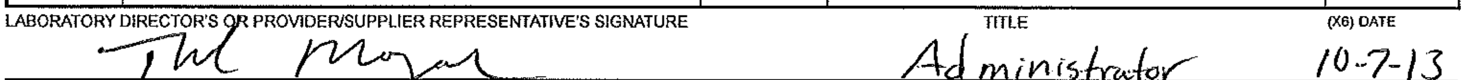
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OCT 0 9 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING ______ B. WING ______	C 09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview and record review the facility failed to speak to a resident in a respectful way for 1 of 3 residents (Resident #33). The findings included: Resident #33 was admitted on 3/14/2007 with diagnoses including dysphasia, cerebral vascular accident and depression. The most recent Minimum Data Set (MDS), a Quarterly Assessment dated 7/24/13, revealed Resident # 33 was moderately cognitively impaired. On 9/9/13 at 1:00 PM Resident #33 was observed from the doorway of her room. She was in bed with the head of the bed raised 75 degrees. Nursing Assistant # 1 (NA # 1) was holding a towel near the resident ' s face and Resident #33 was observed pulling at the towel. Resident #33 was also yelling but was not speaking any words as she yelled; she was making a loud repeated noise that sounded like "ahhhhhhh". NA # 1 was heard to say to Resident #33 at this time "that's how babies act." NA # 1 then removed the towel and placed it in a plastic dirty linen bag. She then exited the room with the dirty linen bag.	F 241	**F 241** **STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).** Resident #33, Nursing Assistant #1 was pulled from resident care immediately when notified of event and a one on one inservice was performed on the importance of residents rights and that all residents must be treated with dignity at all times by the Director Of Nursing on 9-9-13. Social worker consulted resident #33 about the incident that occurred on 9-9-13 with Nursing Assistant #1. Resident #33 could not remember incident or any mistreatment or dignity issues that occurred. Social worker will continue to monitor Resident# 33 monthly for three months. All residents have the potential to be affected by the same alleged deficient practice, all staff will be inserviced by Social Worker by 10-10-13, on the importance of Residents Rights and that all residents have a right to be treated with dignity at all times.	9-9-13 10-10-13



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10-7-13

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 241	Continued From page 1 On 9/9/13 at 1:02 PM during an interview NA #1 acknowledged that she had said "that's how babies act" to Resident #33. NA # 1 stated that she had said this to the resident because Resident #33 had been crying out but that she should not have said that to the resident. NA #1 indicated that what she said was not respectful or acceptable and she was sorry that she said it. On 9/9/13 at 1:05 PM interview with Administrative Staff # 3 stated that the statement "that's how babies act" made to a resident was not acceptable and was a dignity issue. He said that dignity was one of the things the staff had been inserviced on several times recently and that he would discuss the incident with NA # 1. On 9/9/13 at 1:08 PM Administrative Staff # 3 went to Resident #33's room and NA #1 was setting up Resident # 33's meal tray. When NA # 1 exited the room the Administrative Staff # 3 walked with her down the hall. NA # 1 was heard to say "I'm sorry." On 9/9/13 at 1:10 PM Resident #33 was interviewed. Resident # 33 acknowledged that she had been annoyed with the Nursing Assistant who had just left the room (NA # 1) because "she was telling me to wash my face." Resident # 33 was asked if NA # 1 said anything that bothered her or if NA # 1 had said something about acting like a baby. Resident #33 then said "yes, she (NA # 1) was acting like a baby." Resident # 33 indicated that it did not matter to her whether or not NA # 1 worked with her again.	F 241	To ensure compliance, the Social Worker or Clinical Coordinator will perform Resident Satisfaction Surveys, which will include question regarding dignity and residents rights on 10% of alert and oriented residents weekly for one month, then once a month for six months and then quarterly thereafter. To monitor residents with decreased cognition, Social Worker will observe interactions between staff and residents for infringement of resident's rights or dignity issues. Social worker will observe 10% of cognitively impaired residents weekly for one month, monthly for six months and quarterly thereafter. The Social Worker or Clinical Coordinator will report any results from surveys and monitoring to the QA committee monthly.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332		

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F 332	Continued From page 2 The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure that medication error rate was 5% or below by not following the doctor ' s orders and the manufacturers specification for 1 (Resident #150) of 6 sampled residents observed during medication pass. There were two errors of 31 opportunities for error resulting in a 6.45 % error rate. The findings included: 1a. Resident #150 was admitted to the facility on 8/27/13 with multiple diagnoses including constipation. Review of the physician's orders for Resident #150 revealed that on 8/27/13, there was an order for Colace (stool softener) 100 mgs (milligrams) 2 tablets by mouth twice a day for constipation. On 9/11/13 at 8:49 AM, Resident #150 was observed during medication pass. Nurse #1 was observed to prepare and to administer the medications including Pericolace (stool softener/laxative) 50 mgs (milligrams)/8.6 mgs 2 tablets by mouth. On 9/11/13 at 9:18 AM, Nurse #1 was interviewed. He looked at the bottle of the Pericolace and acknowledged that he had administered the wrong medication. He stated that he didn't realize that Pericolace and Colace were two different drugs.	F 332	**F 332** **STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).** Nurse #1 was inserviced on medication Administration and to read and follow physician's orders by the Director Of Nursing on 9-11-13. Physician was contacted and notified by the Director Of Nursing of the medication errors on 9-11-13. Resident #150 was monitored for adverse reaction to medication errors and none were noted. Resident # 150 is currently receiving Colace 100 mg twice daily and Symbicort 2 puffs twice daily with a minute between each puff with a mouth rinse after each use per physician order. All residents have the potential to be affected by the same alleged deficient practice, all licensed nurses and medication aides have received inservice education by the Director Of Nursing on 9-27-13, which included appropriate medication administration including the importance of 1) reading the physician's order and 2) administering medications according	9-11-13 9-27-13

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F 332	Continued From page 3 1b. Resident #150 was admitted to the facility on 8/27/13 with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD). Review of the physician's orders for Resident #150 revealed an order dated 8/27/13 for Symbicort (steroid/bronchodilator) 2 puffs twice a day for COPD. The order included "shake well and rinse mouth after each use." The manufacturer's specification for Symbicort revealed "the patient should rinse mouth with water without swallowing." On 9/11/13 at 8:49 AM, Resident #150 was observed during medication pass. Nurse #1 was observed to prepare and to administer the medications including Symbicort 2 puffs. Nurse #1 was not observed to rinse the resident's mouth with water after administering the inhaler. On 9/11/13 at 9:20 AM, Nurse #1 was interviewed. He stated that he would rinse the mouth with water only if the resident asked for it. He added that the resident didn't ask to rinse his mouth and he normally didn't do the rinsing because the resident was on fluid restriction.	F 332	to the Five Rights of Medication Administration (e.g. right medication, right dosage, right resident, right route, right time). To insure compliance the Director of Nursing, Staff Development Coordinator or Consultant Pharmacist shall complete medication pass observations on licensed staff and medication aides administering medications in the facility to included all shifts and weekends. Consultant Pharmacist will give Medications Observations results to the Director of Nursing with in 48 hours of completion. Medications observations will be completed on 25% of licensed staff and medication aids weekly for 4 weeks, then 10% licensed staff and medication aids will be audited for six months and random Medications Observations will continue monthly thereafter. The Director of Nursing Staff Development Coordinator or Consultant Pharmacist shall report results of all medication observations to the QA committee monthly. If errors occur in the medication observation, results will be reported to attending physician immediately, resident will be monitored for any adverse affects, and the staff member will be inserviced on the Five Rights of Medication Administration.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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F 371	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review the facility failed to label foods when opened, failed to discard foods by their discard by date and failed to wash or sanitize hands, or change gloves, when handling dirty and then clean dishes during the dish washing process. The findings included: On 9/9/13 at 10:45 AM the reach in refrigerator was observed to have a container of pasta with meat sauce that the Dietary Manager stated was prepared in house, and that was undated. The Dietary Manager removed this item and said it would be discarded and added that it should have been dated by the cook who prepared it. There was also an opened container of ready to eat chicken tuna salad dated as received in the facility on 8/14/13, but the date opened was not indicated. The Dietary Manager stated that once opened he thought the containers of ready to eat foods could be kept until their expiry date which was not until October /2013 for this item. On the bottom shelf of the reach-in refrigerator there was a box containing a bag of pooled eggs that had been opened. The box was dated as received in the facility on 9/4/13, but the date opened was not indicated. The box had a written instruction to discard the eggs 3 days after opening. On 9/9/13 at 10:55 AM the walk-in refrigerator was observed to have a metal pan covered with foil. The contents of the pan were indicated on the label that read turkey and it was dated	F 371	**F 371** **STANDARD DISCLAIMER:** **This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).** No individual residents were identified as having been affected by the alleged deficient practice. All residents having the potential to be affected by the same alleged deficient practice, Items that were identified during the survey as having been mislabeled, expired or improperly labeled were discarded immediately. The Dietary Manager has created a new labeling system that includes, date opened, use by date, and user initials. Dietary employees received in-service education on proper storage of food - perishable and non-perishable, labeling items when opened, new expiration date guidelines and cleaning and sanitizing equipment, dishes, utensils and other items by the Dietary Supervisor on 9-11-13. New expiration date guidelines including refrigeration times and freezer times on fresh, cooked, mixed, and processed meats; this also includes new storage guidelines on how long perishable items can be kept when opened, which included mixed cooked items. To insure compliance the dietary manager or Assistant Dietary Manager	9-11-13

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F 371	Continued From page 5 9/29/13. The Dietary Manager stated that the turkey should have been discarded already and removed it from the refrigerator. On 9/9/13 at 3:55 PM the Dietary Manager stated the facility did not have a written policy or procedure for discarding ready to eat of prepared foods. He was able to provide "Food Storage Guidelines Meat and Dairy Items" used at the facility that indicated cooked poultry, not in broth or gravy, should be discarded in 3 - 4 days. On 9/9/13 at 4 PM Cook #1 was interviewed. She stated that ready to eat foods should be discarded 7 days after opening and that prepared foods should be discarded within 3 days. She acknowledged that these items also needed to be dated when opened or prepared to determine when they needed to be discarded. On 9/11/13 at 2 PM Dietary Aide # 1 was observed wearing gloves and arranging dirty dishes on a dishwashing rack and then moving the rack of dirty dishes into the dishwasher. Dietary Aide #1 then dipped her gloved hands in a bucket of solution and moved a rack of clean dishes out of the way. She then touched some of the clean dishes in the rack with her gloved hands. On 9/11/13 at 2:03 PM the Dietary Manager was present to observe Dietary Aide # 1 touch dirty dished with gloved hands, then dip her gloved hands in solution and then touch clean dishes. The Dietary Manager had the Dietary Aide stop what she was doing and asked another dietary staff member to take over the dirty dish area so Dietary Aide # 1 would not be going back and forth from dirty to clean. Dietary Aide # 1 also	F 371	will audit proper labeling procedures and will insure that all food is within new date guidelines with the new Dietary Sanitation Audit. Dietary manager has inserviced all dietary staff on new expiration dates which follows state and federal guidelines on 9-11-13. New dietary washing procedures have been implemented. All dietary staff has been inserviced on the new three personnel procedure for washing dishes. This procedure consist of three dietary staff members washing dishes 1) one dietary staff member bus trays 2) one dietary staff member will rinse off dishes and place them into the dishwasher 3) one dietary staff member will remove clean dishes and store dishes when dry. This has been put in place to insure no cross contamination occurs. All dietary staff was inserviced on this new procedure by the Dietary Manager on 9-11-13. To insure that this alleged deficiency does not occur again, the dietary manager or assistant dietary manager will complete daily audits for four weeks and weekly audits for two months, and monthly audits for three months. The Dietary Manager or assistant dietary manager shall report results of audits in accuracy to the QA committee monthly.	9-11-13 9-11-13

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F 371	Continued From page 6 washed her hands and applied new gloves. On 9/11/13 at 2:08 PM Dietary Aide # 1 was interviewed. She stated that she had sanitized her gloves between the dirty and clean dish tasks because that's what she was told to do by the previous Dietary Manager, and she didn ' t know it was wrong. On 9/11/13 at 2:13 PM the Dietary Manager was interviewed. He indicated that he had only been in his position for a couple of weeks and had not been aware Dietary staff was attempting to sanitize their gloves between dirty and clean dish tasks. He acknowledged that the staff needed to be washing or sanitizing their hands between these tasks, or changing their gloves, and that attempting to sanitize gloves was not acceptable practice.	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 431	F 431 **STANDARD DISCLAIMER:** **This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).** For all residents having the potential to be affected by the alleged deficient practice, the unlabeled or outdated Advair inhaler, Symbicort inhaler, Fiber Stat, Lactase/ Fast Acting dairy	

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F 431	Continued From page 7 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 record review, review of the manufacturer's specification, observation and staff interview, the facility failed to discard expired medications and to date multi dose medications in 2 (400(odd rooms)/500 hall and 400(even rooms)/600 hall medication carts) of 4 medications carts observed. The findings observed: The facility's policy on drug storage and expiration date guidelines (undated) was reviewed. The policy revealed that Advair Diskus (steroid/bronchodilator) expired 30 days after foil overwrap was removed and Symbicort (steroid/bronchodilator) expired 3 months after foil overwrap was removed. The manufacturer's specification for Fiber Stat and Symbicort were reviewed. The direction on	F 431	aide tablets, and Aricept 10mg were all disposed of immediately. The Director of Nursing completed an audit on all four medication carts and medication rooms on 9-17-13. Expired or undated medications were removed. The Consultant Pharmacist inserviced all license medication staff and medication aids by 10/2/2013 regarding the proper labeling, dating and storage of drugs, and proper discarding of expired drugs and/or biologicals. The Director of Nursing or Clinical Coordinator will monitor proper storage of drugs and proper discarding of expired drugs and/or biologicals for 4 weeks and monthly thereafter. Director of Nursing or Clinical Coordinator will monitor by completing an audit using the "Medication/Biologicals & Medication Cart Observation Worksheet" weekly for 4 weeks and monthly thereafter to ensure proper storage of drugs, proper discarding of expired drugs and/or biologicals, and locking the medication cart locked when unattended. The Director of Nursing, Clinical Coordinator or Pharmacy Consultant shall report all auditing results to the QA committee monthly. In addition, the Pharmacy Consultant shall perform Medication Cart and Medication Room Inspections	10-2-13

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F 431	Continued From page 8 the bottle for Fiber Stat read "discard 3 months after opening" and on the box of Symbicort, it read "expired 3 months after foil package opened." 1. On 9/11/13 at 11:25 AM, the medication cart on 400(even rooms)/600 hall was observed. The following were observed: 1. (1) used Advair inhaler with no date opened 2. (2) used symbicort inhalers with no date opened 3. (1) bottle of Fiber stat with an open date of 5/25/13 On 9/11/13 at 11:30 AM, Nurse #1 was interviewed. The nurse stated that he did not date the inhalers when opened because he thought that the inhalers were good until the manufacturer's expiration date. He added that the Fiber Stat was good until the manufacturer's expiration date. 2. On 9/11/13 at 11:35 AM, the medication cart on 400(odd rooms)/500 hall was observed. A box of Lactase/Fast acting dairy aide tablets with expiration date of 7/2013 and a bottle of Aricept 10 mgs tablet with expiration date of 5/7/2013 were observed. On 9/11/13 at 11:40 AM, Nurse #2 was interviewed. The nurse stated that nurses were supposed to be checking the expiration dates on the bottle during medication pass but obviously not. He added that Aricept was scheduled to be given at bedtime so the evening nurses should have caught it. He acknowledged that it was missed and he would discard the expired medications.	F 431	quarterly and shall report all results to the Director of Nursing upon completion immediately and report results quarterly to the QA committee.	

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F 431	Continued From page 9 On 9/12/13 at 9:30 AM, administrative staff #1 was interviewed. She stated that she was aware of the expired medications and the undated medications that were observed in the medication carts. She added that it was the policy of the facility and her expectation for the nurses to date the inhalers when opened.	F 431		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the ceilings in the activity room and in the main dining room in good condition as evidenced by peeling paint, stained areas and cracks in the ceiling. The findings included: On 9/9/13 at 12:18 PM., restorative dining was observed in the activity room. The ceiling of the activity room was observed to have loose paint hanging from the ceiling, cracked paint and drywall and stained areas on the ceiling that had the appearance of having been wet, then dried. Peeling paint was noted over the area where the residents were eating and over the refrigerator, sink and counter areas. On 9/11/13 at 12:20 PM., Administrative staff #2 stated she had been employed at the facility since	F 465	F 465 **STANDARD DISCLAIMER:** **This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).** No residents were specifically identified as having been affected by this alleged deficient practice. For all residents having the potential to be affected by the same alleged deficient practice, all loose ceiling paint was scraped and removed. New paint was applied to any areas affected by the Maintenance Directory on 9-11-13. Outside construction team refinished both the activity room and dining room ceilings on 10-2-13. The Maintenance Director will audit all facility ceilings with zone auditing sheets five days a week for disrepair and make repairs as needed.	10-2-13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING ______ B. WING ______	C 09/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

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F 465	Continued From page 10 Nov. 19, 2012 and the ceiling had been like that since she had come here. She said she thought they had a contractor scheduled to come and see the ceiling and fix it. Administrative staff #2 indicated the room was utilized for activities and for restorative dining. On 9/11/13 at 12:30PM., a tour of the activity room and main dining room was conducted with Administrative staff #3. In the main dining room, there were areas on the ceiling where the paint was loose and peeling. Cracks were noted where the drywall sheets were joined together. Administrative staff #3 stated the drywall had not been put up correctly. Only one side of the drywall was paintable. The side of the drywall that had been painted was the wrong side and the paint would not adhere to that side. Administrative staff #3 said he had talked to maintenance and they had tried to scrape and paint the main dining room and the area was still peeling. Administrative staff #3 said he knew it was an issue and he was going to have the activity room ceiling scraped but it would not solve the problem. He indicated he was waiting for life/safety to come so he could ask for their recommendations regarding the repair of the ceiling in the main dining room and activity room. On 9/11/13 at 2:03 PM., Administrative staff #4 stated the ceiling in the activity room and in the main dining room was the original ceiling constructed around 1992-1993. He said he had been employed in the maintenance department for about four years. Administrative staff #4 said there had been a leak in the attic about 1 ½ months ago. At that time, they removed any of the loose popcorn texture, applied primer and joint compound and painted some of the areas on	F 465	The Maintenance Director will report results of audits to the QA committee monthly.	

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F 465	Continued From page 11 the ceiling in the activity room. On 9/11/13 at 2:03 PM., maintenance personnel were observed scraping and repairing the areas on the activity room ceiling. There was an area over the counter where the ceiling area had leaked and black areas were noted on the drywall. On 9/11/13 at 2:12 PM., Administrative staff #3 stated he had been at the facility since December. The ceiling areas in the main dining room and activity room were in that condition when he came to the facility. He stated he had not contacted life safety at all for their recommendations.	F 465		

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

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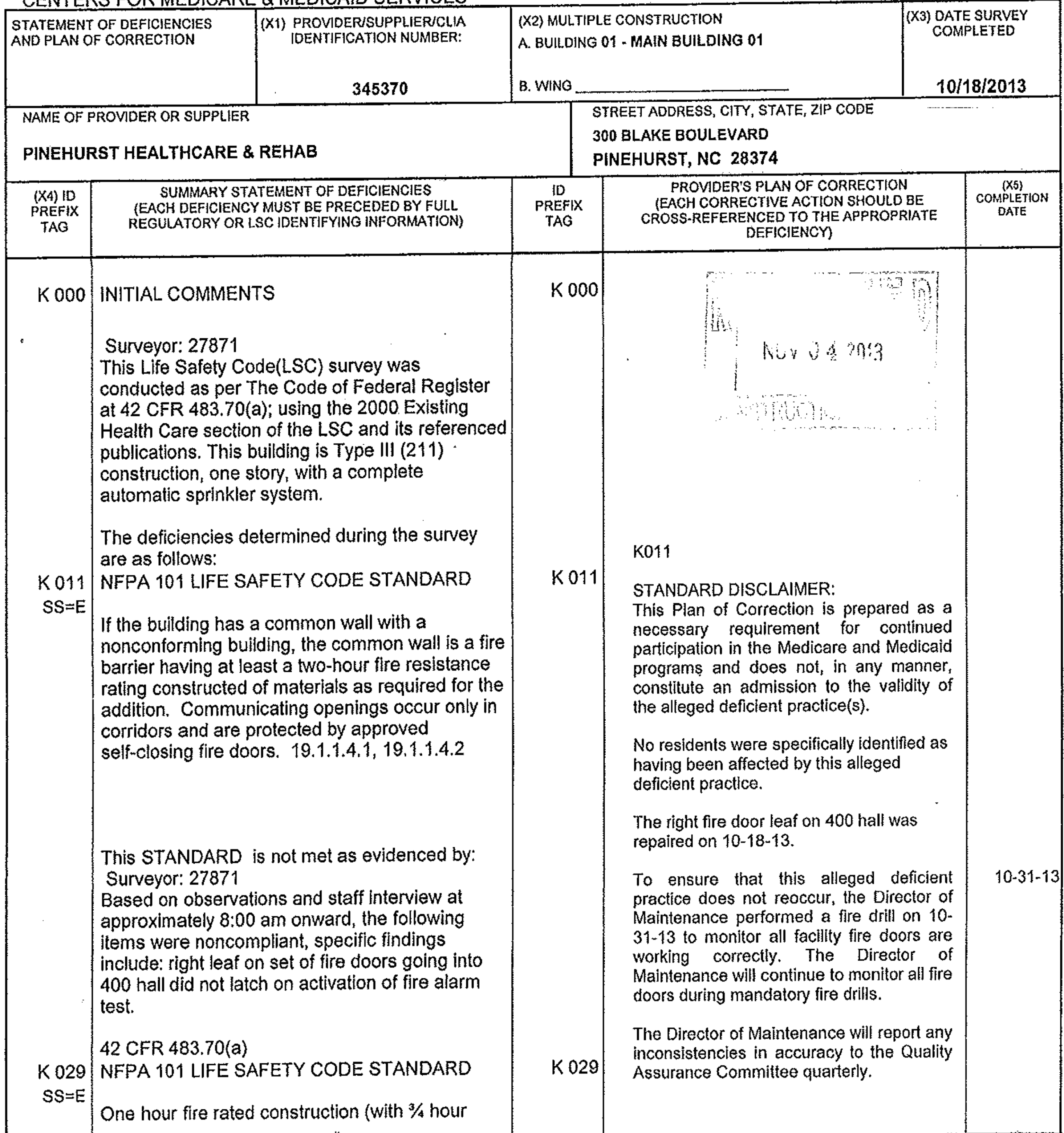

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	10/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PINEHURST HEALTHCARE & REHAB	300 BLAKE BOULEVARD PINEHURST, NC 28374

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 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	NOV 04 2013	
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings include: right leaf on set of fire doors going into 400 hall did not latch on activation of fire alarm test. 42 CFR 483.70(a)	K 011	K011 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). No residents were specifically identified as having been affected by this alleged deficient practice. The right fire door leaf on 400 hall was repaired on 10-18-13. To ensure that this alleged deficient practice does not reoccur, the Director of Maintenance performed a fire drill on 10-31-13 to monitor all facility fire doors are working correctly. The Director of Maintenance will continue to monitor all fire doors during mandatory fire drills. The Director of Maintenance will report any inconsistencies in accuracy to the Quality Assurance Committee quarterly.	10-31-13
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 11-1-13

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.

GW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345370	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 062	Continued From page 2 include: 1. sprinkler heads in front and back of dryer have excess lent on bulb. 2. Sprinkler heads installed in the kitchen(in front of stove) smoke compartment were a mixture of quick response heads(red) and green heads. 42 CFR 483.70(a)	K 062	K 062 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). No residents were specifically identified as having been affected by the same alleged deficient practice. All sprinkler heads in the dryer room have been cleaned of excess lent. Sprinkler heads will be replaced in front of the stove smoke compartment by 11-15-13. To ensure that this alleged deficient practice does not reoccur, the Director of Maintenance or designee will monitor all sprinkler heads with daily walking rounds. Any sprinkle heads that need to be cleaned will be cleaned within 8 hours of finding excess lent. Advanced fire designs will check sprinkler heads during their quarterly audit. The Director of Maintenance and/or designee will routinely inspect sprinkler heads for any dirt or lent. The Director of Maintenance will report any inconsistencies in accuracy to the Quality Assurance Committee quarterly.	11-15-13

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K 029	Continued From page 1 fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings include: rooms 212 and 512 are being used for storage. Doors are not self closing. 42 CFR 483.70(a)	K 029	K029 STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). No residents were identified as having been affected by the same alleged deficient practice. Director of Maintenance will remove all stored items from room 212 and 512. Both rooms will be cleaned and residents will be able to occupy those rooms. To ensure that this alleged deficient practice does not reoccur, the Director of Maintenance or his designee will monitor all rooms for stored items during their morning walking rounds. The Director of Maintenance will report any inconsistencies in accuracy to the Quality Assurance Committee quarterly.	11-8-13
K 062 SS=E	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: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings	K 062		