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

AUG 1 4 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING ______ B. WING ______	C 07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUGH CHATHAM MEMORIAL NURSING	700 JOHNSON RIDGE RD ELKIN, NC 28621

(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 No deficiencies were cited as a result of the complaint investigation survey of 7/11/13. Event ID# KIWX11.	F 000	F 170 Residents' mail to be delivered within 24 hours of delivery by the postal service.	
F 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on interview with residents, interview with staff and review of the facility policy and procedure the facility failed to deliver mail to residents on Saturdays. This was evident in 5 of the 5 resident care units. The findings included: Review of the facility policy titled " Resident Receipt of Mail and Mail Delivery " dated 10/90 revealed in part: Under Procedures #2 " On weekends, the mail will be delivered as soon as possible by the staff to the residents addressed on the mail. " Interview with the resident council president on 7/8/13 at 7:30pm revealed she delivers mail Monday through Friday. The council president stated "The Saturday mail is delivered on Monday. We (referring to the facility) had an incident where a watch or something got missing possibly from the copy room where the mail was kept so it stopped being delivered on Saturdays."	F 170	Postal Service notified to resume delivery of mail on Saturday. Policy and procedure revised see attachment #1 Shift Supervisor's in-serviced on policy and procedure revision. Attachment #2 Mail room audit daily by the administrative assistant and/or designee times 30 days then weekly times 3 months. See attachment # 3 Follow up with resident council monthly and document feed back in minutes by activity director. **Activity Director will report feedback to monthly PI Committee for the next 6 months to ensure compliance.** Report finding from mail room audit to monthly PI	07/20/13 08/02/13 08/08/13 08/05/13 08/26/13 09/16/13 08/20/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lindsay B. Smith, NHA
TITLE: Administrator
(X6) DATE: 8/12/13

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 170	Continued From page 1 Interview with an alert and oriented resident on 7/10/13 at 1:10pm revealed any mail from Saturday would be delivered on Monday. Interview on 7/11/13 at 12:22 PM with the activities director reveals she makes sure that the president of resident council has the mail to be delivered Monday through Friday. The administrative secretary sorts the mail by hall and there was no one in the front office on Saturdays. Interview on 7/11/13 at 12:30 PM with the administrative assistant at the front desk revealed she sort the mail and arranges by unit for the president of resident council to deliver. The administrative assistant indicated the facility requested from the post office to not deliver mail on a Saturday due to a package for a resident had been missing. We " wanted to safe guard the resident's packages. " Interview on 7/11/13 at 5:43 pm with the administrator and the assistant director of Quality management was held. The administrator indicated the facility stopped delivering mail to residents on Saturdays because she was trying to make sure that packages delivered to the facility were safeguarded over the weekend.	F 170		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280		

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F 280	Continued From page 2 within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and staff and family interviews, the facility failed to invite a family member for resident # 68 to a care plan meeting since October 2012. This was evident for 1 of 4 families interviewed. Findings include: On 7/11/ 13 at 9:30 am during an Interview with the family member of resident #68, she revealed she had not had a care plan meeting scheduled since last October 2012. An interview with the MDS Coordinator, RN (Registered Nurse) on 7/11/13 at 2:00 pm revealed she did quarterly reviews with the care plan team. She stated she sends a letter after the meeting to the family member asking if they would like to have a conference about the meeting that was held. She continued that, " we used to meet with the resident's (#68) family quarterly, with the care plan team, but we have	F 280	F 280 Resident #68 next Care Plan Meeting scheduled for 08/13/13 at 11:00am. Letter delivered to wife by MDS Coordinator. See attachment # 4 Letter to be sent to resident/family at least 2 weeks prior to scheduled conference. See attachment #5-15 (*these letters were sent out prior to policy and procedure change*) See attachment 16-21(*letters sent out for 08/05/13* after the 08/02/13 policy revision.) Interdisciplinary Care Plan policy and procedure reviewed and revised. See attachment # 22 MDS Coordinator/designee will monitor and document response to notification on copy of letter sent to family/resident. See Attachment # 5-15 MDS Coordinator /designee will monitor weekly times 30 days, then monthly times 3 months then quarterly thereafter. MDS Coordinator/designee will report finding to PI monthly time 3 months then quarterly there after. Follow up with resident council monthly and document feed back in minutes by activity director. Activity director to report feedback from residents to monthly PI Committee. **Activity Director will report feedback to monthly PI Committee for the next 6 months to ensure compliance.**	08/13/13 08/02/13 07/23/13 08/02/13 08/20/13 08/20/13 08/26/13 09/17/13

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F 280	Continued From page 3 not had a meeting one on one with the family member because the family member is here daily and she makes the staff aware of her concerns and needs." When asked if the family member of resident #68 had been notified of care plan meetings she stated she has not sent letters to any families since January 1, 2013 due to time constraints. She further stated the last letter sent to the resident's family member was sent in October, 2012. On 7/11/13 at 3:20 PM an interview with the DON revealed she was not aware that notifications were not being done quarterly. She further stated her expectation was that notification be given to the family and or resident on a quarterly basis. An interview with the Social Worker on 7/11/13 at 3:40 pm revealed she was not aware that letters were not being sent out to families on a quarterly basis. She further stated she meets with the care plan team for reviews as well as family members and residents when they have concerns or after a team review. An interview with the Administrator on 7/11/13 at 5:00 pm stated she was not aware that letters were not being sent to family members regarding care plan meetings and it was her expectation that family members and or residents need to be notified. She further stated that letters will be sent out for the next quarter. She also stated that the entire IDT (Interdisciplinary Team) should meet with family, not the way they have been doing it, and stated this too will change.	F 280		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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F 329	Continued From page 4 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with resident and staff, the facility failed to ensure a resident's drug regimen was free of unnecessary drugs by not doing a gradual dose reduction (GDR) for 1 of 6 residents, (Resident #71), reviewed for unnecessary medications. The facility failed to conduct a Dyskinesia Identification System: Condensed: User Scale (DISCUS) assessment every 6 months.	F 329	F 329 Gradual dose reduction for resident # 71 declined by physician # 1. **This reduction was denied because resident remains anxious. Progress note dated 08/02/13 states "Anxiety/depression continues supportive care with the medicine she is on." Pharmacist will recommend another GRD then the next order.**	7/16/13
			Nursing received a list from pharmacy of all current residents with orders for antipsychotic medications.	08/05/13
			Audit for gradual dose reduction completed See attachment # 23	08/20/13
			Residents with antipsychotic orders will be reviewed by the consultant pharmacists monthly and by the care plan team during the regularly scheduled care plan updates to confirm that GDRs have been attempted consistent with the schedule identified above. The physician will be notified by the pharmacist and/or care plan team if a GDR has not been attempted as described above and the physician will be asked to order a GDR or document in the clinical record the rationale regarding why a GDR is clinically contraindicated at this time.	08/20/13
			Once monthly, the nursing staff will receive a list of active antipsychotic orders from pharmacy. Nursing will review those records monthly to confirm that GDRs have been attempted or the rationale regarding why a GDR is clinically contraindicated has been added to the chart records. The results of this monitoring program will be presented to the CQI Committee monthly for a minimum of six months. The CQI team will evaluate finding and determine the method and frequency of any additional monitoring or other interventions.	08/20/13

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F 329	Continued From page 5 (Resident #83) Findings included: Resident #71 was admitted to the facility on 11/12/08 with diagnoses that included chronic pain, insomnia, osteoarthritis, osteoporosis, anxiety, and dementia. The psychiatry consult note dated 6/13/12 revealed the resident had joint discomfort with increasing anxiety and obsessive thoughts for several years. The diagnosis was, "obsessive negative thought pattern [with] chronic anxiety." The psychiatry consult note dated 7/11/12 revealed the resident continued with anxious obsessive thoughts ...sleep was good but the resident awoke with anxiety. An antipsychotic medication was added. The care plan dated 11/22/12 revealed Resident #71 was at risk for side effects related to use of antidepressant, anxiety, and antipsychotic medications. Interventions included monitoring for side effects, monthly pharmacy review, and monitoring for GDR. The pharmacist chart review note dated 2/20/13 revealed a recommendation for decreasing Resident #71 ' s antipsychotic medication. The pharmacist chart review note dated 3/19/13 indicated "no behavior issues noted." The pharmacist medication review sheet dated	F 329	The Medical Director will be notified at PI Meeting if attending physician fail to address GDR and/or did not validate clinical contraindications to GDR Resident # 71 DISCUS completed 06/06/13 located in current medical record DISCUS dated 07/19/13 and 08/02/13 located in current medical record. See attachment # 24, #25, # 26 Resident # 83 DISCUS completed and located in current medical record. See attachment # 27 Nursing obtained a list from pharmacy of all residents with active orders for antipsychotic. **An audit was completed and it was confirmed that each resident has a DISCUS completed as of 08/05/13 on their chart per policy. See attachment # 28 Resident DISCUS.** Policy and procedure revised. See attachment #29 Staff Development Coordinator/and or designee will report to PI Committee monthly for a minimum of six months. The PI Committee will evaluate finding and determine the method and frequency of any additional monitoring or other interventions.	08/20/13 08/21/13 07/10/13 08/02/13 08/05/13 08/20/13

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F 329	Continued From page 6	F 329		

4/17/13 stated, "This resident had had an order for [an antipsychotic medication] since July (diagnosis appears to be obsessive thoughts) per psych. I cannot find any subsequent psych notes. She is due for an evaluation for a gradual dose reduction." An added note to the Director of Nursing stated, "This consult was issued in February and does not appear to have been addressed."

Record review revealed a request from the pharmacist to Physician #1 on 4/25/13 for a dose reduction of the resident's antipsychotic from 0.25 mg at bedtime to 0.125mg at bedtime. There was no response noted from Physician #1 and the request was re-faxed on 5/21/13. Physician #1 responded "not at this time" on 5/21/13.

The quarterly Minimum Data Set (MDS) dated 4/26/13 revealed the resident was cognitively intact, felt depressed never or only 1 day the week of the assessment, had no psychosis or behavioral symptoms, did not reject care, did not wander, and had diagnoses of anxiety and depression.

The Physician #1 progress note dated 5/2/13 stated, "[Resident #71] has a little more anxiety than she has had" and "Psychiatric illness. Stable."

The 5/16/13 update of the care plan indicated the pharmacist had requested a reduction of the resident's antipsychotic medication and stated, "[Physician] has declined reduction in the past."

The Physician #1 progress note dated 6/1/13 stated, "[Resident #71] is doing about the

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F 329	Continued From page 7 same...She also has some decreased sleep and anxiety but overall is fairly stable. We are just a little concerned that she is sleeping more" and "Psychiatric situation, seemingly stable." The pharmacist chart review note dated 6/18/13 indicated the physician had declined a gradual dose reduction of the Resident #71's antipsychotic medication and there were no mood or behaviors noted. A review of the Documentation of Behavior sheets dated March - July 2013 revealed the resident's behavior was assessed each shift and there was one episode of paranoia and one episode of anxiety during the 4 months. A review of Nurse's notes dated 5/1/13 - 7/10/13 revealed no notes indicating any anxiety or other behaviors. A review of the July Medication Administration Record revealed the resident had not needed any additional dose of anxiety medication. On 7/10/13 at 3:20 pm Resident #71 was observed with a calm, pleasant demeanor, walking with her walker, smiling, and talking to a staff member in the hallway. On 7/10/13 at 3:30 pm Resident #71 was interviewed and indicated that she does feel anxious sometimes, takes medication for her anxiety, and did not recall the physician discussing with her any attempts to decrease the dose of her medication. On 7/10/13 at 4:15 pm Nurse Aide #1 indicated	F 329		

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F 329	Continued From page 8 Resident #71 does not exhibit behaviors, including anxiety, when she provided care. She stated, " [Resident #71] is cooperative and calm with me. " On 7/10/13 at 5:03 pm, Physician #1 was interviewed and indicated Resident #71 "stays extremely nervous" and he felt she would do better on an antipsychotic medication than increasing her anxiety medication that she took 4 times a day. He indicated the resident had been evaluated by psychiatry services when she was placed on the antipsychotic medication, but there were now no psychiatry services available to come to the facility. He stated he felt with her severe chronic pain that traveling to an appointment some distance away would not be the best thing for her. He further indicated that he had not attempted any dose reductions of her antipsychotic medication, was aware of the pharmacy recommendation, and stated, "That is something we might could try. " On 7/10/13 at 5:27 pm the Director of Nursing (DON) stated "We used to have psychiatry services. The administrator has been calling around but we don't have anyone right now." On 7/11/13 at 10:05 am Nurse #1 stated, "[Resident #71] likes habits. If things change she gets very nervous. If she is supposed to get her medicine at 8 and it is 8:05, she comes out to remind me that she needs her medicine. I don't notice any side effects from her meds. She is steady on her feet. She uses her walker and cane." On 7/11/13 at 3:00 pm the DON indicated that the	F 329		

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F 329	Continued From page 9 Resident #71 had been on an antipsychotic medication for a year, Physician #1 had not done a GDR after several pharmacy recommendations, and the lack of a GDR attempt had not been addressed by the facility. On 7/11/13 at 5:45 pm the Administrator indicated her expectations were that gradual dose reductions would be attempted unless contraindicated by documented behaviors, that there would be a process to monitor how pharmacy recommendations were handled and followed up with, and if the physician did not do a reduction the medical director would be informed. The facility failed to conduct a Dyskinesia Identification System: Condensed: User Scale (DISCUS) assessment every 6 months. (Resident #83) 2. The facility has a policy and procedure titled " Antipsychotic Drug Therapy " in effect since 10/2011 revealed in part revealed residents on a prescribed antipsychotic will be scheduled for a DISCUS evaluation once every 6 months. Review of the July 2013 physician orders revealed Risperdal (an antipsychotic drug) 0.5 milligrams (mg) every 12 hours by mouth twice a day. Review of the medical record of Resident #83 revealed no Discus assessment. A DISCUS assessment monitors for Abnormal Involuntary Movements associated with the use of antipsychotic drugs. Review of the pharmacy consultation report dated	F 329		

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F 329	Continued From page 10 4/19/13 revealed the pharmacy informed the facility that DISCUS assessments were missing. Interview on 7/10/13 at 11 am with the MDS coordinator#1 revealed the facility does DISCUS assessments every 3 months but only required every 6 months. Interview on 7/10/13 at 2:49 pm with the consultant pharmacy representative revealed Resident#83 ' s current DISCUS assessment could not be located (since 10/12) and an assessment should have been done in April 2013. Further inquiry about the lack of a DISCUS assessment was done on 7/11/13 at 3 pm with the assistant director of nursing (ADON). Interview on 7/11/13 at 3 pm with the ADON and the assistant director of Quality management (ADQM) revealed the last time a DISCUS evaluation done was 8/9/12 (a different date). The ADON indicated the assessment should be done twice a year. Interview on 7/11/13 at 5:43 pm with the administrator and the ADQM was held. The administrator revealed the expectation was a DISCUS assessment should be done every 6 months.	F 329		

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FORM APPROVED
OMB NO. 0938-0391

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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		
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Surveyor: 02249 Based on observation, on August 6, 2013 at approximately 10:00am onward, there is lint and debris on fusible links of ceiling fire dampers located in the kitchen area. 42 CFR 483.70(a)	K 067	K 067 REMOVED RETURN GRILL, CLEANED FIRE DAMPER AND CHECKED FUSIBLE LINKS OF CEILING FIRE DAMPERS. CHECK ALL FUSIBLE LINKS OF CEILING FIRE DAMPERS TO ASSURE FREE FROM LINT AND DEBRIS. ADD CHECKING OF ALL FIRE DAMPERS TO PREVENTATIVE MAINTENANCE PROGRAM. SEE ATTACHMENT #2. REPORT TO PI COMMITTEE MONTHLY X 3 THEN QUARTERLY THEREAFTER BY PLANT OPERATIONS DIRECTOR OR DESIGNEE FOR 1 YEAR.	08/07/13 09/06/13 09/06/13 08/20/13
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:	K 069		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature], NHA — TITLE: Administrator — (X6) DATE: 8/23/13

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.

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

PRINTED: 08/11/2013
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
	345095	A. BUILDING 01 - MAIN BUILDING B. WING ______	08/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUGH CHATHAM MEMORIAL NURSING	700 JOHNSON RIDGE RD ELKIN, NC 28621

(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 1 Surveyor: 02249 Based on observation, on August 6, 2013 at approximately 10:00am onward, there is no baffle between gas range and deep fryer located in the kitchen area. 42 CFR 483.70(a)	K 069	K069 Deep Fryer Was Moved 16 inches From Electric Range.	08/07/13
			A metal bracket / bar was placed in floor to secure the deep fryer and to prevent deep fryer from shifting towards electric range.	08/28/13
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147	The deep fryer has been permanently moved and secured to floor to avoid this deficient practice occuring in future.	08/28/13
	This STANDARD is not met as evidenced by: Surveyor: 02249 Based on observation, on August 6, 2013 at approximately 10:00am onward, the visual indicator for normal power did not function for the 800 amp automatic transfer switch - located at rear of facility. 42 CFR 483.70(a)		Plant Operations Director or Designee will monitor the placement and security of metal bracket of deep fryer quarterly and report to PI Committee quarterly for next 6 months.	08/20/13
			K147 The bulb was replaced on visual indicator for 800 amp automatic transfer switch located at rear of building.	08/07/13
			All transfer switches were checked for visual indicator.	08/07/13
			Added visual indicator switch to preventative maintenance monthly log to ensure it is checked.	08/23/13
			Plant Operations Director or Designee to report to P.I. monthly x3 then quarterly thereafter for 1 year.	08/20/13

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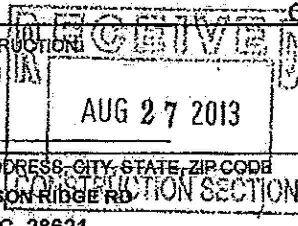

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345095	A. BUILDING 02 - MAIN B. WING	08/06/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUGH CHATHAM MEMORIAL NURSING	700 JOHNSON RIDGE RD ELKIN, NC 28621

(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 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		
K 147 SS=D	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 August 6, 2013 at approximately 10:00am onward, the exit discharge light is missing for fixture located near speech therapy - located under canopy serving Regional Rehab Center. 42 CFR 483.70(a)	K 147	K147 EXIT DISCHARGE LIGHT REPLACED FOR FIXTURE NEAR SPEECH THERAPY UNDER CANOPY SERVING REGIONAL REHAB CENTER.	08/07/13
			ALL EXIT DISCHARGE LIGHTS FOR ENTIRE FACILITY WILL BE CHECKED AND REPLACED TO ASSURE FUNCTIONING PROPERLY.	08/23/13
			EXIT DISCHARGE LIGHTS TO BE ADDED TO MONTHLY PREVENTATIVE MAINTENANCE SEE ATTACHMENT #1.	08/23/13
			PLANT OPERATION DIRECTOR OR DESIGNEE TO REPORT TO PI COMMITTEE MONTHLY x3 MONTHS THEN QUARTERLY THEREAFTER FOR 1 YEAR.	08/20/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lindsay B. Smith, NHA
TITLE: Administrator
(X6) DATE: 08/23/13

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