DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/11/2012 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTIO (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 345496 04/27/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **791 BOONE STATION DRIVE** LIBERTY COMMONS N&R ALAMANCE **BURLINGTON, NC 27215** SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY F 226 483.13(c) DEVELOP/IMPLMENT F 226 SS=D ABUSE/NEGLECT, ETC POLICIES The statements made on this plan of correction are not an admission to and do not constitute an agreement with the The facility must develop and implement written policies and procedures that prohibit alleged deficiencies. mistreatment, neglect, and abuse of residents To remain in compliance with all and misappropriation of resident property. federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The This REQUIREMENT is not met as evidenced plan of correction constitutes the by: facility's allegation of compliance such Based on staff interviews and record reviews the that all alleged deficiencies cited have facility failed to report 1 of 2 allegations of abuse been or will be corrected by the dates to the appropriate agencies within the State's indicated. required timeframe. Resident #93. Corrective Action for Resident Findings included: Affected For Resident #93 the facility allegedly failed to report an A review of the facility's policy on "Abuse allegation of abuse to the Prohibition" (revised 5/1/07) included: "Reportable appropriate agencies within the Incidents: Any ALLEGATIONS (regardless of State's required timeframe on 4/23/12. whether the allegations are substantiated) against unlicensed personnel, including injuries of unknown origin that appear to involve the conduct **Corrective Action for Resident** of abuse, neglect, misappropriating property of **Potentially Affected** the patient or facility, committing fraud against a All residents have the potential to patient or facility or diverting drugs belonging to be affected by this alleged deficient the patient or facility, MUST BE REPORTED to practice. All abuse investigations the Health Care Personnel Registry via the 24 were reviewed by the Director of hour and 5 day report. A 24-Hour investigation Nursing on 5/1/12 to ensure that and report must be completed and faxed in to failure to report allegations of abuse DHHS (fax number is on DFS-4501 form-revised to the appropriate agencies within 8/16/00) Facilities will use the 24-Hour Initial the State's required timeframe were

LABORATORY DIRECTOR'S OR PROVIDER'SUPPLIER REPRESENTATIVE'S SIGNATURE

Report form and follow the guidelines for

completion that are on the instruction sheet

provided with the form." Further review of the

policy documented: "Allegations occurring after

hours or on weekends: It is the SUPERVISOR '

present for those residents with an

allegation of abuse. Also all staff

were interviewed to ensure that all

allegations of abuse were reported and followed up in a timely manner.

TITLE

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: R3ZK11

Facility ID: 960494

if continuation sheet Page 1 of 15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A BUILDING	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
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F 226	in person or by phe and ensure that the faxed into DHHS A appropriate follow- During an interview Resident #93 (ider cognitively, modera nursing assistant werbally abusive to that on the previou Friday, a nursing a provide incontinent preparing for the de the nursing assistant of voice, if she still nastyl I'm gonna ge it back anymore". I nightgown was her s laundry departme everyday. Residen nursing assistant g arm, three times. T then told the nursing release her arm, sher. The resident s assistant released sore. During this in back the sleeve of purplish bruise on the resident revealed the the Head Nurse aft alleged abuse. The she had not seen the reported the incident	Ty to review the information via one with the initiating nurse, a completed 24-hour report is aND to notify management for up the next business day." If on 4/23/12 at 4:47pm, atified by the facility as ately impaired) alleged that a vas recently, physically and her. Resident #93 revealed as early morning of Thursday or ssistant came into her room to a care or to assist her in any. The resident stated that ant asked her in a hateful tone had "that same gown on, that's eat it and you're not gonna get the resident indicated the favorite gown and the facility' ent would wash it for her at #93 further revealed that the resident stated that she ag assistant if she didn't here (the resident) would slap tated that when the nursing her arm, it was bruised and terview, Resident #93 pulled her pullover top revealing a her left arm (near elbow). The neat she reported the incident to here breakfast on day of the resident also revealed that he nursing assistant since she	F 226	Systemic Changes An in-service was conducted for all RN supervisors and 5/17/12 and 5/22/12 by the Nursing for all additional in Those who attended were LPNs, and CNAs, FT, PT, Hospice providers were included to the facility. Any in-house member who did not receive training will not be allowed training has been complete service topics included time completion of the 24-hr repethere is an allegation of abmisappropriating property and facility, or diverting druto the patient or facility, or unknown origin. This information has been into the standard orientation the required in-service recourses for all employees a reviewed by the Quality Asprocess to verify that the cobeen sustained. Quality Assurance The Director of Nursing or Managers will monitor this the "Survey QA Tool for thin notification to DHHS of any abuse". The monitoring wiverifying that the 24 hr reprocompleted timely and faxed All RN supervisors and 5 similible reviewed with the autime. See attached monito This will be done daily (Mo Friday) for four weeks and times three months or until QOL/QA committee. Repogiven to the weekly Quality committee and corrective as appropriate.	on 5/16/12, e Director of ursing staff. all RNs, and PRN. cluded esident care se staff /e In-service to work until ed. The in- ely ent when use, neglect, of the patient ags belonging injury of integrated in training and efresher and will be surance hange has Unit issue using nely / alleged Il include ort was d to DHHS. taff members udit tool each ring tool. nday thru then weekly resolved by orts will be of Life- QA		

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#93 's allegation of variance and supervisor). However was not submitted to agencies until 4/23/12 Nursing). During an interview of (Nursing Supervisor) 4/19/12, she was informative with her with blood pressure check interviewed Resident "carabbed her arm caus stated that she did ob the resident 's upper pressure cuff would be refused to have the air stated that she complementation of the Night Nurse, and who were in the resident 's physician. She also in the Night Nurse, and who were in the resident to the DON vinursing assistant was resident 's hall on Frie NS#2 revealed the not consider the episons of the provision of the not consider the episons of the post of the not consider the episons was resident to the post of the not consider the episons was resident to the episons of the post of the not consider the episons was resident to the episons of the episons o	erbal and physical abuse by as documented as a 4/20/12 by NS#2 (Nursing the 24-Hour Initial Report the appropriate state by the DON (Director of a 4/26/12 at 10:12am, NS#2 revealed that on Friday, and a bout a confrontation and a 11:00pm-7:00am and a line a bar was conducting a line a heart a liar and and a line a painful bruise. NS#2 aserve a large dark bruise on left arm (where the blood a placed). The resident and a line and an incident report, and as Responsible Party and her atterviewed, via telephone, the two nursing assistants and incident and saligned to a different day, Saturday, and Sunday, as were given by the DON, at she did not complete a incident because she did add a case of abuse after	F 226			
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page #93 's allegation of ve a nursing assistant wa Grievance Report on Supervisor). However was not submitted to a gencies until 4/23/12 Nursing). During an interview or (Nursing Supervisor) of 4/19/12, she was infort between Resident #93 nursing assistant. Not assistant told her that combative with her with blood pressure check interviewed Resident in combative with her with blood pressure check interviewed Resident in ursing assistant "ca grabbed her arm caus stated that she did ob the resident 's upper pressure cuff would be refused to have the ar stated that she comple notified the resident 's Physician. She also in the Night Nurse, and the who were in the reside the incident. NS#2 sta incident to the DON vi nursing assistant was resident 's hall on Fric No further instructions The NS#2 revealed the 24-Hour Report of the not consider the episo interviewing a second	COMMONS N&R ALAMANCE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 2 #93 's allegation of verbal and physical abuse by a nursing assistant was documented as a Grievance Report on 4/20/12 by NS#2 (Nursing Supervisor). However, the 24-Hour Initial Report was not submitted to the appropriate state agencies until 4/23/12 by the DON (Director of	CONTINUED ROUNDER OR SUPPLIER COMMONS NAR ALAMANCE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ORLSC IDENTIFYING INFORMATION) Continued From page 2 #93 's allegation of verbal and physical abuse by a nursing assistant was documented as a Grievance Report on 4/20/12 by NS#2 (Nursing Supervisor). However, the 24-Hour Initial Report was not submitted to the appropriate state agencies until 4/23/12 by the DON (Director of Nursing). During an interview on 4/26/12 at 10:12am, NS#2 (Nursing Supervisor) revealed that on Friday, 4/19/12, she was informed about a confrontation between Resident #93 and a 11:00pm-7:00am nursing assistant. NS#2 stated that the nursing assistant told her that the resident had been combative with her while she was conducting a blood pressure check. NS#2 revealed she then interviewed Resident #93 who told her that a nursing assistant " called her a liar " and grabbed her arm causing a painful bruise. NS#2 stated that she did observe a large dark bruise on the resident's upper left arm (where the blood pressure cuff would be placed). The resident refused to have the arm bandaged or load. NS#2 stated that she completed an incident report, and notified the resident's Responsible Party and her Physician. She also interviewed, via telephone, the Night Nurse, and the two nursing assistants who were in the resident's room at the time of the incident. NS#2 stated that she reported the incident to the DON via telephone. The accused nursing assistant was assigned to a different resident's hall on Friday, Saturday, and Sunday. No further instructions were given by the DON. The NS#2 revealed that she did not complete a 24-Hour Report of the incident because she did not consider the episode a case of abuse after interviewing a second nursing assistant who was	OWIDER OR SUPPLIER COMMONS N&R ALAMANCE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR SCIENTIFYING INFORMATION) CONTINUED From page 2 #93 's allegation of verbal and physical abuse by a nursing assistant was documented as a Grievance Report on 4/20/12 by NS#2 (Nursing Supervisor). 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She also interviewed, via telephone, the Night Nurse, and the two nursing assistants who were in the resident's room at the time of the incident to the DON via telephone. The accused nursing assistant was assigned to a different resident resident he episode a case of abuse after interviewing a second nursing assistant wows as	COMPLET ON SUPPLIER COMMONS NAR ALAMANCE SUMMANY STATEMENT OF DEFICIENCISS GLAN HOFFICIANNY MIST BE PRECEDED BY FULL REGULATORY OR I.S.C. IDENTIFYING INFORMATION) COntinued From page 2 #39 's allegation of verbal and physical abuse by a nursing assistant was documented as a Grievance Report on 4/20/12 by NS#2 (Nursing Supervisor), However, the 24-Hour Initial Report was not submitted to the appropriate state agencies until 4/23/12 by the DON (Director of Nursing). During an interview on 4/26/12 at 10:12am, NS#2 (Nursing Supervisor), revealed that on Friday, 4/19/12, she was informed about a confrontation between Resident #33 and at 11:00pm-7:00am nursing assistant. NS#2 stated that the nursing assistant "called her a liar" and grabbed her arm causing a painful bruise. NS#2 stated that she clid observe a targe dark bruise on the resident's supper left arm (where the blood pressure cuff would be placed). The resident refused to have the arm bandaged or icod. NS#2 stated that she completed an incident report, and notified the resident's Reponsible Party and her Physician. She also interviewed, via telephone, the Night Nurse, and the two nursing assistants who were in the resident's reponsible Party and her Physician. She also interviewed, via telephone, the Night Nurse, and the two nursing assistants who were in the resident's reponsible Party and her Physician. She also interviewed, via telephone, the Rolph Nurse, and the two nursing assistants who were in the resident's reponsible Party and her Physician. She also interviewed, via telephone, the solid interviewing a second nursing assistant was assigned to a different resident's Reponsible Party and her Physician. She also interviewed, via telephone, the course of the incident to the placed a case of abuse after interviewing a second nursing assistant who was

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F 226	DON confirmed that of notified and discussed involving a nursing as #93; and they conclud However; the following the incident with the A was made to submit a State Agency and to the incident. 483.60(b), (d), (e) DR LABEL/STORE DRUCT The facility must emply a licensed pharmacist of records of receipt a controlled drugs in sufficient accurate reconciliation records are in order a controlled drugs is materially and biologicals labeled in accordance professional principles appropriate accessory instructions, and the eapplicable. In accordance with Statellity must store all colocked compartments controls, and permit of have access to the ket.	in 4/26/12 at 11:15am, the sin Friday, 4/19/12, NS#2 if with her the incident sistant and Resident sistant and services of six sistant and sistant s		431	The statements made on this correction are not an admiss do not constitute an agreem alleged deficiencies. To remain in compliance will federal and state regulations has taken or will take the act forth in this plan of correctiplan of correction constitute facility's allegation of compathat all alleged deficiencies been or will be corrected by indicated. Corrective Action for Readfected No specific resident was that based on facility obstand staff interviews the facility allegedly failed to remove medications from medical storage areas and assure medications and biological stored at the proper temporal All expired medication was discarded from the medical storage areas and the termof the refrigerator was addiscarded from the medical storage areas and the termof the refrigerator was addiscarded from the medical storage areas and the termof the refrigerator was addiscarded from the medical facility policy and pron 4/26/12. Corrective Action for Responsible to the policy areas and medical refrigerators were reviewed supervisor's on 4/26/12 at to ensure that there were expired medication in the areas and the medication refrigerators were at the comparatures.	tion to and ent with the thall the facility tions set on. The s the diance such cited have the dates esident dentified ervation cility expired tion that al's were erature. It is attoin a to deficient deficient deficient deficient desident ential to desident ential entire ential entitles ential entitles ent	5/22/12
	permanently affixed co	ompartments for storage of			temperatures.		and the second s

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F 431	Continued From page controlled drugs listed Comprehensive Drud Control Act of 1976 abuse, except when package drug distrib quantity stored is midbe readily detected. This REQUIREMEN by: Based on facility oblinterviews the facility medications from 3 (100 hall medication medication storage storage room) and a biological's were storage room; and a biological's were storage room, and a biological storage room, and a storage room, and a storage room. Guaifenesin 400mg lot # \$0905002 - Extending the storage room.	din Schedule II of the gabuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can. T is not met as evidenced servations and staff failed to remove expired of 6 medication storage areas storage cart, 100-300 room, 400/500 medication assure that medications and red at the proper. 2:00 PM an observation of all medication storage room Staff member #1. The rer The Counter (OTC) observed in wooden cabinets, and on wire shelves in the tablets (1 bottle unopened)	F 431	Systemic Changes An in-service was conducted or 5/16/12, 5/17/12 and 5/22/12 by Director of Nursing. Those who attended were all RNs, LPNs, a CNAs, FT, PT, and PRN. Hospi providers were not included because they do not provide medication in the facility. Any in house staff member who did no receive in-service training will nobe allowed to work until training been completed. The in-service topics included monitoring of the medication storage areas for expired medications and monitor of the medication refrigerators for proper temperatures. This information has been integrated the standard orientation training and in the required in-service refresher courses for all employ and will be reviewed by the Quangulity Assurance The Director of Nursing or Unit Managers will monitor this issue using the "Survey QA Tool for medication storage and medicat refrigerators". The monitoring winclude verifying that there are no expired medications in the medication storage areas and the temperatures of all medication refrigerators are correct within facility policy. See attached monitoring tool. This will be don	or the control of the
	(unopened) Lot # 86 Bacteriostatic 0.9% (unopened) Lot # 84	3-460DK - Expired 02/01/2012 solution bottle for injection I-301DK - Expired 01/12/2011 bandage wrap - (12 Boxes)		daily for two weeks and then we times three months or until resol by QOL/QA committee. Reports will be given to the weekly Qualit of Life- QA committee and corrective action initiated as	ved iy
FORM CMS-25	67(02-99) Previous Versions C	bsolete Event ID:R3ZK	11 Facilit	_y appropriate.	on sheet Page 5 of 15

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F 431	Continued From page Lot# 8178 - Expired 1		F	431			ļ
	An interview was con 1 (floor nurse) on 04/2 member # 1 indicated above and found in it storage room were expulled from the storage stated that it was each check the expiration of the medication room. Stated the facility had also assisted in check expiration dates. An interview was conversing (DON) on 04/2 DON was asked her expectation carts for estated the nursing stated the nursing stated the spiration dates on the expiration dates on the expiration dates of the stated the sta	ducted with staff member # 25/2012 at 12:10 PM. Staff I all the medications listed the 100-300 medication expired and should have been go room. Staff member #1 th nurse's responsibility to dates of the medications in Staff member #1 also an OTC stock person who king the medications for ducted with the Director of /27/2012 at 1:44 PM. The expectation for checking the edication storage rooms and expiration dates. The DON off was supposed to check of the medication carts and					
	04/25/2012 with staff In the cart the followin to be expired: 1 unopened Glucagor Blood Sugar treatmen 11/2011 9 unopened Albuterol breathing treatment m						

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F 431	Continued From page	9 6	F 431			
	on 04/25/2012 at 12:: indicated the medication the 100 hall's medication the 100 hall's medication the 100 hall's medication are responsibility dates of the medication. An interview was con Nursing (DON) on 04 DON was asked here medications in the medication carts for estated the nursing state the expiration dates of medication rooms and remove the medication. 3. On 4/25/2012 at 10 made in the medication halls of Colace with a When asked who che for expiration dates, Nourses and the nurses #7 stated that the medication the medication in the for expiration dates. To staff were supposed to of the medication in the forting the medi	0:00 am an observation was on room for the 400-500 expiration date of 3/2012. It is cked the stock medications lurse # 7 responded that the supervisor checked. Nurse edications were checked at lurse # 7 also removed the				

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F 431	Continued From pa	ge 7	F 431			
	pen by Nova Nordis Aventis, and Phena these medications s temperatures betwee degrees when unop Protein Derivative (I Pasteur was to be s after opening and w to freezing tempera temperature change the medication. At 10:15 am on 4/2 refrigerator located 400-500 halls was o temperature of 32 d large piece of ice ha compartment at the interior. Observation this refrigerator four checked at midnight for 4/23/2012 at 20 deg degrees. On 4/25/20 temperature control no other changes no the following medica 1. Opened Turbin- Sanofi Pasteur 2. Unopened Nov- Nova Nordisk 3. Unopened Lant Sanofi Aventis	ecommendations for Novolog sk, Lantus pen by Sanofi doz by Paddock all indicated should be stored at refrigerator sen 36 degrees and 46 sened. Turbinol (Purified PPD) tuberculin test) by Sanofi stored at 36-46 degrees even reas to be discarded if exposed stures as the freezing sed the chemical makeup of 5/2012 the medication room for the observed to have a segrees. There was also a ranging out of an open freezer top of the refrigerator's not the temperature log for all that temperatures were at each day. The temperature ocumented at 26 degrees, for grees, and for 4/25/2012 at 30 on 12 the log indicated the was turned to #4. There were obted. Inside the refrigerator ations were observed: of PPD manufactured by stidual Phenadoz manufactured				

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F 431	Nurse # 7 was asked temperatures for the reply was that the nig acceptable range was indicated temperature degrees and 42 degrees and 42 degrees to have this range price Asked what should be were out of range, Nurseally know as she did At 1:15 pm on 4/25/26 had turned the temper refrigerator and the trendegrees. The temperature able to find it in the fall in an interview on 4/2 supervisor for the 400 checked the temperature is out of nurse supervisor state the temperature is out of nurse supervisor state the temperature should either a verbal commorder. At 2:05 pm on 4/25/26 conducted with the fall manager in his office. for repairs that needed was for the staff to fill needed repair and turmaintenance manager.	who checked the medication refrigerator. Her ht shift did. Asked what the source # 7 said the log as should be between 32 ees. The log was observed inted at the top of the page. The log was observed inted at the top of the page. The log was observed inted at the top of the page. The log was observed inted at the top of the page. The log was observed inted at the top of the page. The log was observed interest # 7 stated she was under a was observed to be 39 interest was not collity's online policy manual. 5/2012 at 1:30 pm the nurse observed that the previous shift. Sould happen if the the acceptable range, the ed that the nurse checking id notify maintenance by unication or written work.	F 431				

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	OVIDER OR SUPPLIER		7	REET ADDRESS, CITY, STATE, ZIP CODE 191 BOONE STATION DRIVE BURLINGTON, NC 27215	1 04/2	.//2012
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F 441 SS=D	a shelf in his office. The was asked if there had in for repair of the 40 to it being logged with those required for me maintenance manage and stated he did not refrigerator and was problem with the refrigeration storage from the indicated that the me be maintained with the degrees. 483.65 INFECTION SPREAD, LINENS The facility must estan Infection Control Prosafe, sanitary and control provent the dof disease and infection Control The facility must estan Program under which (1) Investigates, continuity in the facility; (2) Decides what proshould be applied to (3) Maintains a recording related to infection the facility when the Infection (b) Preventing Spread (1) When the Infection (5) Preventing Spread (1) When the Infection (1) the facility when the Infection (2) the facility when the Infection (3) When the Infection (4) When the Infection (5) Preventing Spread (1) When the Infection (6) Preventing Spread (1) When the Infection (1) Preventing Spread (1) When (1) Preventing Spread (1) When (1) Preventing Spread (1) Prevent	the maintenance manager and been a work order turned 0-500 halls' refrigerator due in temperatures colder than edication storage. The experience of the work orders thave a work order for the not aware that there was a gerator being too cold. If or the 400-500 halls on a provided an updated acility policy. The policy dication refrigerators should emperatures from 36-46 CONTROL, PREVENT Ablish and maintain an gram designed to provide a mfortable environment and evelopment and transmission ion. Program ablish an Infection Control in it—trols, and prevents infections are dures, such as isolation, an individual resident; and dof incidents and corrective ections. Individual Program and Control Program	F 444	The statements made on this correction are not an admissic do not constitute an agreement alleged deficiencies. To remain in compliance with federal and state regulations thas taken or will take the actiforth in this plan of correction plan of correction constitutes facility's allegation of complithat all alleged deficiencies of been or will be corrected by thindicated. Corrective Action for Research	on to and int with the a all he facility ons set in. The the lance such lited have he dates sident and #11 to ensure nent was int 1 4/26/12, laced with d in sident en annulas lected by ce. All lidentified N d 4/26/12 inula attached	5/22/12
	should be applied to (3) Maintains a recording actions related to info (b) Preventing Spread (1) When the Infection	an individual resident; and d of incidents and corrective ections. d of infection		and reviewed by the two R supervisors on 4/25/12 and to ensure that all nasal can tubing was in plastic bags	N d 4/26/12 nnula attached	

CENTERS FOR MEDICARE & MEDICAID SERVICES		MEDICAID SERVICES	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL			COMPLET	TED .
		345496	B. WIN			04/2	7/2012
	OVIDER OR SUPPLIER	NCE		7	REET ADDRESS, CITY, STATE, ZIP CODE 791 BOONE STATION DRIVE BURLINGTON, NC 27215		
LIBERTY	COMMONS N&R ALAMA	<u></u>		<u> </u>	PROVIDER'S PLAN OF COR	RECTION	(X5)
(X4) ID PREFIX TAG	(CACH DESICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF	FΙΧ	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	COMPLETION DATE
	Continued From page prevent the spread of isolate the resident. (2) The facility must communicable disease from direct contact will trace (3) The facility must hands after each direct contact will trace (3) The facility must hands after each direct contact will trace (2) Linens Personnel must hand transport linens so infection. This REQUIREMED by: Based on facility of interviews, and receive resident trace in a manor to prevent a manor to prev	prohibit employees with a asse or infected skin lesions with residents or their food, if ansmit the disease. require staff to wash their ect resident contact for which icated by accepted	F	= 44	Systemic Changes An in-service was conducted 5/16/12, 5/17/12 and 5/22/10 of Nursing. Those who atter RNs, LPNs, and CNAs, FT, PRN. Hospice providers we because they do provide rein the facility. Any in-house member who did not receiving training will not be allowed training has been complete service topics included stortubing in a plastic bag attaction of the oxygen concent the tubing is on the floor unwill be replaced with new to the standard orientation in the required in-service recourses for all employees reviewed by the Quality As Process to verify that the concentrators and tubing or monitoring will include ver resident with an oxygen cand tubing has a plastic be and the tubing is correctly the bag and not unprotect residents with an oxygen and oxygen tanks in use to be reviewed. See attachtool. This will be done do weeks and then weekly timonths or until resolved icommittee. Reports will weekly Quality of Life-Quand corrective action initial appropriate.	2 by Director ded were all PT, and re included sident care staff e In-service to work until d. The ingoxygen shed to the rator and if protected it ubing. Integrated in training and efresher and will be surance shange has designee will e "Survey QA foxygen. The ifying that any concentrator and tubing will ed monitoring illy for four mes three by QOL/QA be given to the A committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		345496	B. WN	э		04/2	7/2012
	ROVIDER OR SUPPLIER			791 B	ADDRESS, CITY, STATE, ZIP CODE BOONE STATION DRIVE LINGTON, NC 27215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x :	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	medical record indica receiving oxygen via a receiving oxygen via a tase of the concentrator and the staff member # 4. The observed connected a concentrator and the unprotected on the fice of the concentrator and the unprotected on the fice of the resident's nasal cannot the floor and stated, "before the resident reconcentrator." A third observation of conducted with staff of at 3:10 PM. The resident at 3:10 PM. The resident reconcentrator." A third observation of conducted with staff of at 3:10 PM. The resident reconcentrator on the resident of the cannot supposed to floor and removed the cannot from the resident his of the cannot was observed unprotected on the first stated, "The cannot was observed unprotected on the first stated, "The cannot place of the first stated, "The cannot place of the cannot place of the cannot place of the first place of	ted the resident was to be nasal cannula at night. It was made on 04/25/2012 It # 141's nasal cannula with e oxygen tubing was to the resident's nasal cannula was laying for under the concentrator. It ducted with staff member # nember #4 recognized the full was lying unprotected on the fire it is nasal cannula was ying unprotected on the fire it is a stated the nasal cannula was ying unprotected on the fire it is a stated the nasal cannula be laying unprotected on the fire it is a stated the nasal cannula be laying unprotected on the fire it is here and they will now cannula staff member # 3 it is here and they will now cannula before they can oxygen tonight." Was made of resident # 141 If I have it is here it is nasal to y staff member # 5 laying for. Staff member # 5 laying for. Staff member # 5 was supposed to be ed on the oxygen light shift to prevent it from	F	441			

	OF DEFICIENCIES FCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345496	B. WN	G	taller granden and the second	04/	27/2012
	ROVIDER OR SUPPLIER	NCE		791 E	ADDRESS, CITY, STATE, ZIP CODE BOONE STATION DRIVE ILINGTON, NC 27215		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	(EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
F 441	Continued From page	e 12	 	441			
	interview was attempt During the interview the resident's oxygen laying unprotected or resident's medical rewas to be receiving of cannula. A second observation on 04/25/2012 at 2:50 cannula was observed the floor next to the recould not communicate been on the floor. Ar with staff member #4	1:30 PM an observation and ted with resident # 59. attempt it was observed that a tubing/nasal cannula was in the floor. A review of the cord indicated the resident continuous oxygen via nasal of of resident # 59 was made D PM. The resident's nasal d still laying unprotected on esident's bed. The resident atte how long the cannula had a interview was conducted who could not state how ag and nasal cannula had					
	made of resident # 1 resident's oxygen tub observed to be laying and under the resident was observed in the asked about the resident asked about the resident # 1 should be staff member # 6 was oxygen tubing/nasal place it on resident # resident's medical resident's medical resident's oxygen tubing/nasal place it on resident #	ing and nasal cannula were non the floor unprotected nt's bed. Staff member # 6 room. Staff member # 6 was dent's oxygen tubing/nasal floor. Staff member # 6 on the resident." At that time is observed to pick up the cannula off the floor and					
		ducted with staff member # 45 PM When asked about					

STATEMENT OF DE AND PLAN OF COR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPL	LE CONSTRUCTION	(X3) DATE SU COMPLE	
:		345496	B. WN	IG		04/2	27/2012
NAME OF PROVID	DER OR SUPPLIER	NCE		79	EET ADDRESS, CITY, STATE, ZIP CODE 31 BOONE STATION DRIVE URLINGTON, NC 27215		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
planyhir resinav resin	ich was observed of ident staff member ve placed the nasal ident, I should have brown a with a new change of the facility must equiparted handrails on the sed on facility observed handrails on the facility observed handrails on the facility observed handrails on the facility observed in the facility observed handrail of the facility's 4 of the facility's 4 of the facility's 4 of the facility of the facility is a conducted in one finger's pressinterview with staff see) was conducted in nurse observed the ed, "It is not suppofacility's rehabilitating the handrails a lot the facility's rehabilitating the facility of the facility's rehabilitating the facility of the facility	ontaminated nasal cannula on the floor back on the # 6 stated, "I should not I cannula back on the e replaced the nasal ean cannula and tubing." ORS HAVE FIRMLY LS o corridors with firmly each side. is not met as evidenced ervation, staff interviews, and reviews the facility failed were firmly secured to the eall) resident hallways. FPM an observation was 00/500 hall's handrails. O hall (nearest the nurses and the entry point to the und to be loose and could st 1/2 inch from the wall		441	The statements made on this place correction are not an admission do not constitute an agreement valleged deficiencies. To remain in compliance with a federal and state regulations the has taken or will take the actions forth in this plan of correction. I plan of correction constitutes the facility's allegation of compliant that all alleged deficiencies cited been or will be corrected by the indicated. Corrective Action for Resid Affected No specific resident was iden The facility allegedly falled to ensure all handrails were firm secured to the wall for resident hallways. The handrail was tightened on 4/25/12. Corrective Action for Resid Potentially Affected All residents have the potentiabe affected by this alleged de practice. All handrails were reviewed by the Maintenance Director on 4/25/12 and 4/26/ensure that all handrails were secured firmly to the wall on a hallways.	to and vith the facility is set The set such I have dates ent tified. It to ficient	5/22/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , , ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345496	B. WiN	B. WING		04/27/2012		
NAME OF PROVIDER OR SUPPLIER LIBERTY COMMONS N&R ALAMANCE				STREET ADDRESS, CITY, STATE, ZIP CODE 791 BOONE STATION DRIVE BURLINGTON, NC 27215				
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION S	HOULD BE	(X6) COMPLETION DATE	
F 468	On 04/25/2012 at 2:0 maintenance manage the 400 hall and obse handrail. An interview maintenance manage the handrail was supper wall and observed the pressure to bring the inch away from the was a loose ar work order for the loomaintenance manage facility's process for a deficiency was identified manager stated, "The walls at each nurse's orders in them. Any san issue requiring repwork order and either me to pick up on my adaily, or place it in my and review the item that administration know it the work order in priosomething that needs start repairs immediated. On 04/25/2012 at 2:1 was conducted with the manager in his office, pulled out the turned he kept in a cardboar office. The work order of the maintenance in the manager of the work order of the maintenance in the manager of the work order of the maintenance in the manager of the work order	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 14 On 04/25/2012 at 2:00 PM the facility's maintenance manager was observed to come to the 400 hall and observe the identified loose mandrail. An interview was conducted with the maintenance manager at 2:02 PM who indicated the handrail was supposed to be secure to the vall and observed that it only took 1 finger messure to bring the handrail approximately 1/2 the haway from the wall. The maintenance manager stated, "I was not aware that the maintenance manager was asked to describe the maintenance in the maintenance manager in the maintenance in the file box for me to pick up on my rounds as I make 3-4 rounds laily, or place it in my office inbox. I will inspect und review the item that needs repair, let the idministration know if necessary, and then file me work order in priority for repair. If it is momenting that needs immediate attention I will tart repairs immediately." On 04/25/2012 at 2:10 PM a second interview was conducted with the facility's maintenance manager in his office. The maintenance manager mulled out the turned in work orders he had which he kept in a cardboard box on the shelf in his		PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR			on by the constant will ining way ork will wat d. Floor sue g that dent cring for limes by will of citive	

DEPART CENTER	TMENT OF HEALTH	I AND HUMÁN SERVICES & MEDICAID SERVICES		· ••		PRINTED FORM OMB NO	APPRO
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED	
345498		B. WIN	IG		05/17/2012		
	ROVIDER OR SUPPLIER COMMONS N&R AL	AMANCE		79	EET ADDRESS, CITY, STATE, ZIP CODE 11 BOONE STATION DRIVE URLINGTON, NC 27215		
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	COMPLE DAT
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ½ 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		K 029	929	The statements made on this plan of are not an admission to and do not congreement with the alleged deficience. To remain in compliance with all fed state regulations the facility has taken the actions set forth in this plan of corplan of correction constitutes the faci allegation of compliance such that all deficiencies cited have been or will be by the dates indicated.	onstitute an ies. eral and or will take rrection. The lity's	
	42 CFR 483.70(a) By observation on 5 the following hazard non-compliant, spe-	s not met as evidenced by: 5/17/12 at approximately noon fous areas were cific findings include soiled the 300, 400, & 500 Hall			Corrective Action for the deficite practice: The soiled linen was removed from and 500 hall bathrooms on 5/17/12 pm. Corrective Action for Resident F Affected All residents have the potential to	n 300, 400 2 at 12:30 Potentially	The state of the s
	国区国IV国 JUN 05 2012 NSTRUCTION SECTION				by this alleged deficient practice. Administrator and Director of Nurs walking rounds and checked 300, 500 hall bathrooms to ensure no s was in these rooms on 5/18/12 and	ing did 400 and oiled linen	
ABORATORY	ADIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE		TITLE	1.	(X6) DATE
~	2mm + 8				Administrative on may be excused from correcting provide		111

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 day 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 to 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.

PRINTED: 05/21/ **FORM APPRC** OMB NO. 0938-I

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING 01 - MAIN BUILDING 01 B. WING 345496 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

(X3) DATE SURVEY COMPLETED

05/17/2012

791 BOONE STATION DRIVE BURLINGTON, NC 27215

LIBERTY COMMONS N&R ALAMANCE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY K 029 NFPA 101 LIFE SAFETY CODE STANDARD K 029 SS=D One hour fire rated construction (with 1/4 hour Systemic Changes fire-rated doors) or an approved automatic fire An in-service will be conducted on 6/6/12, 6/7/12 and 6/8/12 by the Staff Development extinguishing system in accordance with 8.4.1 Coordinator. Those who will attend are all and/or 19.3.5.4 protects hazardous areas. When housekeeping personal, RNs, LPNs, and the approved automatic fire extinguishing system CNAs, FT, PT, and PRN. Any in-house staff option is used, the areas are separated from member who did not receive in-service other spaces by smoke resisting partitions and training will not be allowed to work until doors. Doors are self-closing and non-rated or training has been completed. The in-service field-applied protective plates that do not exceed topics included proper way to handle soiled 48 inches from the bottom of the door are linen. All soiled linen will be place in a plastic permitted. 19.3.2.1 bag and placed in a laundry barrel on the hall, when the container must be removed off the hall and stored in 300, 400 and 500 hall bathrooms the housekeeper assigned to the hall will collect the soiled linen and take to laundry and the empty barrel will be placed This STANDARD is not met as evidenced by: in the hall bathrooms. 42 CFR 483.70(a) This information has been integrated into the By observation on 5/17/12 at approximately noon standard orientation training and in the the following hazardous areas were required in-service refresher courses for all non-compliant, specific findings include soiled employees and will be reviewed by the Quality Assurance Process to verify that the linen was stored in the 300, 400, & 500 Hall change has been sustained. bathrooms. **Quality Assurance** The Director of Maintenance or Floor Technician will monitor this issue using the "Survey QA Tool for monitoring soiled linen". The monitoring will include verifying that no soiled linen is stored in 300, 400, and 500 hall bathrooms. See attached monitoring tool. This will be done daily for four weeks and then monthly times three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life-QA committee and corrective action initiated as appropriate.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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 day 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 1 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.