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

PRINTED: 10/07/2013
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
	345024	A. BUILDING ______ B. WING ______	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLAPPS NURSING CENTER INC	5229 APPOMATTOX ROAD PLEASANT GARDEN, NC 27313

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F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to anchor a urinary catheter tubing to avoid tugging, prevent catheter dislodgement or tissue damage for 2 of 2 sampled residents with urinary indwelling catheters. Resident #151 and Resident #92 Findings included: The facility policy titled " Urinary Catheter Care " (revised August 2002) read in part under " General Guidelines " , step 15 and " Steps in the Procedure" step 17 indicated the catheter was to be " secured with a leg strap. " 1. Resident #151 had diagnoses that included chronic urinary retention. Review of the most recent quarterly Minimum Data Set (MDS) dated 7/20/13, indicated Resident #151 was cognitively intact and required extensive assistance from 2 staff for toileting. Review of the September 2013 physician orders	F 315	This plan of correction is being submitted pursuant to the applicable federal and state regulations. Nothing contained herein shall be construed as an admission that this Facility violated any federal or state regulation or failed to follow any applicable standard of care. F315 1. Catheter tubing has been secured with leg straps for resident #151 & resident #92 to prevent tugging, catheter dislodgement or tissue damage by the nurses. 2. All residents with indwelling catheters have anchors/leg straps to secure the tubing in order to prevent tugging, catheter dislodgement or tissue damage. The anchors/straps are applied by the nurses. CNA's alert the nurse if the strap is soiled, needing replacement or if it is not positioned properly. 3. Nurses and CNA's have been in-serviced on "Urinary Catheter Care" including the proper placement of leg straps. When a resident requires an indwelling catheter a copy of the order is sent to medical supplies. The catheter kit including an appropriate strap/anchor is then distributed to the nurse. Additional anchors/leg straps are kept at each nurses' station in the medication room. con't	10/10/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cheryl Clapp [signature] TITLE: Administrator (X6) DATE: 10/16/13

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 315	Continued From page 1 revealed a physician ' s order since 8/23/12 for a urinary indwelling catheter for urinary retention. Review of the care plan updated 02/12/2013, included interventions for " proper _____ (brand name of catheter) catheter care. " Interview on 9/26/13 at 9:15 am with MDS #1 revealed catheter care written on the careplan included securing the catheter with a leg strap. Observation of the resident on 9/24/13 at 3:45 PM with (nursing assistant) NA#3 revealed the resident ' s urinary catheter was not anchored or secured with a leg strap. Interview on 9/25/13 at 3:20 PM with NA#3 revealed we (referring to the facility) just have two straps attached to the leg bag. NA#3 indicated the facility "don't [does not] have anything here" to anchor the catheter. Observation of the resident on 9/25/13 at 11:05 AM revealed the resident's urinary catheter was not anchored or secured with a leg strap. Observation on 9/25/13 at 2:45 PM with Nurse #2 and NA #4 revealed the resident ' s urinary catheter was not anchored or secured with a leg strap. Interview on 9/25/13 at 3 PM with NA#4 revealed she had never seen within the facility a leg strap to secure the catheter. Interview on 9/25/13 at 3:20 PM with Nurse#3 revealed the staff should use a leg strap to anchor the catheter. Interview on 9/26/13 at 9:15 am with the assistant	F 315	4. All residents with indwelling catheters are monitored daily to ensure anchors/leg straps are appropriately placed by the nurse. The nurse documents catheter care and placement of leg straps daily in TAR. Nurse managers/supervisors monitor weekly to make certain compliance is maintained. A QA monitoring tool has been implemented by the QA nurse to ensure the corrective action is appropriate and effective. This has been incorporated in our monthly QA meeting and is reported and overseen by our QA nurse.	

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F 315	Continued From page 2 director of nurses, the director of nurses (DON), MDS#1 and the assistant administrator was held. The DON indicated her expectation was the nurse should ensure each resident's catheter was secured with a leg strap. 2. Resident # 92 was admitted to the facility on 3/21/11 with cumulative diagnoses which included Incomplete Bladder Emptying. Review of the Admission Nursing Evaluation of 3/21/13 indicated the resident did not have a History of (brand name of catheter) catheter use in the last 30 days. Review of the Urology Consult dated 6/13/13 read Active Problems: Hydronephrosis and Incomplete Emptying of Bladder. Has now been on In and Out Catheterization Every 6 Hours since 6/9/13. Review of the note by the Nurse Practitioner dated 6/13/13 read: Diagnosis: Severe Urethral Dilation. Recommendations: Attempted In and Out Catheterization several times without success. Will have patient return for follow up/urethral dilation with MD. The Initial Care Plan dated 6/18/13 read: (Brand name of catheter) RT (Related To) Urinary Retention. Goals: Resident will have no urinary retention by next review. Approaches: Clean per facility protocol, monitor insertion site for blood or irritation. Observe consistency of urine, odor, and color. Position tubing appropriately, no pressure, (brand name of catheter) bag dependent position. The MD Progress note of 7/8/13 read: The resident was seen by Urology last month for large	F 315		

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F 315	Continued From page 3 post-residual void volumes and an 18 inch French Indwelling (brand name of catheter) Catheter was inserted. The Quarterly Minimum Data Set (MDS) Assessment dated 8/1/13 indicated the resident had short and long term memory problems and was moderately impaired with cognitive skills for daily decision - making. The MDS was coded to indicate the resident had an indwelling urinary catheter. Review of the new MD orders dated 9/14/13 read: Change Indwelling (brand name of catheter) Catheter (20 French) every month. Flush with 20 cc (cubic centimeters) Sterile Normal Saline every 3 days. Interview on 9/25/13 at 2:45 PM with Nurse #1 indicated, "We tried a series of in and out catheterization, and the Urologist put in a Foley Catheter in July, because (the resident) had a twisted bladder. (The resident) has a (brand name of catheter) Catheter with a leg bag for comfort." During an observation conducted on 9/25/13 at 4:20 PM with (nursing assistant) NA #1 revealed the resident's urinary catheter was not anchored or secured with a leg strap. A Direct Care staff interview was conducted on 9/25/13 at 4:30 PM with NA #1. When asked about what care was required for the resident's urinary catheter and tubing, the NA indicated, " There is no strap to hold the tubing down. I just let it rest on (the resident ' s) leg. I'm supposed to make sure the straps are secured."	F 315		

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F 315	Continued From page 4 A staff interview was conducted on 9/26/13 at 8:00 am with Nurse #1 regarding care required for the resident's urinary catheter. The Nurse indicated, "The aide is supposed to make sure the bag is secured with the leg straps and flush every 3 days." An additional observation of the resident's urinary catheter was conducted on 9/26/13 at 9:10 AM with NA #2 revealed the resident's urinary catheter was not anchored or secured with a leg strap. NA #2 indicated, "There's not anything else I know of to use besides the leg straps to secure the catheter." Interview on 9/26/13 at 9:15 am with the assistant director of nurses, the director of nurses (DON), MDS Nurse #1 and the assistant administrator was held. The DON indicated her expectation was the nurse should ensure each resident's catheter was secured with a leg strap. An additional staff interview was conducted on 9/26/13 at 11:10 AM with the DON who indicated, "They (referring to the Nursing Assistants) should have known that there is a leg strap to secure the tubing around the upper thigh. I think they are confused about what that is. We are going to In-Service them today, and all the Nurses."	F 315		
F 329 SS=E	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	F 329	F329 1. Appropriate diagnoses indicating the need for antipsychotic drug therapy has been established for resident #26 and resident #51 per physicians' orders and documented in their clinical charts and care planned by the nursing department. con't	10/10/13

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F 329	Continued From page 5 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, staff and pharmacist interview and record review the facility failed to request suitable diagnoses (indication) for the use of antipsychotics for 2 (Residents #26,#51) of 6 residents reviewed for unnecessary drugs and failed to monitor behaviors for 2 of 6 residents reviewed. Residents #193, Res #51 Findings included: 1. Resident #193 was admitted to the facility on 07/18/13 with cumulative diagnoses of traumatic hip fracture, hypertension and depression. Review of the physician ' s order sheet for September 2013 revealed the resident had order for Ativan 0.5 mg (milligram) twice a day (anti-anxiety), Buproprion HCl XL (extended release)	F 329	Behaviors for resident #193 & resident #51 are being monitored and charted by their nurse when administering antipsychotic medications. 2. Clinical charts of all residents receiving antipsychotic medications have been reviewed to ensure appropriate diagnosis and behaviors are noted and documented by Nursing Administration. The Pharmacy Consultant has completed a double check of diagnosis for every antipsychotic medication has made certain diagnoses are on chart. 3. The Pharmacy Consultant has completed a "Monthly Psychotropic Review" as well as a "New Admission Antipsychotic Diagnosis Verification" form. This info is given to the DON and attending physician for review and to maintain compliance. E-MAR orders have been updated to alert the nurse to indicate type of behaviors and number of occurrences when administrating all antipsychotic medications. The nurse cannot proceed to the next medication until documentation has been entered. The update was completed by the DON on 10/10/2013. con't	

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F 329	Continued From page 6 150 mg daily (antidepressant), Celexa 20 mg daily (antidepressant) and Zyprexa 10 mg at bedtime (antipsychotic). Lexi-Comp ' s Geriatric Handbook defines Zyprexa as an antipsychotic use for schizophrenia and bipolar disease. The monograph also stated that this medication carries a U.S. Boxed warning from the Food and Drug Association " Elderly patients with dementia-related psychosis treated with antipsychotic are at an increased risk of death compared to placebo. " Observation of the resident on 09/25/13 at 1 PM revealed the resident sitting up in bed, picking at the covers. She could answer simple questions like " Are you in pain? " , " do you need anything? " but could not answer where she was. Interview with the floor nurse on 09/25/13 at 2 PM failed to identify any behaviors for the use of an antipsychotic. Review of the admission care plan (July 18/13) on 09/25/13 at 1 PMfailed to identify any behaviors for the resident. Review of the nurses ' notes for September of 2013 failed to establish any behaviors for the resident. Interview with the consultant pharmacist on 09/26/13 at 11 AM, she stated she had not written a review to the physician asking for a diagnosis for the use of an antipsychotic. She did state that she had asked the attending physician on other occasions about the use of two antidepressants, and he had told her that use of the two antidepressants listed above had given him good results. 2. Resident #51 was admitted to the facility on 12/15/10 with cumulative diagnoses of chronic	F 329	4. Nursing staff have been in-serviced on antipsychotic medications, obtaining appropriate diagnosis to administer medications, the importance of documenting behaviors and the E-MAR update requesting documentation of behaviors and occurrences. In-services were conducted by SDC, DON, Pharmacy Consultant, and through our on-line in-service training "HealthCare Academy" beginning on 9/26, 9/27, 10/1, 10/2, 10/3, 10/5, 10/6, and 10/9. QA monitoring tools have been developed, and completed by nursing administration and pharmacy consultant to ensure compliance. Forms are attached. The QA Nurse integrated the plan in our monthly QA meeting for review and to ensure compliance is sustained.	

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F 329	Continued From page 7 airway obstruction, congestive heart failure and cerebellar ataxia. Review of the physician ' s order sheets for September 2013 revealed the resident had orders for: Depakote 125 mg (milligrams) sprinkle capsules, 3 capsules (375mg) at bedtime and 125 mg every morning (mood stabilizer) but physician order sheet said for dementia, Citalopram 40 mg daily (antidepressant) written 07/04/11, and Seroquel 50 mg at bedtime (antipsychotic) written 01/12/12 for insomnia. Lexi-Comp ' s Geriatric Handbook defines Seroquel as an antipsychotic use for schizophrenia and bipolar disease. The monograph also stated that this medication carries a U.S. Boxed warning from the Food and Drug Association " Elderly patients with dementia-related psychosis treated with antipsychotic are at an increased risk of death compared to placebo. " On observation of the resident on 09/25/13 at 1:30 PM, he was sitting in his wheelchair watching TV in the day room. He was pleasant and alert in conversation and dressed neatly in street clothes. In an interview with the floor nurse on 09/25/13 at 2 PM, no behaviors could be identified. Review of the care plan revealed that he was care planned for exit seeking behavior and combative behavior on 12/15/10 on admission. Floor nurse could not remember any exit seeking behavior. Length of time on the antipsychotic was 21 months. No addendum was added to the care plan and the problem was not resolved. No behaviors were documented in the nursing notes for September 2013. In an interview with the consultant pharmacist on 09/26/13 at 11 AM, she was not aware of any	F 329		

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F 329	Continued From page 8 behaviors and had not asked the doctor for a suitable diagnosis for the continued use of an antipsychotic.	F 329		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON 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 observation, staff and pharmacist interview and record review the consultant pharmacist failed to request suitable diagnoses for the use of antipsychotics from the attending physician for 2 (Residents #26,51 of 6 residents reviewed for unnecessary drugs and failed to alert the Director of Nursing and the attending physician on the use of a second antipsychotic on Resident #49. Findings Included: 1. Resident #193 was admitted to the facility on 07/18/13 with cumulative diagnoses of traumatic hip fracture, hypertension and depression. Review of the physician ' s order sheet for September 2013 revealed the resident had order for Ativan 0.5 mg (milligram) twice a day (ant anxiety), Buproprion HCl XL (extended release)	F 428	F428 1. Appropriate diagnoses have been obtained for the use of antipsychotic medications for resident #26 and resident #51 by their attending physicians. The second antipsychotic for resident #49 has been reviewed by the DON and the attending physician. Nursing has and will continue to monitored behaviors for resident #49 to ensure appropriateness of antipsychotic medications. 2. Clinical charts of all residents receiving antipsychotic medications have been reviewed to ensure appropriate diagnosis and behaviors are noted and documented by Nursing Administration. The Pharmacy Consultant has completed a double check of diagnosis for every antipsychotic medication to ensure diagnoses are charted. The pharmacy consultant has reviewed all residents receiving antipsychotic medications and has alerted the DON and physician of any resident receiving more than one medication and/or needing GDR. con't	10/10/13

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F 428	Continued From page 9 150 mg (milligram) daily (antidepressant), Celexa 20 mg daily (antidepressant) and Zyprexa 10 mg at bedtime (antipsychotic). Lexi-Comp ' s Geriatric Handbook defines Zyprexa as an antipsychotic use for schizophrenia and bipolar disease. The monograph also stated that this medication carries a U.S. Boxed warning from the Food and Drug Association " Elderly patients with dementia-related psychosis treated with antipsychotic are at an increased risk of death compared to placebo. " Observation of the resident on 09/25/13 at 1 PM revealed the resident sitting up in bed, picking at the covers. She could answer simple questions like " Are you in pain? ", " do you need anything? " but could not answer where she was. Interview with the floor nurse on 09/25/13 at 2 PM failed to identify any behaviors for the use of an antipsychotic. Review of the admission care plan (July 18/13) failed to any behaviors for the resident. Review of the nurses ' notes for September of 2013 failed to establish any behaviors for the resident. Interview with the consultant pharmacist on 09/26/13 at 11 AM, she stated she had not written a review to the physician asking for a diagnosis for the use of an antipsychotic. She did state that she had asked the attending physician on other occasions about the use of two antidepressants, and he had told her that use of the two antidepressants listed above had given him good results. 2. Resident #49 was admitted to the facility on 05/05/12 with cumulative diagnoses of hypertension, diabetes mellitus, mental disorder and depression.	F 428	3. The Pharmacy Consultant has completed a "Monthly Psychotropic Review" as well as a "New Admission Antipsychotic Diagnosis Verification" forms. The forms are completed with the monthly Drug Regimen Review. This info is given to the DON and attending physician for review and to maintain compliance. The DON and attending physician are alerted in the event a diagnosis is not noted and orders/corrections are made immediately by the DON. All orders are checked daily by Nursing Administration. Orders for antipsychotic medications are reviewed for diagnosis and the nurses' notes are reviewed for indications of behaviors. E-MAR orders have been updated to alert the nurse to indicate type of behaviors and number of occurrences when administrating all antipsychotic medications. The nurse cannot proceed to the next medication until documentation has been entered. The update was completed by the DON on 10/10/2013. con't	

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F 428	Continued From page 10 Review of the physician ' s order sheet for September 2013 revealed the resident had orders for Depicted 375 mg (milligrams) sprinkle capsules twice a day(mood stabilizer), Zepeda 15 mg at bedtime (an antipsychotic) Remer on 15 mg at bedtime (antidepressant), Trazodone 50 mg at bedtime (antidepressant), Lorazepam 0.5 mg in the morning, Lorazepam, 0.5 mg every 4 hours as needed for anxiety, Lorazepam 1 mg Gel every 6 hours as needed for excess anxiety and agitation (ant anxiety), and Geodon 10 mg (0.5 ml [milliliter] every 6 hours as needed for agitation (a second antipsychotic). Lexi-Comps Geriatric Dose Handbook, 17th addition stated that Geodon is used in the treatment of schizophrenia and acute mania associated with bipolar disease and the maintenance treatment of bipolar disease. The monograph does not endorse the use of an antipsychotic on an as needed basis. Treatment of acute psychiatric syndrome must be addressed with the physician within seven days. Review of the nursing notes for September revealed that when the resident became restless or exhibited behaviors, nursing would use the Ativan Gel and if this was not effective, the resident would be given an as needed dose of an antipsychotic. Review of care plan dated 7/11/13 revealed that the resident had behavior that supported the use of the Zyprexa such as exit seeking and combativeness with care at times. Review of the Medication Administration Record revealed that the resident had received six doses of the as needed second antipsychotic in September. In an interview with the Director of Nursing and	F 428	4. QA monitoring tools have been completed by the pharmacy to monitor residents' diagnoses indicating the need for antipsychotic medications and monthly drug regimen review looking at all medications for GDR. DON reviews charts for accuracy and documents on drug regimen review report. QA Nurse monitors for timeliness of recommendations received from physician and corrective actions taken. This is reported at our monthly QA meeting with a plan of action as needed.	

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F 428	Continued From page 11 Minimum Data Set (MDS) coordinator on 09/25/13 at 4 PM, they were not aware that the as needed dose was used frequently, that the as needed Ativan Gel was not effective in changing the resident ' s behaviors and that most of the incidents documented in the nursing notes were around bedtime. The resident also received two sedating antidepressants at bedtime, Trazodone 50 mg and Remeron 15 mg. When asked if there were alternative plans for a psychiatric consult for medication management, they stated that it was difficult to get that type of service in a rural environment. In an interview with the consultant pharmacist on 09/26/13 at 11 AM, she stated that she had not written a review to the attending physician documenting the multiple times the second antipsychotic was used, and anti anxiety agents had been used without effect. 3. Resident #51 was admitted to the facility on 12/15/10 with cumulative diagnoses of chronic airway obstruction, congestive heart failure and cerebellar ataxia. Review of the physician ' s order sheets for September 2013 revealed the resident had orders for: Depakote 125 mg (milligrams) sprinkle capsules, 3 capsules (375mg) at bedtime and 125 mg every morning (mood stabilizer) but physician order sheet says for dementia, Citalopram 40 mg daily (antidepressant) written 07/004/11, and Seroquel 50 mg at bedtime (antipsychotic) written 01/12/12 for insomnia. Lexi-Comp ' s Geriatric Handbook defines Seroquel as an antipsychotic use for schizophrenia and bipolar disease. The monograph also stated that this medication carries a U.S. Boxed warning from the Food and Drug Association " Elderly patients with	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	346024	A. BUILDING ______ B. WING ______	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 428	Continued From page 12 dementia-related psychosis treated with antipsychotic are at an increased risk of death compared to placebo. " On observation of the resident on 09/26/13 at 1:30 PM, he was sitting in his wheelchair watching TV in the day room. He was pleasant and alert in conversation and dressed neatly in street clothes. In an interview with the floor nurse on 09/25/13 at 2 PM, no behaviors could be identified. Review of the care plan revealed that he was care planned for exit seeking behavior and combative behavior on 12/15/10 on admission. Floor nurse could not remember any exit seeking behavior. Length of time on the antipsychotic was 21 months. No addendum was added to the care plan and the problem was not resolved. No behaviors were documented in the nursing notes for September 2013. In an interview with the consultant pharmacist on 09/26/13 at 11 AM, she was not aware of any behaviors and had not asked the doctor for a suitable diagnosis for the continued use of an antipsychotic.	F 428		

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	345024	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	10/25/2013

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V (111) construction, one story, with a complete automatic sprinkler system.	K 000	This plan of correction is being submitted pursuant to the applicable federal and state regulations. Nothing contained herein shall be construed as an admission that this Facility violated any federal or state regulation or failed to follow any applicable standard of care.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Friday 10/25/13 at approximately 9:00 AM onward the following deficiencies were noted: 1) The dry storage room in the kitchen was found wedged open. When the wedge was removed the door would not close, latch and seal. 2) The Supply Room corridor door at the Gold nurse Station would not close, latch and seal. 42 CFR 482.41(a)	K 029	K029 1. The door to the dry storage room has been repaired to close and latch properly by the maintenance department. The Supply Room corridor door at the Gold Nurses' Station has been repaired to close and latch properly by the maintenance department. 2. All doors have been inspected to ensure they close and latch properly by the maintenance department. Staff has been in-serviced on not using a wedge on any door by the maintenance director. 3. The maintenance department inspects doors weekly and repairs, if needed, are completed immediately to make certain doors close and latch properly by maintenance. The 'Inspection of Doors' checklist is completed by the maintenance person as he inspects the doors for compliance. 4. Weekly maintenance rounds include the inspection of doors to ensure they close and latch properly. The (QA) 'Inspection of Doors' checklist is kept on a clipboard in the maintenance office and monitored by the Director weekly to (con't)	10/28/13
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 045		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 11/06/13

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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	345024	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	10/25/2013

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K 045	Continued From page 1 Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation on Friday 10/25/13 at approximately 9:00 AM onward the following deficiencies were noted: 1) The path from the 600 Hall to the public way was not adequately illuminated. Lighting must be arranged to provide light from the exit discharge leading to the public way (parking lot). The walking surfaces within the exit discharge shall be illuminated to values of at least 1 ft-candle measured at the floor. Failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candles in any designated area. NFPA 101 7.8.1.1, 7.8.1.3, and 7.8.1.4. 42 CFR 483.70(a)	K 045	ensure the doors have been checked and function properly. K 045 1. Adequate lighting has been installed to provide illumination leading from the 600 Hall to the public way (parking lot) by Allways Electric Company. 2. All areas of the facility have been assessed by the Maintenance Department and are in compliance with NFPA K 045 (continuous illumination of means of egress) 3. The Maintenance Department has been re-educated on the requirements on continuous illumination of means of egress. All areas of facility requiring continuous illumination is in compliance. 4. The Maintenance Department monitors all lighting throughout the facility including all exit areas correcting any failure in lighting corrected immediately. Lighting is checked weekly during preventative maintenance rounds and recorded on QA PM checklist.	11/6/13
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	K052 1. The battery backup pack has been replaced on the Fire Alarm Control Panel by T & S Fire System Company. 2. The notification devices on the Fire Alarm Control Panel has been tested by T & S Fire System Company the Maintenance Department and the notification devices activate properly when the Fire Alarm is activated. 3. The fire alarm system is properly tested and maintained by the maintenance (con't)	10/29/13

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K 052	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation on Friday 10/25/13 at approximately 9:00 AM onward the following deficiencies were noted: 1) Upon testing the Fire Alarm Control Panel under battery backup power the notification devices did not activate upon activation of the Fire Alarm. Notification devices would activate under normal power.	K 052	department quarterly and by Sunland Fire Protection (outside contractor) annually in accordance with requirements of NFPA 70 and 72 guidelines. 4. The notification devices on the Fire Alarm Control Panel are checked and recorded by the maintenance department during monthly fire drills to ensure they are working properly and in compliance. This is reviewed at monthly Safety Comm. meeting.	
K 056 SS=F	42 CFR 482.41(a) NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on Friday 10/25/13 at approximately 9:00 AM onward the following deficiencies were noted:	K 056	K056 K056 1. The sprinkler head in room 403 has been replaced by Sunland Fire Protection and is in good repair. The sprinkler heads in the laundry and the kitchen have been cleaned by the maintenance department and are in proper working condition. The sprinkler system is inspected quarterly by the maintenance department and annually by Sunland Fire Protection Company. 2. All sprinkler heads have been inspected and cleaned by the maintenance department to ensure they are in proper working condition. 3. Quarterly testing and inspections are performed on the entire sprinkler system by the maintenance department to ensure the system is properly working. (cont)	10/25/13

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K 056	Continued From page 3 1) The sprinkler head in resident room 403 was missing missing the fluid in the glass bulb and not maintained in good repair. 2) The sprinkler heads in the Laundry and in the Kitchen were not maintained clean and in good condition. Sprinkler heads were were covered in lint, dust and/or dirt. 3) Upon staff interview and documentation the sprinkler system is inspected only annually. Facility will need to have the sprinkler system inspected quarterly. 42 CFR 483.70(a)	K 056	4. Inspections are monitored and documented by the maintenance director. All repairs/replacements are completed by the maintenance department as needed in accordance with NFPA 25.	
K 076 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation on Friday 10/25/13 at approximately 9:00 AM onward the following deficiencies were noted; 1) In the oxygen storage room on 200 Hall an oxygen cylinder were not properly chained or	K 076	K076 1. Oxygen cylinders stored in the oxygen storage room on 200 Hall have been properly chained/secured and are supported in a proper cylinder stand. All cylinders in the 200 hall storage room have been designated with "full" or "empty" signage. Full and empty cylinders are segregated and marked to ensure easy identification. All empty cylinders have been removed from the Therapy Department. 2. All O2 cylinders have been checked to ensure they are properly chained/secured and supported in a proper cylinder stand. All O2 cylinders have been checked to make certain "full" and "empty" tanks are segregated and have the appropriate signage in accordance with NFPA 99. (con't)	10/25/13

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K 076	Continued From page 4 supported in a proper cylinder stand or cart. [NFPA 99 4-3.5.2.1b(27)] 2) In the 200 Hall oxygen storage room and in the Therapy Room full and empty oxygen cylinders were stored together. If stored within the same enclosure, empty cylinders shall be segregated and designated (with signage) from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. [NFPA 99 4-3.5.2.2b(2)] 42 CFR 483.70(a)	K 076	3. When O2 is delivered all empty cylinders are picked up and all full cylinders are placed in the appropriate area with signage and properly secured and chained. 4. Supervisors will monitor O2 cylinders during weekly QA rounds to ensure all cylinders are stored securely and segregated with appropriate signage in accordance with NFPA 99 and reported at the monthly QA meeting.	