. This nurse did remember discussing Resident #2 in a morning meeting and a referral was made to therapy. She explained further, therapy screens were done routinely two weeks before the MDS assessment was to be completed. Interview on 1/17/13 at 10:24 AM with the therapy manager revealed she had not received a referral to screen Resident #2 after the 12/15/12 contracture assessment showed a decline in ROM. Continued interview revealed Resident #2 had severe contractures of both hands when she was on the therapy caseload in February 2012. The therapy manager was not aware of declines in areas of flexion of the hips or knees. Interview on 1/17/13 at 2:58 PM with aide #4 revealed she did not do ROM on 3-11 shift. This staff member stated " I think restorative does that. " Interview with Administrative nursing staff member #1 on 1/17/13 at 3:15 PM revealed she would expect the nursing staff to follow the care plan. Resident #2 would have ROM performed by the aides who worked on the floor.	F 318	INDICATE HOW THE FACILITY PLANS TO MONITOR its PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY. The QA Committee will review the Contracture assessments completed by the MDS nurse weekly and will evaluate if appropriate referrals or interventions were made and/or implemented. The QA Committee will review the facility's progress weekly for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions. • F:431 ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: Resident #4 on 1-15-13 was ordered a new inhaler. An audit was done on 1-15-13 to ensure all residents meds were labeled with date opened if necessary. No others were found unlabeled.	01-15-13
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 7 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 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 observations, staff interviews and policy review the facility failed to date an Advair	F 431	All nurses have been re educated on 1-15-13 by the Director of nursing on labeling of medications for date of opening. On 1-15-13 the Maintenance Director checked the two medication carts narcotic boxes to ensure they were permanently affixed inside the medication cart. All nurses have been reeducated on 1-15-13 by the director of nursing on Proper Drug Storage of medications. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Any resident has the potential to be affected by this alleged cited practice. An in-service was held on 1-15-13 by the Director of Nursing concerning labeling medications with date opened and proper drug storage. There have been two different audits initiated to ensure deficient practice does not recur. A. Weekly Drug Storage Audit: this form is completed weekly by the Clinical Service Supervisor, DON, and Administrator to make sure all drugs are stored properly.	

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F 431	Continued From page 8 Diskus (inhaler) when first opened for administration and failed to maintain narcotic medications in a permanently affixed box within one of two medication carts. (East hall medication cart). The findings were: Review of the policy " Storage of Medications " that was not dated revealed #4. No discontinued, outdated, or deteriorated drugs or biological are available for use in this facility ... " This policy did not address narcotic boxes should be permanently fixed inside the medication cart. On 1/15/13 at 1:00 PM the medication cart on east hall was observed for medication storage in the presence of nurse # 1. An Advair Diskus (inhaler) was located in the medication cart for usage. Review of the label on the side of the inhaler revealed a place to date and initial when the inhaler was first opened. The doses were numbered as administered beginning with dose 60. The current dose was number 24. The date the pharmacy sent the inhaler was on a label on the bag that contained the inhaler. The inhaler had a sent date of 12/12/12. Advair inhalers may be used for 30 days after opening per manufacturer ' s recommendations. Interview with nurse #1 on 1/15/13 at 2:15 PM revealed she had used the inhaler during the morning medication pass. This staff member stated she did not open the discus, but knew it should have been dated when it was opened. Interview with administrative nurse #1 on 1/15/13 at 2:50 PM revealed the medication carts were	F 431	B. Weekly Expired Medication Audit, this form is completed weekly by the Clinical Service Supervisor, DON, and Administrator to make sure all drugs are labeled properly. ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: There have been two different audits initiated to ensure deficient practice does not occur. A. Weekly Drug Storage Audit: this form is completed weekly by the Clinical Service Supervisor, DON, and Administrator to make sure all drugs are stored properly. B. Weekly Expired Medication Audit, this form is completed weekly by the Clinical Service Supervisor, DON, and Administrator to make sure all drugs are labeled properly.	

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	345140	A. BUILDING _____ B. WING _____	C 01/17/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 9 checked weekly by administrative nurses. The nurses checked medications for expiration, date opened, medications not in use, and they looked for discrepancies in orders/ order changes. The administrative nurse #1 explained " she didn't know how it (Advair inhaler not being dated) got by us. " She would expect the nurses to date medications when opened. Continued observation on 1/15/13 at 1:10 PM of the medication cart for East hall revealed two locked narcotic boxes. The third storage drawer of the medication cart contained the second locked narcotic box. The lid remained locked on the narcotic box, but the entire narcotic box could be pulled out of the storage drawer. The narcotic box was not permanently affixed to the drawers and the bottom of the box was not sealed. The medications were visible and accessible by lifting it out of the storage drawer and turning the narcotic box upside down. Interview with nurse #1 on 1/15/13 at 1:12 PM revealed she had not checked to see if the narcotic box was permanently affixed to the medication cart. Interview with the corporate staff member #1 on 1/15/13 at 2:25 PM revealed she had the maintenance director check the medication cart. The corporate staff member #1 had been informed by the maintenance director the narcotic box had never been bolted to the medication cart drawer Interview with administrative nurse #1 on 1/15/13 at 2:50 PM revealed the medication carts were checked weekly by administrative nurses. The	F 431	INDICATE HOW THE FACILITY PLANS TO MONITOR its PERFORMANCE TO MAKE SURE THAT SOLUTIONS ARE SUSTAINED. THE FACILITY MUST DEVELOP A PLAN FOR ENSURING THAT CORRECTION IS ACHIEVED AND SUSTAINED. THE PLAN MUST BE IMPLEMENTED AND THE CORRECTIVE ACTION EVALUATED FOR ITS EFFECTIVENESS. THE PoC IS INTEGRATED INTO THE QUALITY ASSURANCE SYSTEM OF THE FACILITY. The DON, Clinical Service Supervisor, and Administrator will do Drug Storage Audit and Expired Medication audit daily. Any discrepancies noted will be followed by reeducation with the nurses by the Director of Nursing. The QA Committee will review weekly, the facility's progress towards implementation of corrective action(s) and the facility's performance to ensure that corrective performance is achieved and sustained. The QA Committee will review the facility's progress weekly for effectiveness and revise or develop new measures as necessary to ensure that corrective action is integrated and the system is sustained or revised as needed to achieve and maintain corrective solutions.	

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F 431	Continued From page 10 nurses checked medications for expiration, date opened, medications not in use, and they looked for discrepancies in orders/ order changes. The administrative nurses did not check the narcotic boxes to ensure they were permanently affixed to the storage drawers. She further explained she was not aware of any problems with a narcotic box in the medication carts.	F 431		

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

PRINTED: 02/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345140	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS Surveyor: 02249 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 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	THIS FACILITY'S RESPONSE TO THIS REPORT OF SURVEY DOES NOT DENOTE AGREEMENT WITH THE STATEMENT OF DEFICIENCIES; NOR DOES IT CONSTITUTE AN ADMISSION THAT ANY STATED DEFICIENCY IS ACCURATE. WE ARE FILING THE POC BECAUSE IT IS REQUIRED BY LAW.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 02249 Based on observation, on February 22, 2013 at approximately 8:30am onward, the sprinkler system maintenance is noncompliant due to the following: 1. excessive rust and deterioration of sprinkler escutcheon cover and body - ceiling sprinkler located in janitor's closet in kitchen area. 2. low pressure supervisory switch cover is not secured with tamperproof screws - cover could be removed at time of survey. Switch is located on sprinkler riser in pump room adjacent to center hall.	K 062	• K 062 ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The sprinkler located in the ceiling of the janitor's closet has been replaced and secured to ceiling. The low pressure switch cover has been secured with tamperproof screws located on sprinkler riser in pump room adjacent to center hall. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Any resident has the ability to be affected by the cited practice. The sprinkler has been changed and secured to the ceiling. The building has been inspected by Elite Fire Control to determine if any other sprinklers are rusted or not secured. None were found. The low pressure supervisory switch cover has been secured with tamperproof screws. The building has been inspected Elite Fire Control to determine if any other low pressure switch is not secured.	3-28-13

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

Debi Woodlief | Adm | 3-8-13

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.

JW

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

The facility has been inspected to determine if any other sprinklers have rust or that are not secured. None were found.

The facility has been inspected to determine if ay low pressure switches are not secured with tamperproof screws. None were found.

The Maintenance Supervisor will inspect all sprinklers to ensure they are free of rust and are secured to ceiling. If any found, the Maintenance Supervisor will notify Elite Fire Control to repair and document on a log.

The Maintenance Supervisor will inspect all low pressure switches to ensure all low pressure switches are secured with tamperproof screws. If any found the Maintenance supervisor will repair at time and document on log.

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

The Maintenance Supervisor will be responsible for ensuring all sprinklers are free of rust and secured to ceiling.

The Maintenance Supervisor will be responsible for ensuring all low pressure switches are secured with tamperproof screws.

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

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

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	345140	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/22/2013

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K 062	Continued From page 1 42 CFR 483.70(a)	K 062	• K 069 ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: There will be a semi-annual inspection done on the range hood on a routine basis.	
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: Surveyor: 02249 Based on observation, on February 22, 2013 at approximately 8:30am onward, there is no semiannual inspection report for the range hood fire suppression system after January 2013 - documents available for review consisted of cost estimates for replacing the existing system.	K 069	ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Any resident has the ability to be affected by the cited practice. The range hood will have a semi-annual inspection on a routine basis. The building has been inspected to determine if any other areas found to be noncompliant with the range hood. None were found.	3-12-13
K 147 SS=D	42 CFR 483.70(a) 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: Surveyor: 02249 Based on observation, on February 22, 2013 at approximately 8:30am onward, The facility is noncompliant with the National Electrical Code due to the following: 1. liquidtight flexible conduit is separated from fitting on outdoor condensing unit - located at the rear of facility. 2. there is storage items in front of electrical switchgear - located in boiler room at rear of	K 147	ADDRESS WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: The facility has been inspected to determine if any other areas are noncompliant with inspection to the range hood. None were found The Maintenance Supervisor will inspect range hood and make sure all semi-annual inspections are completed. If not completed the Maintenance Supervisor will notify the Salisbury Fire Appliance to inspect and document on a log.	

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

The Maintenance Supervisor will be responsible for ensuring that the semi-annual inspection will do on a routine basis.

The Administrator will present the Maintenance supervisor log to the QA committee on a quarterly basis. If no issues are discovered it will be monitored on a semi-annual basis.

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

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K 147	Continued From page 2 facility. 3. there is a nonlisted multioutlet receptacle adapter connected to patient bed receptacle in room 309 - the device doesn't provide a redundant ground path in accordance with Article 517 of the National Electrical Code. 42 CFR 483.70(a)	K 147	• K 147 ADDRESS HOW CORRECTIVE ACTION (S) WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: The liquidtight flexible conduit is sealed to the outdoor condensing unit located at the rear of facility. The storage items in front of the electrical switchgear located in the boiler room at rear of facility have been removed. The nonlisted multioutlet receptacle adapter connected to patient receptacle in room 309 has been removed. ADDRESS HOW CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Any resident has the ability to be affected by the cited practice. The liquidtight flexible conduit is sealed on the outdoor condensing unit. The building has been inspected to determine if any other areas are not sealed on the outdoor condensing unit. None were found. The storage items in front of the electrical switchgear have been removed. The building has been inspected by the Maintenance Supervisor to determine if any storage items are noncompliant with National Electrical Code. None were found. The nonlisted multioutlet receptacle adapter connected to patient bed receptacle in room 309 has been removed. The building has been inspected to determine if any items are noncompliant. It was determine that other rooms had been affected by this practice and multioutlet receptacles were removed.	2-26-13

JW

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

The facility has been inspected to determine if any other areas are not sealed on outdoor condensing unit. None were found.

The facility has been inspected to determine if any other storage items are noncompliant with the National Electrical Code with pertaining to storage items in front of electrical switchgear. None were found.

The facility has been inspected to determine if any other areas have nonlisted multioutlet receptacle adapters connected. It was found that other rooms had been affected by this practice and all have been removed by the Maintenance Supervisor.

The Maintenance Supervisor will inspect any areas on the condensing unit to ensure that all areas are sealed. If any are found the Maintenance Supervisor will repair at time and document on a log.

The Maintenance Supervisor will inspect all areas to ensure that the facility is not noncompliant with the National Electrical Code pertaining to storage items in front of electrical switchgear. If any are found the Maintenance Supervisor will repair at time and document on a log.

The Maintenance Supervisor will inspect all areas to ensure no nonlisted multioutlet receptacle adapters are connected. If any are found the Maintenance Supervisor will remove at the time and document on a log.

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

The Maintenance Supervisor will be responsible for ensuring all areas are sealed on outdoor condense unit.

The Maintenance Supervisor will be responsible for ensuring no storage items are in front of electrical switchgear.

The Maintenance Supervisor will be responsible for ensuring no nonlisted multioutlet receptacle adapters are used.

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

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