STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HEALTH & REHAB/HE	1300 DON JUAN ROAD HERTFORD, NC 27944

(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 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to follow a physician's order by failing to give eye drops as ordered for 1 of 5 resident's record reviewed for unnecessary medications.(Resident #13) Resident #13 was admitted to the facility on 3/14/05 with diagnoses including Glaucoma and Diabetes. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 6/4/13 identified the resident as having Glaucoma. Review of the Care Area Assessment (CAAs) Summary dated 12/3/12 identified Vision as triggering related to Resident #13 having Glaucoma and Diabetic Retinopathy. Review of the Ophthalmology Consult dated 3/20/13 documented the resident ' s Xalatan solution (eye drops) were to be given in both eyes for Glaucoma. Review of the Physician ' s orders dated 3/20/13 documented an order for Xalatan Ophthalmic Solution to be given in both eyes nightly for Glaucoma. Review of the Medication Administration Records for March 2013 through August 2013 showed that Resident #13 received Xalatan .005% eye drops	F 281	"Preparation an/or excutation of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of defencies. The plan of correction is prepared and/or excuted solely because it is required by the provisions of federal and state law." F-281 1. The physician's order dated 3/20/13 for resident #13 prescribes Xalatan Opthalmic Solution to be given in both eyes nightly for treatment of Glaucoma and Diabetic Retinopathy. The order is now in properly transcribed on the MAR to be given 2. All residents receiving eye drops have been reviewed for correct transcription 3. September monthly physician's order updates have been compared with the current September MARs for accurate transcription of current orders. This MAR review process will continue ongoing. 4. Outside consults or appointments which have occurred over the last 60 days were reviewed to assure any recommend-ationshave been noted and followed. 5. Consults/Reports will be set aside in a newly created "Outside Report Inbox" for detailed review and follow up including writing physician's order, implementing the order, then filing in the chart. Orders for that day to be reviewed during clinical rounds. (continued...)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jan Mayo, LNHA	Administrator	9/18/13

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 281	Continued From page 1 to the right eye only. During an interview with the Director of Nursing on 8/28/13 at 9:50AM she stated that all Physicians ' orders should be followed. During an interview with the Administrator on 8/29/13 at 2:15PM he stated that he would expect Physician ' s orders to be followed.	F 281	Clinical rounds include the direct comparison between the physician's order and the MAR, TAR, Dietary Communication or other method of assuring the physician's order has been fully and and accurately transcribed and implemented. The DON will track and trend these daily and report findings to QAPI for further interventions as appropriate and will continue for at least 90 days with QAPI determining the need for further corrective action.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to report a change in condition for one of four residents reviewed for skin conditions (resident #104). Resident #104 was admitted to the facility on 5/23/13 and discharged on 5/27/13 with diagnoses including Alzheimer ' s disease, Hypertension, Arthritis and Hypothyroidism. Review of the Minimum Data Set (MDS) Assessment dated 5/27/13 identified Resident #104 as moderately impaired cognitively. She did not have any skin conditions on admission.	F 309	The Director of Nursing is ultimately responsible for this corrective action which will be fully implemented by September 25, 2013. F-309 1. The physician has been notified and action taken regarding resident 104#s skin condition. 2. Nurses have been in-serviced regarding MD notification of Resident Change of Condition. 3. Twenty four hour reports for the last 30 days have been audited for changes in condition and the clinical record reviewed to determine if notification has been made. Follow up with these findings will include notification and re-education of individual nurses as needed. 4. A daily review of physicians orders is completed during clinical rounds. 5. These will include a record review to validate that a note has been written regarding notification of appropriate parties. Any failure to notify will be included on the physician's order review daily follow up list and noted in DON's tracking and trending. 6. Results will be reviewed by the Plan of Correction PIP Team with recommendations made for any additional follow up action as appropriate (continued...)	

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F 309	Continued From page 2 Review of the Interim Plan of Care, dated 5/23/13 identified Resident #104 as having a potential for pressure ulcers related to her immobility, incontinence and nutritional impairment. Interventions initiated to prevent pressure ulcers included turning and repositioning frequently and weekly skin checks. Review of the Nursing Admission Assessment, dated 5/23/13 documented Resident #104 skin condition as " warm. " The resident had no other skin conditions on admission. Review of the Nursing Daily Skilled Summary, dated 5/25/13, documented no skin conditions for the resident. Review of the Nursing Notes, dated 5/26/13 documented the nurse was called to the resident ' s room by a visitor to observe a " cluster of blisters to the left outer arm. " The physician was notified. Further review documented on 5/27/13 at 3:00AM the physician returned the call and ordered Zovirax 200mg (milligrams) QID (four times a day) for 10 days. The resident ' s responsible party was notified of the new order. The resident was discharged home on 5/27/13 with all medications. Review of the facility investigation of the incident was reviewed. The conclusion was documented that the nurse working with Resident #104 on Saturday, 5/25/13 had seen the blisters and failed to report a change in condition to the physician. During an interview with the Resident Care Specialist #1 (RCS) on 8/28/13 at 12:08PM, who worked with Resident #104 on 5/25/13 she stated that she noticed the blisters on the resident ' s left	F 309	7. Nurses have been in-serviced regarding the requirement to notify pysician as well as clarification on what constitutes "change in condition" and how to convey such information by using the SBAR tool. The Director of Nursing is ultimately responsible for sustaining this corrective action which will be fully implemented by 9/25/13.	

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F 309	Continued From page 3 elbow area and notified the nurse at 7:30AM. During an interview with the Director of Nursing she stated that the facility had done an investigation into the incident involving the blisters after a family member contacted the facility and in conclusion it was determined through staff interviews that the nurse working with Resident #104 on 5/25/13 was made aware from RCS #1 of the blisters on 5/25/13 and this nurse admitted she did not notify the physician of a change in condition. The DON stated that this nurse is no longer working at the facility. Attempts were made to contact this nurse by telephone unsuccessfully. The DON stated that it is expected that all changes in condition be reported to the physician.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview the facility failed to accurately assess a resident's skin integrity on admission and failed to notify the physician and provide treatment for a resident with a stage 2 pressure ulcer for 1	F 314	F-314 1. All residents with Braden Scores indicative of moderate risk (14 and below) have had full skin assessments to assure no areas of concern go unrecognizable. 2. All residents who have known pressure or non-pressure have been reassessed for correct staging and appropriate treatment modality by the Treatment Nurse. Each resident with a wound has been reassessed for proper interventions including treatment, surface and positioning, nutritional intervention and potential contributing factors. This audit has been provided to the physician for review and recommendations. 3. The DON will ensure that all TARs are reviewed each day for potential missed treatments. Any missed treatments will be handled in a comprehensive manner including completing the treatment, re-educating the nurse who missed the treatment and discipline as needed. (continue...)	

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F 314	Continued From page 4 (Resident #103) of 3 residents reviewed for pressure ulcers. Findings include: Resident #103 was admitted to the facility on 8/22/13 with diagnoses of Dementia. Review of Resident #103's nursing admission assessment dated 8/22/13 revealed she was assessed with a 3 centimeter (cm) blister to her left buttocks and identified as having a stage 1 pressure ulcer. Resident #103 was assessed with risk factors of impaired mobility and decreased functional ability. Review of the skin treatment book revealed no orders for treatment for Resident #103 ' s 3 cm purple blister on her left buttocks. Review of the interim plan of care revealed on 8/22/13 Resident #103 had an actual 3 cm blister to her left buttocks and interventions were to notify the physician of changes in the wound or emerging wounds and to turn and reposition frequently to decrease pressure. During an observation on 8/27/13 at 10:23 AM Resident #103 was observed without a bandage to her left buttocks. Resident #103 was observed with a 3 cm length and ¼ inch wide dried open area to her left lower hip. During an interview on 8/27/13 at 10:24 AM the treatment nurse stated a 3 cm purple blister would mean the resident had a stage 2 pressure ulcer. The treatment nurse stated staff should have put a cover on it and notified the physician.	F 314	4. An updated weekly wound report detailing each wound by stage, whether admitted with or facility acquired and the treatment being completed with any changes will be provided to the DON, the Administrator, the Medical Director and the Regional Clinical Director on a weekly basis for 90 days. 5. The DON will track the incidence of any missed treatments and reported to QAPI for 90 days. The DON is ultimately responsible for sustaining compliance with this corrective action which will be completed by 9/25/13.	

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F 314	Continued From page 5 During an interview with the DON on 8/29/13 at 10:22 am she stated she did assess the resident on admission. She stated she assessed Resident #103 with a blister and it was a stage 2 pressure ulcer. On the admission assessment it was checked as a pressure ulcer and was checked as a stage 1 pressure ulcer. She stated she should have checked the assessment as a stage 2. The physician should have been notified to obtain and initiate a treatment order.	F 314		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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.	F 329	F-329 1. Pharmacy recommendations for the last 120 days have been reviewed for response time and comprehensiveness of response. Unresolved recommendations have been identified and resolved. 2. Pharmacy Consult Recommendations will be provided to the DON for review, copying and follow up. The DON will forward recommendations requiring physician's response by mail or hand delivery to the Medical Director for action. The Medical Director will promptly respond by returning both the cover sheet and a recommendation for each resident named on that cover sheet. Upon receipt, the DON will compare the returned completed recommendations to the package which had been sent to the physician. Any missed recommendations will be noted for follow up with the physician. 3. The DON will ensure that the physician's recommendations are transcribed onto appropriate orders, then recorded onto the MAR, TAR or other appropriate documents 4. The pharmacist will note any discrepencies during his monthly visit and make the DON, Administrator, and Regional Clinical Director aware of any missed recommendation he	

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F 329	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review, pharmacy consultant review and staff interview the facility failed to discontinue a medication the pharmacy consultant had identified as being used for an excessive duration and the physician had ordered to be discontinued for 1of 5 residents (Resident #22) reviewed for unnecessary medications. Resident #22 was admitted on 7/3/2017 with diagnoses of CHF (congestive heart failure), Hypertension and Diabetes Mellitus. Findings include: Review of the pharmacy consultation report dated 10/23/12 revealed the pharmacist recommended Vitamin C be discontinued due to the resident taking the medication since 8/15/12. The physician agreed and checked to implement as written on 10/31/12. Review of the pharmacy consultation report dated 1/29/13 revealed the pharmacist recommended Vitamin C be discontinued due to the resident taking the medication since 8/15/12. The physician's response was checked as accepting the recommendation and to implement as written on 2/12/13. Review of the pharmacy consultation report dated 3/12/13 revealed he pharmacist recommended Vitamin C be discontinued due to the resident taking the medication since 8/15/12. The physician's response was checked as accepting the recommendation and to implement as written on 3/22/13.	F 329	he may have identified. Any such findings will be addressed both by the completing the process correctly as well as identifying the root cause of the process failure. 5. Compliance with timely response will be tracked and trended fo reporting to QAPI for 120 days at which time the Committee will determine appropriate follow up action based on any patterns identified. The Administrator is ultimately responsible for sustaining compliance with this corrective action which will be fully implemented by 9/25/13.	

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F 329	Continued From page 7 Review of the pharmacy consultation report dated 5/10/13 revealed he pharmacist recommended Vitamin C be discontinued due to the resident taking the medication since 8/15/12. The physician's response was checked as accepting the recommendation and to implement as written on 5/28/13. Review of the physician's orders dated 5/28/13 revealed the Director of Nursing (DON) wrote an order and the physician signed the order to discontinue the Vitamin C. Review of the medication administration record for the Month of May 2013 until 5/28/13 revealed the resident received vitamin C daily, During an interview on 8/29/13 at 12:20 PM with the Nurse Consultant, the Administrator and the Vice President of the corporation present, the Nurse Consultant stated when the facility pharmacist came to the facility on the day he exits he would give verbal information regarding his medication reviews. The pharmacy consultant then would e-mail his report in about 1 and one half to 2 weeks to the Administrator and the DON. The DON would send the consultations to the physician and he was to return his recommendations back to the facility. The DON was supposed to keep a copy so she could make sure all the pharmacy consultation reports were acted on. She was to keep a copy and she failed to keep a copy of the consultation report. Because the facility did not have the copy they did not know what was still outstanding.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428	F-428 1. Nurses will write a physician's order for (continued...)	

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F 428	Continued From page 8 The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on medical record review, pharmacy consultant review and staff interviews the facility failed to act on pharmacy recommendations for 2 of 5 (Resident #5 and #22 sampled residents with pharmacy recommendations by failing to act on laboratory tests and failing to discontinue a medication per physician order and the pharmacist failed to report to the facility a change in medication dosage for eye drops for 1 of 5 residents (Resident #13)reviewed for unnecessary medications. The findings include: 1. Resident #5 was admitted to the facility on 8/23/2006 with diagnosis that included cerebral vascular accident (CVA) with left side hemiplegic, sarcoidosis, osteoarthritis, diabetes mellitus with retinopathy, hypertension, hyperlipidemia, anxiety, anemia and heartburn. Review of the pharmacy recommendation of 7/9/13 revealed a recommendation in part, as " Resident #5 ' s Potassium was 3.4 on 6/1/13.	F 428	a lab to be drawn. 2. The physcian's order will be reviewed the following day during clinical rounds to assure the lab has been drawn and placed in a pending file awaiting results. 3. As results are received, the lab value is reported to the physcian as appropriate, noted and the copy removed from the pending file. The signed and noted copy of the laboratory report is then filed in the chart. The DON is ultimatley responsible for sustaining compliance with this corrective action which will be implemented by 9/25/13. Resident #22's order for daily vitamin C was discontinued on 5/28/13 and has not been given since. 4. Any resident who has a pharmacy consultation recommendation made in the last 120 days have been reviewed for response time and comprehensiveness of response. 5. Recommendations will be provided to the DON for review, copying, and follow up. The DON will forward recommendations requiring physician's response by mail or hand delivery to the Medical Director for action. The Medical Director will promptly respond by returning both the cover sheet and a recommendation for each resident named on the cover sheet. 6. The DON will ensure that the physician's recommendations are transcribed onto appropriate orders then recorded on the MAR, TAR, or other appropriate documents The Admininstrator is ultimately responsible for sustaining compliance with this corrective action which will be fully implemented by 9/25/13.	

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F 428	Continued From page 9 Please consider repeating a Potassium level. " During an interview on 8/28/13 at 11:00 AM the Nurse Consultant stated the Potassium level did not get sent to the Physician. It was a copying issue; staff did not copy this order. Review of the pharmacy recommendation of 7/9/13 revealed a recommendation in part, as "Repeated Recommendation from 6/11/13. Please respond promptly to assure facility compliance with Federal regulations. Resident # 5 had orders for labs to be drawn, but at the time of this review they were not available in the resident record. The missing lab values include: PTH (Para Thyroid Hormone). " During an interview on 8/28/13 at 11:00 AM the Nurse Consultant stated staff drew a TSH (thyroid stimulating hormone) instead of a PTH, the TSH was within normal limits. The Nurse Consultant stated staff failed to draw the PTH. During an interview on 8/28/13 at 2:45 PM the Director of Nursing (DON) revealed the PTH recommendation should have been pulled over to the lab book and drawn. Instead staff drew a TSH. The lab for the Potassium should have been sent to the Physician for him to respond to. During an interview on 8/29/13 at 10:37 AM Nurse #1 stated when the facility received an order either by voice or written, they took the order off. If an order was for labs, staff would write it in the lab book for the next day or the next lab draw day. Nurse #1 indicated night shift took the orders off and would process it to the lab book. If there was a problem with that lab, staff would notify the Physician the lab could not be	F 428		

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F 428	Continued From page 10 drawn and wait for his response. Nurse #1 revealed staff would also document on the 24 hour report and discuss the lab the next morning in stand up meeting for follow up. Nurse #1 did not know why the Potassium or PTH were not on the lab book. 2. Resident #22 was admitted on 7/3/2017 with diagnoses of congestive heart failure (CHF), Hypertension and Diabetes Mellitus. Review of the pharmacy consultation report dated 10/23/12 revealed the pharmacist recommended Vitamin C be discontinued due to the resident taking the medication since 8/15/12. The physician agreed and checked to implement as written on 10/31/12. Review of the pharmacy consultation report dated 1/29/13 revealed the pharmacist recommended Vitamin C be discontinued due to the resident taking the medication since 8/15/12. The physician's response was checked as accepting the recommendation and to implement as written on 2/12/13. Review of the pharmacy consultation report dated 3/12/13 revealed he pharmacist recommended Vitamin C be discontinued due to the resident taking the medication since 8/15/12. The physician's response was checked as accepting the recommendation and to implement as written on 3/22/13. Review of the pharmacy consultation report dated 5/10/13 revealed he pharmacist recommended Vitamin C be discontinued due to the resident taking the medication since 8/15/12. The physician's response was checked as accepting	F 428		

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F 428	Continued From page 11 the recommendation and to implement as written on 5/28/13. Review of the physician's orders dated 5/28/13 revealed the Director of Nursing (DON) wrote an order and the physician signed the order to discontinue the Vitamin C. Review of the medication administration records for the Month of May 2013 until 5/28/13 revealed the resident received vitamin C daily, During an interview on 8/29/13 at 12:20 pm with the Nurse Consultant, the Administrator and the Vice President of the corporation present, the Nurse Consultant stated when the facility pharmacist came to the facility on the day he exited he would give verbal information regarding his medication reviews. The pharmacy consultant then would email his report in about 1 and one half to 2 weeks to the Administrator and the DON. The DON would send the consultations to the physician and he was to return his recommendations back to the facility. The DON was supposed to keep a copy so she could make sure all the pharmacy consultation reports were acted on. She was to keep a copy and she failed to keep a copy of the consultation report. Because the facility did not have the copy they did not know what was still outstanding. 3. Resident #13 was admitted to the facility on 3/14/05 with diagnoses including Glaucoma and Diabetes. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 6/4/13 identified the resident as having Glaucoma. Review of the Care Area Assessment (CAAs) Summary dated	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 08/29/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 428	Continued From page 12 12/3/12 identified Vision as triggering related to Resident #13 having Glaucoma and Diabetic Retinopathy. Review of the Medication Administration record for the month of August 2013 revealed Resident #13 was receiving Xalatan .005% eye drops to the right eye for Glaucoma. Review of the Ophthalmology Consult dated 3/20/13 documented the resident ' s Xalatan solution (eye drops) were to be given in both eyes. Review of the Physician ' s orders dated 3/20/13 documented an order for Xalatan Ophthalmic Solution to be given in both eyes nightly for Glaucoma. Review of the Medication Administration Records for March 2013 through August 2013 showed that Resident #13 received Xalatan .005% eye drops to the right eye only. Review of the monthly Pharmacy review documentation from May 2013 through August 2013 did not show any documentation regarding the change in dosage of the eye drops. During an interview with the Director of Nursing on 8/28/13 at 9:50AM she stated that all Physicians ' orders should be followed. During an interview with the Pharmacy Consultant on 8/29/13 at 12:49PM he stated that he did not recall the medication change. During an interview with the Administrator on 8/29/13 at 2:15PM he stated that he would expect	F 428		

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F 428	Continued From page 13 the Pharmacy Consultant to review the medical records monthly and if there is a discrepancy to report it to the facility. He further stated the process would be for the consultant pharmacist to check physician's orders and consults for any changes and confirm those changes have been made on the Medication Administration Record.	F 428		

PRINTED: 09/30/2013
FORM APPROVED
OMB NO. 0938-0391

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

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	345282	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/18/2013

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K 000	INITIAL COMMENTS Based on observation on 09/18/2013 the facility was type V, fully sprinkled, protected wiyh(78) seventy-eight beds.	K 000	K018 Correction for the alleged deficient practice noted as rooms 21, 402, and 403 failed to latch when closed, was to immediately adjust those doors to reliable working, latching condition. The Maintenance Director surveyed the remainder of the building checking all doors for proper operation and made any needed repairs or adjustments upon discovery. The Maintenance Director will do a weekly survey of all doors for proper operation for the next three months and present all findings at the corresponding monthly Safety Committee meetings for review and discussion. Reviews will continue quarterly thereafter until next annual survey to insure continued compliance. Completion date of 9/19/2013	9/19/13
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: A. Based on obsevation on 09/18/2013 the doors to rooms 214,402 and 403 failed to latch when closed. 42 CFR 483.70 (a)	K 018		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating	K 062		

RECEIVED
OCT 28 2013
CONSTRUCTION SECTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/12/13

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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K 062	Continued From page 1 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: A. Based on observation on 09/18/2013 the sprinkler heads under the over hang at the end of the 200 corridor were corroded and must be replaced. 42 CFR 483.70 (a)	K 062	K062 Correction for the alleged deficient practice noted as "sprinkler heads under the overhang at the end of 200 corridor were corroded and must be replaced", was a call placed to sprinkler contractor to assist Maintenance Director to survey the entire building and note for replacement, those and any other sprinkler heads found to be corroded. The Maintenance Director will continue with monthly inspections of the sprinkler heads and present all findings for discussion and review to the next three monthly Safety Committee meetings. These monthly inspections will then continue to be reviewed by the Safety Committee quarterly thereafter until next annual survey to insure continued compliance. Date of correction _____	10/21/13

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