OCT 07 2013

PRINTED: 09/11/2013 FORM APPROVED

	MDER/SUPPLIER/CLIA TIFICATION NUMBER: 345286	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE S	
	345286					
		B. WING			08/3	30/2013
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		, , , , , , , , , , , , , , , , , , ,
WHE OF I KONDER ON OUT FEET			710	0 JULIAN ROAD		
SALISBURY CENTER				ALISBURY, NC 28147		
(X4) ID SUMMARY STATEMENT OF REFIX (EACH DEFICIENCY MUST BE REGULATORY OR LSC IDENTICAL STATEMENT OF L	PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 156 SS=C  483.10(b)(5) - (10), 483.10(b)(6) RIGHTS, RULES, SERVICES  The facility must inform the reand in writing in a language the understands of his or her right regulations governing resident responsibilities during the stay facility must also provide their notice (if any) of the State device (if any) of the State device (if any) of the Act. Such made prior to or upon admission resident's stay. Receipt of such any amendments to it, must be writing.  The facility must inform each entitled to Medicaid benefits, if of admission to the nursing faresident becomes eligible for items and services that are in facility services under the State which the resident may not be other items and services that and for which the resident may the amount of charges for the inform each resident when cheat the times and services specifically (i)(A) and (B) of this section.  The facility must inform each at the time of admission, and the resident's stay, of services facility and of charges for the including any charges for service muder Medicare or by the facility must furnish a writegal rights which includes:	sident both orally at the resident sand all rules and tonduct and in the facility. The esident with the reloped under notification must be ion and during the ch information, and e acknowledged in resident who is in writing, at the time cility or, when the Medicald of the cluded in nursing the plan and for a charged; those the facility offers by be charged, and se services; and anges are made to ed in paragraphs (5) resident before, or periodically during is available in the se services, vices not covered lity's per diem rate.	F	156	<ol> <li>The contact information for State Agency was posted at a nurses station on August 29. by Social Worker.</li> <li>Residents that reside at the have the potential to be affed by this alleged deficient practions.</li> <li>Resident Council meeting was on 9-6-13 by Activity Director the posting of the contact information for the State Agwas reviewed along with what the information is posted. Education was provided to the Social Service Department by Manager of Clinical Operation 9-4-13 regarding the regulat requirements for posting of pertinent State client advocations are not an admission to not constitute an agreement with the alleged deficiencies herein.</li> <li>To remain in compliance with all Feand State regulations, the Center how will take the actions set forth in following Plan of Correction. The Porrection constitutes the Center's allegation of compliance such that alleged deficiencies cited have been be corrected by the date or dates in the state of the state of the corrected by the date or dates in the state of the corrected by the date or dates in the state of the corrected by the date or dates in the state of the corrected by the date or dates in the state of the state of the corrected by the date or dates in the state of the</li></ol>	center cted ctice.  as held or and ency ere  he y ons on ory acy dotline  of and do he ederal as taken the lan of all n or will	2.25.13

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.

9.20.13

TITLE

(X6) DATE

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345286	B. WNG		ı	C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147		/30/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		SHOULD BE	(X5) COMPLETION DATE	
	funds, under paragrapher funds, under paragrapher for establishing eligibithe right to request and 1924(c) which determing non-exempt resources institutionalization and spouse an equitable scannot be considered toward the cost of the medical care in his or down to Medicaid eligion. A posting of names, an umbers of all pertined groups such as the Stagency, the State licet ombudsman program, advocacy network, and unit; and a statement of complaint with the Stagency concerning resimisappropriation of resignal formation of resignal formation and witten information, and applicants for admission information about how Medicare and Medicaid	quirements and procedures lity for Medicaid, including assessment under section ines the extent of a couple's at the time of I attributes to the community hare of resources which available for payment institutionalized spouse's her process of spending ibility levels.  In State client advocacy at survey and certification insure office, the State the protection and the Medicaid fraud control that the resident may file at the survey and certification is ident abuse, neglect, and is ident property in the liance with the advance s.  In each resident of the vay of contacting the for his or her care.  Intently display in the facility deprovide to residents and on oral and written to apply for and use	F	Administrator and or will validate posting of Agency contact inform for 30 days and mont for 60 days.  4. The Administrator or Nursing will analyze a the data gathered about for patterns and trend results of this evaluat reported weekly for 3 then monthly x 90 day Quality Assurance and Improvement (QAPI) QAPI committee will make recommendation modification as needed continued compliance.  The statements made on the Correction are not an adminot constitute an agreement alleged deficiencies herein. To remain in compliance we and State regulations, the Correction constitutes the Correction constitutes the Correction constitutes the Coallegation of compliance su alleged deficiencies cited has be corrected by the date or	of State mation weekly chiy thereafter  Director of and evaluate ove looking ds. The ion will be do day and ys to the d Process committee. review and ons or ed to assure e.  his Plan of ssion to and do nt with the with all Federal Center has taken forth in the h. The Plan of Center's ch that all ave been or will	8.25.13	

STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE S	
MNU PLAN UI	CORRECTION	DETTI IS NOT TORNS				c	
		345286	B. WNG_			08/3	30/2013
	ROVIDER OR SUPPLIER			71	REET ADDRESS, CITY, STATE, ZIP CODE 0 Julian Road Alisbury, NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 156	Continued From pag	e 2	F	156			
	by: Based on observation facility failed to post information. The find On 8/26/13 at 11:00 was conducted. Stanot observed posted On 8/27/13 at 10:00 information was not facility.  On 8/28/13 at 4:00 F was not observed posted On 8/29/13 10 AM., on tour with this sun information was post the building was reminformation was wait When asked regardistated the remodeling 2012. Administrative contact information in State Contact information was edited the remodeling Con 8/30/13 at 8:47 A President stated that State contact information was edited the state contact informa	AM, an initial tour of facility te contact information was in the facility.  AM., State contact observed posted in the  PM., State contact information			The statements made on this Plan Correction are not an admission to not constitute an agreement with alleged deficiencies herein.  To remain in compliance with all and State regulations, the Center or will take the actions set forth in following Plan of Correction. The Correction constitutes the Center allegation of compliance such that alleged deficiencies cited have been be corrected by the date or dates	e and do the Federal nas taken the Plan of s all	9.25.13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
	345286	B. WING			С	
NAME OF PROVIDER OR SUPPLIER	343200		STREET ADDRESS, CITY, STATE, ZIP CODE	0	8/30/2013	
SALISBURY CENTER						
PREFIX (EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
realize there were two On 8/30/13 at 11:55 A stated the State conta addressed in the Resisince most concerns wo Ombudsman. 483.15(h)(2) HOUSEK MAINTENANCE SEN The facility must provide maintenance services sanitary, orderly, and of the sanitary orderly, and of the sanitary condition in 1 Findings included: On 8/27/13 at 11:48 Al rooms 302 B, 303, 318 observed to be dirty will on the seat and the sid The base of the tube fewas dirty with dried tube of the sanitary with dried tube of the sanitary with dried tube fewas dirty with dried tube fewas dirty with dried tube fewas dirty with dried tube feeding pole. He have a wheelchair clean	the Ombudsman and did not a different agencies.  M., the activity director ct information was not dent Council meetings were referred to the CEPING & VICES  de housekeeping and necessary to maintain a comfortable interior.  is not met as evidenced ew, observation and staff ailed to maintain the feeding pole in a clean and (300 hall) of 5 halls.  M, the wheelchairs in 3 A and 318 B were th dust and food particles le bars of the wheelchair. Seeding pole in room 321	2 a a a a a a a a a a a a a a a a a a a	room 302B, 303, 316 318B as well as the seeding pole in room cleaned by the hous staff on 8-29-13.	SA and ube a 321 were ekeeping ssistive or use ave the cted by practice. d for feeding for 3 by risor. No es or a need of as ning of on 9-11-ntal written s an are not an ent with the ollance with as taken or Plan of the Center's leftiencies	9.25.13	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345286	B. WING				C /30/2013
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	30/2013
SALISBU	RY CENTER			ŀ	10 JULIAN ROAD ALISBURY, NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 279 SS=J	explain why it was stonursing staff were supthe wheelchair neede  On 8/29/13 at 11:33 A observed the wheelch 318 A and 318 B to be of the tube feeding pothe same with dried to stated that he would to the same with dried to stated that he would to the same with dried to stated that he would to the same with dried to stated that he would to the same with dried to stated that he would to the same with dried to stated that he would to hall. When asked who wheelchair on 300 hall was in July, 2013 and the administrative stated that the housekeeper tube feeding pole wheelchair sweekly by wheelchair needed to housekeeping departrict stated that she was not wheelchairs were dirty 483.20(d), 483.20(k)(1) COMPREHENSIVE COMPREHENSIVE COMPREHENSIVE COMPREMENTINE TO STATE	ppped. He indicated that posed to let them know if d to be cleaned.  M, the floor technician had pairs in room 302 B, 303, and dirty and dusty. The base alle in room 321 remained able feeding formula. He aske care of them right away.  M, administrative staff #5 astated that she had a seaning schedule for each are was the last time the all were cleaned, she stated it showed me an e-mail to a showed me an e-mail to a should have cleaned the anshe cleaned the anshe cleaned the room.  M, Nurse #3 was and that the housekeeping and that t		253	Housekeeping Supervisor on 9 for a monthly cleaning schedu Weekly audits of resident equ by the housekeeping supervisor assistant supervisor to identify equipment that may need clear more frequently and cleaned a needed. The housekeeping supervisor educated the housekeeping staff on the writt schedule on 9-11-13.  4. Housekeeping Supervisor will a and evaluate the data gathered the weekly audit patterns and to the weekly audit patterns and to the results of this evaluation were ported weekly for 30 day and monthly x 90 days to the Qualit Assurance and Process Improve (QAPI) committee. QAPI committee. QAPI committee will review and make recommendations or modification needed to assure continued compliance.  The statements made on this Plan of Corare not an admission to and do not constant agreement with the alleged deficiency herein. To remain in compliance with all and State regulations, the Center has tak will take the actions set forth in the follow Plan of Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiency cited have been or will be corrected by the or dates indicated.	le. ipment or or  / anly as  tten  nalyze I from rends. ill be then y ment nittee son as  rection titute es Federal en or wing n cies	9.5.13

CFIAIFI	O FOR MEDICARE &	MEDICAID SEKVICES				OMR M	<i>J.</i> 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ECONSTRUCTION	COMP	SURVEY PLETED
		345286	B. WING		s arrest of	1	C /30/2013
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	00/20/0
				i	10 JULIAN ROAD		
SALISBU	RY CENTER			ı	SALISBURY, NC 28147		
(74)10	SUMMADV CT	ATEMENT OF DEFICIENCIES	1 10				1
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)  F279 J	3E	(X5) COMPLETION DATE
F 279	Canting of From 1999	. =			1. Resident #102 was discharged	as of	
1 210	Continued From page		F	279	7-25-13 therefore no further		
		lop a comprehensive care			interventions are possible.		
		that includes measurable			, i		
		bles to meet a resident's			2. Social Services Director and So		
		mental and psychosocial ed in the comprehensive			Workers audited current resid		
	assessment.	ed in the complehensive			care plans on 8-29-13 to ident	ify	
	accoccinent.				residents with sexually inappr		
	The care plan must de	escribe the services that are			behaviors. Audit results ident	ifled	
		in or maintain the resident's			one resident with verbally		
	highest practicable physical, mental, and psychosocial well-being as required under				inappropriate comments and	this	
					resident's care plan was update	ted to	
		vices that would otherwise			reflect behavior with interven		
	be required under §48	33.25 but are not provided					
		exercise of rights under			3. On 8-28-13, the Director of Nu	_	(2)
		right to refuse treatment		:	provided training to Social Ser	vices	1:
	under §483.10(b)(4).				staff regarding appropriate		.25.3
			İ		interventions for residents wit	:h	@ · *
	This RECHIREMENT	EQUIREMENT is not met as evidenced			behaviors including sexually		, ,
	by:	is not mot as evidenced			inappropriate behaviors.	ļ	
		ddress in care plan the			Interventions include: Separa	ting	
		behavior for 1 (Resident			residents, offering alternative	ļ	
	#102) of 1 sampled re				activities, one on one supervis	ion,	
	inappropriate behavio	r. Findings included:			psychiatric assessment, medic	ation	
				- 1	regime review, ensure other p	hysical	
		pegan on 7/20/13 at 6:00			needs like hunger and toiletin	gare	
		02 was observed touching			met. Other interventions will	- 1	
		oriately. The care plan for		- 1	developed based upon individ		
		ess the resident's sexually			needs.		
		r. The Immediate Jeopardy /13 and was abated on					
		ity provided an acceptable	-		The statements made on this Plan of Correc not an admission to and do not constitute a		
	credible allegation.	ny provided an acceptable			agreement with the alleged deficiencies her	1	
	anoganom		İ		remain in compliance with all Federal and St		
	Resident #102 was ad	mitted to the facility on			regulations, the Center has taken or will take		
	6/26/13 with multiple of				actions set forth in the following Plan of Cor	T T	
		Dementia, Anxiety State and			The Plan of Correction constitutes the Center	4	į
	Depression. The admi	ssion Minimum Data Set			allegation of compliance such that all allege		
	(MDS) assessment da	ted 7/6/13 indicated that		****	deficiencies cited have been or will be corre the date or dates indicated.	ctea by	

		I IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED	
		345286	B. WING_				C 30/2013	
NAME OF P	ROVIDER OR SUPPLIER		1 1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 001	00/2010	
CALICDIII	RY CENTER			71	0 JULIAN ROAD			
SALISBUI	KI CENTER			SA	LISBURY, NC 28147			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	NTE	(X5) COMPLETION DATE	
F 279	Resident #102 had mand needed supervision unit. The assessment Resident #102 had properties and the privacy or activity. The care plan was revibehavior addressed the and resistance to care resident's sexual imap. On 7/1/13 at 5:29 PM. Resident #102 was sittle hand of Resident in female resident) and vinappropriately. On 7/9/13 at 4:50 PM. Resident #102 was mand to hit staff.  On 7/11/13 at 4:14 PM. Resident and vinappropriately was mand to hit staff.  On 7/11/13 at 4:14 PM. Approached a nurse repulling medications for he was asked to move raise his arm in an atternal to hit staff. On 7/20/13 at 6:00 PM staff member had obshis hands on the pants Resident #72 (cognitive resident).	oderately impaired cognition on for locomotion on and off truther indicated that hysical and verbal behavioral ward others. The cated that the behavior had had significantly intruded on of others.  Viewed. The care plan on the resident's combativeness to but did not address the propriate behavior.  In the notes revealed that thing on the hallway holding #123 (cognitively impaired was touching her  In the notes revealed that aking inappropriate sexual sed his arms and attempted and had eally closed when she was an another resident. When the away, he proceeded to empt to hit her buttocks.  In the notes revealed that erved Resident #102 with and incontinence brief of rely impaired female	F2	279	Residents with sexual, verbal at physical behaviors will be revie along with their written care pleased by the Inter Disciplinary Team (weekly for 30 days and monthly thereafter. This review will encompass the effectiveness of interventions and making appropriate modifications to behavioral care plans. Any new identified behaviors or changes behaviors will be reviewed weef for 30 days and monthly thereafter.  4. The Director of Nursing and or Assistant Director of Nursing we review the monitoring tool frow IDT meeting and will analyze and evaluate the data gathered lock for patterns and trends. The resident of this evaluation will be report weekly for 30 day and then most to the Quality Assurance and Process Improvement (QAPI) committee. QAPI committee we review and make recommendation as needed to a continued compliance.  The statements made on this Plan of Correction and admission to and do not constitute agreement with the alleged deficiencies here to remain in compliance with all Federal and regulations, the Center has taken or will take actions set forth in the following Plan of Correction. The Plan of Correction constituted conter's allegation of compliance such that	wed ans (IDT)  y  f the  vly s in ekly after.  vill m the nd oking esults ted onthly  vill ations assure  ction rein. dd State te the tes the all	9.25.13	
	On 7/23/13 at 3:20 PM nurse aide reported th	1, the notes indicated that a at Resident #102 had			alleged deficiencies cited have been or will corrected by the date or dates indicated.			

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB N	O. 0938-0391
STATEMENT (	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	PLE CONSTRUCTION  G		E SURVEY PLETED
		345286	B. WING		į.	C 8/30/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
SALISBU	RY CENTER			710 JULIAN ROAD SALISBURY, NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 279	slapped her on the but 8/28/13 at 9:50 AM, at interviewed. She state the sexually inapprop #102 towards the resi aware of his behavior added that she was recare plan for behavior she missed to address sexually inappropriate. On 8/28/13 at 1:50 PM She stated that Resid questions which were On 8/28/13 at 1:55 PM She stated that Resid verbally abusive. He and showed her his pure of the stated that Resid around the resident. On 8/28/13 at 2:15 PM She stated that she hasking other resident. On 8/28/13 at 2:15 PM She stated that Resid around the residents. area and was asking the stated that Resid around the residents. Area and was asking the stated that Resid around the residents. Area and was asking the stated that Resid around the residents. Area and was asking the stated that Resid around the residents. Area and was asking the stated that Resid around the residents. Area and was asking the stated that Resid around the residents. Area and was asking the stated that Resid around the residents. Area and was asking the stated that Resid around the residents. Area and was asking the stated that Resid around the residents. Area and was asking the stated that Resid around the residents. Area and was asking the stated that Resid around the residents. Area and was asking the stated that Resid around the residents. Area and was asking the stated that Resid around the residents. Area and was asking the stated that Resid around the residents. Area and was asking the stated that Resid around the residents. Area and was asking the stated that Resid around the residents. Area and was asking the stated that Resid around the residents. Area and was asking the stated that Resid around the residents. Area and was asking the stated that Resid around the residents. Area and was asking the stated that Resid area and was asking the stated that Resid area area. Area and was asking the stated that Resid area area and was asking the stated that Resid area area area area and was asking the stated that Resid area area area area.	administrative staff #4 was ted that she was aware of priate behavior of Resident idents but she was not rowards the staff. She esponsible in developing a resident acknowledged that is in the care plan the esphavior of Resident #102.  M. NA #4 was interviewed. Hent #102 had asked her esexually inappropriate.  M. NA #3 was interviewed. Hent #102 was physically and had hit her on her buttocks private area.  M. NA # 5 was interviewed. Hent #102 was interviewed. Hent #102 was physically and had hit her on her buttocks private area.  M. NA # 5 was interviewed. Hent #102 should not be He was showing his private for sex from her.  AM, administrative staff # 2 was stated that she was made inappropriate behaviors of stated that the social worker reating a care plan for ted that the sexually or should have been	F 27	The statements made on this Plan are not an admission to and do not agreement with the alleged deficit To remain in compliance with all is regulations, the Center has taken actions set forth in the following is Correction. The Plan of Correction Center's allegation of compliance alleged deficiencies cited have be corrected by the date or dates into	ot constitute an iencles herein. Federal and State or will take the Plan of constitutes the exact that all the person or will be	£ 25.13

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		345286	B. WING			I .	C /30/2013	
	PROVIDER OR SUPPLIER			71	TREET ADDRESS, CITY, STATE, ZIP CODE 10 JULIAN ROAD ALISBURY, NC 28147	<u> </u>	/30/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	The facility provided to Allegation of Compliant.  1. Resident #102 witherefore no further in 2. Social Service Diaudited current resident to ensure identification sexually inappropriate identified one resident comments.  3. Social Services Diaudited current resident services identified residents and on 8-29-13. Interventions edication regime revineeds like hunger and interventions will be dindividual needs.  On 8-28-13 the Direct training to social service behaviors including sebenaviors. Intervention seidents, offering alteresidents, ill be deindividual needs.  Residents with sexual behaviors will be revied care plan by the IDT with the effectiveness of the appropriate modification.	the following Credible ance on 8/30/13 at 12:17 PM.  Aras discharged as of 7-25-13 interventions are possible. Irector and Social Workers and 's care plans on 8-29-13 on of resident 's with a behaviors. Audit results at with verbally inappropriate.  Director and or social and care plan interventions for and updated as appropriate ions include: Separating armative activities, one on chiatric assessment, view, ensure other physical ditoileting are met. Other leveloped based upon the sexually inappropriate ions for resident with exually inappropriate pernative activities, one on argent medical assessment, view, ensure other physical ditoileting are met. Other exually inappropriate include: Separating pernative activities, one on argent medical assessment, view, ensure other physical ditoileting are met. Other eveloped based upon the livewell and physical awed along with their written evekly for 30 days and his review will encompass the interventions and making	F	279	The statements made on this Plan of Correct are not an admission to and do not constitut agreement with the alleged deficiencies here. To remain in compliance with all Federal and regulations, the Center has taken or will take actions set forth in the following Plan of Correction. The Plan of Correction constitut Center's allegation of compliance such that a alleged deficiencies cited have been or will be corrected by the date or dates indicated.	te an ein. d State e the es the all	9.2.3	

CENTERS FOR MEDICARE & MEDICAID SERVICES								
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A BUILDING			(X3) DATE SURVEY COMPLETED	
		345286	B. WING		•	08/3	; 30/2 <b>013</b>	
NAME OF PI	ROVIDER OR SUPPLIER		<b></b>	i	TREET ADDRESS, CITY, STATE, ZIP CODE			
SALISBU	RY CENTER				ALISBURY, NC 28147			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 279	in behaviors will be reand monthly thereafted. The Director of Nursing we from the IDT meeting designed to documed and observations of defectiveness of interreview will be analyz Quality Assurance of for 30 days and mon The credible allegatic staff interviews and reviewed. The 1:1 s 7/20/13 until 7/25/13 discharged.  Interview with the so audit of the care plantesident was identified the identified resider was updated on 8/2. The social worker all received training from	eviewed weekly for 30 days er. Nursing and or Assistant ill review the monitoring tool is. The monitoring tool is at the care plan interventions the resident for the ventions. The results of this ed and reported to the ommittee on a weekly basis thly thereafter.	F	279	The statements made on this Plan of Correct are not an admission to and do not constitut agreement with the alleged deficiencies here. To remain in compliance with all Federal and regulations, the Center has taken or will take actions set forth in the following Plan of Correction. The Plan of Correction constitut Center's allegation of compliance such that alleged deficiencies cited have been or will be corrected by the date or dates indicated.  F323 J  1. On 8-27-13, Resident #58 was provided immediate first aid a assessed by the Director of Nu pending transportation to the Emergency Department (ER) for assessment and evaluation. Of 27-13 @ 5:25 PM, Resident #5 was transferred to the ER by low EMS by stretcher.  Resident #58"s attending physicals was notified by the Assistant Director of Nursing (ADNS) on 13 at 5:25 PM of the incident is by providing an physicians or consend to resident to the ER for	e an ein. I State e the es the es the all re local or n 8- 8 ocal sician 8-27- and care	8.22.8	
F 323 SS=J	including sexually in 483.25(h) FREE OF HAZARDS/SUPERV  The facility must ensenvironment remain as is possible; and 6	appropriate behaviors. ACCIDENT	ţ.	<sup>-</sup> 323	evaluation. The Responsible F was notified of the incident of 27-13 at 5:30 PM by the ADNS Resident #58 was returned to building on 8-27-13 at 11:00 F after treatment at the local Ef	n 8- 5. the M		

	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345286	B. WING_				C /30/2013	
	PROVIDER OR SUPPLIER			71	TREET ADDRESS, CITY, STATE, ZIP CODE 10 JULIAN ROAD BALISBURY, NC 28147	l var	30/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 323	Continued From page	÷ 10	F3	323	Upon return, Resident #58 was asso by a Registered Nurse (RN) and plat care updated to include: falls care p by eliminating facility transportation Geri chair and care of staples.	n of plan		
	by: Based on observation review and review of a the facility failed to sa #58) of 3 sampled res by pushing the resider rear of the van without was elevated resulting backward and falling of resident sustained a larequiring 2 staples. The implement intervention sexual inappropriate be cognitively impaired refulling of 1 sampled refulling impaired and broadministrator on 8/28/jeopardy was removed #102 and #58 at 12:17 provided a credible all facility will remain out and severity level D (needs)	the facility also failed to ans to prevent repeated behavior towards other esidents for 1 (Resident esident.  The gan on 7/20/13 when esident inappropriately. Continued when Resident and fell out of the facility /13. Immediate jeopardy ought to the attention of the /13 at 2:31 PM. Immediate d on 8/30/13 for Residents			Driver and Nursing Assistant (NA) was suspended on 8-27-13 pending investigation. Resident transportate have been outsourced as appropriate vendors pending completion of investigation.  Resident #102 was discharged as of 25-13 therefore no further interver are possible.  2. All residents transported in the Center's van have the potential that affected by this deficient practice. Residents that have exhibited was exault and or physical behaviors have been identified by a review the MDS and staff interviews by Inter-Disciplinary Team (IDT) on 28-13. The IDT will include representatives from Nursing, Song Rehabilitation, Activities and Administration.  The statements made on this Plan of Correct are not an admission to and do not constitute agreement with the alleged deficiencies her To remain in compliance with all Federal and regulations, the Center has taken or will take actions set forth in the following Plan of Correction. The Plan of Correction constitute.	tions ate  f 7- ntions  to be e. erbal, es w of y the n 8- Social, dition te an rein. d State e the	5.25.3	
	The findings included:	:			Center's allegation of compliance such that alleged deficiencies cited have been or will be corrected by the date or dates indicated.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI		(X3) DATE SURVEY COMPLETED			
AND PLAN OF	CORRECTION	Marita Carrott Manager	A. BUILDIN				С
		345286	B. WING_			08/	30/2013
	ROVIDER OR SUPPLIER			710	EET ADDRESS, CITY, STATE, ZIP CODE JULIAN ROAD ISBURY, NC 28147		
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F 323	Manufacturer specific read in part, "Vehicle Unloading: The plate floor level) and the inmust be properly pounloading passenge the responsibility of platform and the innustioned at floor leunloading passenge.  1. Resident #58 was 7/16/13. Diagnoses nailing of a right tibia renal disease, hence The most recent Mirchange dated 7/23/ #58 had severely in intact, was non-amb dependent on staff to main entrance of the facility transport var of the main entrance was observed lying resting on the grour gerichair was tipped down from the rear of the resident's her platform's left side plassessed the reside yelling, squirming a The back of the resident and the interest of the resident and the resident an	cations for the wheelchair lift be (Floor Level) Loading and form must be fully raised (at more roll stop (bridge plate) sitioned when loading or rs in or out of the vehicle. It is the lift attendant to ensure the er roll stop are properly evel when loading and ers."  Is readmitted to the facility on included status post surgical arfibula fracture, end stage odialysis and bipolar disorder.  Inimum Data Set, a significant 13, indicated that Resident spaired vision, was cognitively bulatory and was totally	F3		Staffs that provide transportat services were trained on the saloading and unloading of resid 8-27-13 by Maintenance Direct Administrator. Training includ positioning of wheel chair (w/center of lift, when to lock bra lifting and lowering of lift gate positioning of w/c in van, secu w/c to the floor, placement of seatbelt and validation of lift gosition prior to unloading. St provided return demonstration competency for safe loading a unloading of residents. Compand training will be validated annually, upon hire and as need all staff transporting residents Maintenance Director.  Manufacturer's (Century 2) Operations Manual and Q-Strauser instructions) recommend have been incorporated into the material.  The statements made on this Plan of Corare not an admission to and do not constagreement with the alleged deficiencies of Corrections, the Center has taken or will actions set forth in the following Plan of Correction. The Plan of Correction constituted by the date or dates indicated.	afe ents on tor and ed: c) in the kes, ring ate aff n of nd etency ded for by the int ations raining ection tute an terein. and State ake the tutes the at all	9.25.15

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	PROVIDER OR SUPPLIER		7	STREET ADDRESS, CITY, STATE, ZIP CODE 10 JULIAN ROAD SALISBURY, NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETIO	W.
F 323	the assessment, five gerichair, keeping her Emergency Medical S 5:29 PM and transport Emergency Room (Either St. 29 PM and transport Emergency Room (Either St. 29 PM and transport Emergency Room (Either St. 29 PM at 1:31 PM. Not accompanied Resider physician appointment to the facility. NA #6 stother residents (Resider St. 20 Passenger seat and Fewheelchair behind Reference (Driver #1) in the vanuassisted Resident #14 passenger side door with 1:53 out of the van wirear of the van. NA #6 was to immediately raresident off the lift plate be level with the floor moving Resident #150 not raise the lift because Resident #142, who with the floor moving Resident #150 not raise the lift because the resident out the basident #150 and it tipped back. During an interview or interview, Driver #1 stresidents up at three cowanted to get them basupper. Upon returning	staff lifted the resident into a rhead immobilized. Service (EMS) arrived at ted resident to the R).  ducted with NA #6 on IA #6 indicated she in #58 that afternoon to a stand they had just returned stated there were also 2 fent #142 in the front resident #153 in a sident #58) and the driver NA #6 explained Driver #1 IA United the while she took Resident at the wheelchair lift at the stated her usual practice is the lift after wheeling a reform so the platform would of the van. However, after IA off the platform she did use she was distracted by reas walking back into the elchair, and she was in. NA #6 said the driver a the side door to assist out of the van and pushed ack door, thinking the lift ushed the chair off the van k; the resident fell out.	F 323	No staff member will provide transportation services without completing training and demons of competency. The Administrativalidate and ensure all training is completed and documented price authorizing anyone to operate the Center's vehicle and or transport residents.  Maintenance Director and or Administrator will visually validate trained driver weekly including weekends for 30 days and month 90 days to ensure competencies. On 8-28-13, a sign was posted in rear of the Center's van providin visual cue to "Ensure lift gate is in UPRIGHT position prior to unload and placed in the front of the Center's Vehicle Safety Inspection. Checklist Logbook. Maintenance Director will audit and validate placement of signs on a weekly be 30 days and monthly thereafter. Salisbury Center will no longer of transportation in Geri Chairs effective. Salisbury Center will no longer of transportation in Geri Chairs effective. To remain in compliance with all Federal regulations, the Center has taken or will actions set forth in the following Plan of Correction. The Plan of Correction constitutions are not an admission to and do not constitute the sallegation of compliance such the alleged deficiencies cited have been or we corrected by the date or dates indicated.	te each  te each  the ga  n the ding" nter's n  easis for  ffer ective 8- rection itute an herein. and State take the itutes the itu	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUE A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345286	B. WING				30/2013
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F 323	wheelchair from the the resident back into said he wanted to pu. The driver indicated I Resident #58. He ext always face the front them off the van he verificated he realized when the rear wheels went over the edge. I resident from falling I acknowledged that he residents would not be assumed the lift platf indicated there was refollow when two staff residents. He said he Maintenance Directoresidents when the fand one-half years as been provided.  Nurse's notes dated revealed Resident #5 ER records of 8/27/1 superficial laceration staples. X-rays of the tibia and fibula and p fracture. Computerize the head revealed no abnormality and CT on fracture.  On 8/28/13 at 9:40 A observed in her room dialysis. The Nurse F visiting. The resident	van and was going to push to the building but the resident sh his wheelchair and walk. The returned to the van to get plained that the residents of the van, so when taking would be in front of the em backwards. Driver #1 the lift platform was not up soft the resident's gerichair He stated he tried to stop the put could not. The driver e was hurrying so the se late for supper and he just form was up. Driver #1 to specific procedure to members were unloading to was trained by the ron how to transport acility got the van, about one go. No additional training has \$8/27/13 at 11:04 PM to the scalp, closed with 2 to right femur, right foot, right elvis revealed no new ed axial tomography (CT) of	F	323	Staff to include Licensed Nurses, Nassistants, therapist, dietary, housekeeping, maintenance, social business services were provided to by the Director of Nursing and Ass Director of Nursing, Nursing Practice Coordinator and Nursing Supervises 8-28-13 and 8-29-13, Training includents (including sexually inappropriate behaviors) by the completion of an incident report, plan interventions and updating a how to manage residents' behavior Behavior interventions include: to separate residents and ensure safe redirection by: talking, offering sochecking for physical needs and or alternative activities, provide one one supervision, attempt to identify root cause of the behavior, medical reviews, lab reviews and psychological/psychiatric interventions set forth in the alleged deficiencies have a legalations, the Center has taken or will to actions set forth in the following Plan of Correction. The Plan of Correction constitutions controlled the control of the control of the control of the control of the control of the control of the control of the control of	ll and raining istant ce ors on luded nt care nd ors. o ety, nacks, ffering on ify the ation ations. ection tute an erein. Ind State ake the cutes the at all	9.2.3

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		345286	B. WNG			08/	30/2013
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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F 323	immobilizer on her right leg so the leg could be visualized, revealing a healed incision from knee to upper shin. The resident complained of leg pain with any movement but did not indicate an increase in pain after the fall on 8/27/13. Two staples were intact to the crown of her head, slightly to the left.  During an interview on 8/28/13 at 1:26 PM, the Maintenance Director indicated he trained Driver #1 when the facility first got the van, about 2 years ago. The Maintenance Director stated he also trained the 3 activities staff members and one of the maintenance technicians on driving the van at the same time he trained Driver #1. The training did not include procedures for loading/unloading residents if more than one staff was assisting with the transport. The Maintenance Director added that after the training, Driver #1 was responsible for training any additional staff who were expected to drive the van.  During a follow up interview on 8/29/13 at 5:26 PM, NA #6 said she had no training on van transport procedures, but had learned to operate the lift by watching Driver #1 and would therefore operate the lift to facilitate loading and unloading		F	323	reviewed by the IDT Monday thru to identify any sexually inappropri incidents and ensure effective interventions are implemented. Treviews (M-F) will occur for 60 day weekly thereafter. Any resident to resident altercations will be reporthe licensed nurse, after implementation of an intervention the Director of Nursing after each	hese /s and o ted by	
					occurrence. The Director of Nursing will review implemented intervention and adneeded to ensure resident safety. Assistant Directors of Nursing will provide back up to the Director of Nursing for after hours, holidays a vacations. The DON and Social Se Director will visually monitor resid for the effectiveness of interventic a weekly basis for 30 days and the monthly and adjust as needed to esafety of residents.  The statements made on this Plan of Correare not an admission to and do not constitution.	on and adjust as nt safety. Irsing will irector of holidays and Social Services hitor residents on its and then heeded to ensure	
	6/26/13 with multiple Alzheimer's disease, Depression. The adm (MDS) assessment of Resident #102 had nand needed supervisunit. The assessment	Dementia, Anxiety State and nission Minimum Data Set lated 7/6/13 indicated that noderately impaired cognition sion for locomotion on and off nt further indicated that hysical and verbal behavioral	The state of the s		agreement with the alleged deficiencies he To remain in compliance with all Federal a regulations, the Center has taken or will ta actions set forth in the following Plan of Correction. The Plan of Correction constit Center's allegation of compliance such tha alleged deficiencies cited have been or will corrected by the date or dates indicated.	nd State ke the utes the t all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345286	B. WING	-			30/2042
NAME OF P	ROVIDER OR SUPPLIER	343200	10.70		EET ADDRESS, CITY, STATE, ZIP CODE	U8/-	30/2013
SALISBUI	RY CENTER				JULIAN ROAD LISBURY, NC 28147		
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F 323	assessment also inditimpact on others and the privacy or activity. The care plan was rebehavior addressed and resistance to car resident's sexual inal. The physician's orde that Resident #102 widrug) for anxiety stat (antidepressant drug). The nurse's notes, dincident reports were. The notes dated 6/21 and 5:51 AM reveale agitated and combatt physically abusive to scratching the staff of further indicated that around.  On 6/27/13, there was behavioral treatment consult for agitation are Review of the record ACT consult provider 8/28/13 at 5:45 PM, interviewed. She stanot seen by the psychoded that the psychome to the facility of had signed the constit would take a while approval before he constituted.	icated that the behavior had I had significantly intruded on of others.  eviewed. The care plan on the resident's combativeness be but did not address the appropriate behavior.  ers for July, 2013 revealed was on xanax (anti anxiety e and Desyrel ) for depression.	F	4.	The Administrator and or Director Nursing will review Safe Unloadi Audit tool, incident/accident rep and the results of the visual morn on a daily basis Monday thru Frid 30 days, weekly for 90 days and monthly thereafter. The results these reviews will be reported to Quality Assurance committee on weekly basis for 30 days and most thereafter.  The statements made on this Plan of Cornare not an admission to and do not constiture agreement with the alleged deficiencies have regulations, the Center has taken or will to actions set forth in the following Plan of Correction. The Plan of Correction constituents's allegation of compliance such the alleged deficiencies cited have been or will corrected by the date or dates indicated.	orts itoring day for  of  a nthly  ection tute an erein. and State ake the utes the utes the	

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 710 JULIAN ROAD SALISBURY, NC 28147		20.20.10
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F 323	discharged. On 7/1/13 at 5:29 P Resident #102 was the hand of Resider female resident) and inappropriately. The Resident #123 was Resident #102 was report dated 7/1/13 Nurse #2 had seen on a female resident pants. Nurse #2 rel away from him imm AM, Nurse #2 was if she was working on saw Resident #102 touching Resident # was standing. She Resident #102 was away from Resident On 7/2/13 at 11:49 Resident #102 was room 321.  There were no othe aside from moving if On 7/9/13 at 3:49 P notes indicated that mumbles and is diff is limited due to adv On 7/9/13 at 4:50 P Resident #102 was	M, the notes revealed that sitting on the hallway holding at #123 (cognitively impaired downs touching her notes further indicated that removed from the area and redirected. The incident at 5:29 PM revealed that Resident #102 with his hand at 's peri area outside her moved the female resident ediately. On 8/28/13 at 10:45 interviewed. She stated that the hall that day when she sitting in his wheelchair fields on her crotch while she immediately removed then moved to another hall at #123.  AM, the notes indicated that moved to room 504 from  Interventions implemented him to another hall.  M, the doctor's progress Resident #102 "mostly icult to understand. Interview	F	The statements made on this Plate are not an admission to and do agreement with the alleged defit To remain in compliance with all regulations, the Center has take actions set forth in the following Correction. The Plan of Correcti Center's allegation of compliance alleged deficiencies cited have be corrected by the date or dates in	not constitute an iclencies herein. I Federal and State in or will take the gran of ion constitutes the esuch that all the property is the esuch that all the en or will be	5.2.13

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			TE SURVEY MPLETED
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F 323	on 7/11/13 at 4:14 P approached a nurse pulling medications f he was asked to moraise his arm in an athe nurse. Resident inappropriate behavi approaches to the st Resident #102 contininappropriate behavi interventions implement and education.  On 7/20/13 at 6:00 F NA #6 had observed on the pants and inception #102 was inception was shaking his fist on one supervision of The Director of Nurse were notified. The continuous Resident #102 to the evaluation due to se behavior/abuse.  The written statement revealed that she had Resident #102 insid He was moving his Resident #72 was second in the second resident #102 insid He was moving his Resident #72 was second resident #72 was second resident #72 was second resident #72 was second resident #72 was second resident #72 was second resident #72 was second resident #72 was second resident #72 was second resident #72 was second resident #72 was second resident #72 was second resident #72 was second resident resident #72 was second resident resident resident #72 was second resident	M, Resident #102 had really closed when she was or another resident. When we away, he proceeded to tempt to hit the buttocks of #102 was educated on the or, hitting and sexual aff.  Induct to exhibit sexually for and there were no other mented aside from redirection when the resident with his hands continence brief of Resident aired female resident). Immediately stopped and was ident #72. Resident #102 was initiated immediately. Sing (DON) and the doctor doctor had ordered to send the emergency room (ER) for exually aggressive with from NA #6 dated 7/20/13 and witnessed the hand of the the pants of Resident #72. The parts of Resident #72.	F	The statements made on this P are not an admission to and do agreement with the alleged de To remain in compliance with a regulations, the Center has tak actions set forth in the followin Correction. The Plan of Correct Center's allegation of complian alleged deficiencies cited have corrected by the date or dates	not constitute an ficiencies herein, all Federal and State en or will take the ag Plan of tion constitutes the ace such that all been or will be	5. 3. B

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	IPLE CONSTRUCTION	(X3) D/	TE SURVEY MPLETED
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	ROVIDER OR SUPPLIER	343200	B. WING	STREET ADDRESS, CITY, STATE, ZIP CO 710 JULIAN ROAD SALISBURY, NC 28147		<u>18/30/2013</u>
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	moved to room 102 fr placed on one on 7/22/13 at 6:00 PM removed immediately was placed on 1:1 sup the hospital and he re He was referred to AC and the social worker alternate placement.  On 7/23/13 at 3:20 PM nurse aide reported the slapped her on the bu On 7/25/13 at 9:30 AM Resident #102 was disliving facility.  On 8/28/13 at 9:50 AM was interviewed. She had been requesting to facility closer to home could not find one. She aware of the sexual in Resident #102 towards She added that she had another hall to be awa also stated that she was inappropriate sexual be she indicated that afte she started looking for	ergency room. He was om room 504 and was supervision.  AM, the care plan evaluation esident #102 was observed ants/brief of Resident #72 h. Resident #102 was from the environment and pervision. He was sent to turned without interventions. Tr., his room was changed was actively seeking for  A, the notes indicated that a lat Resident #102 had ttocks.  A, the notes revealed that scharged to an assisted  A, administrative staff #4 stated that Resident #102 be moved to another since admission but she le revealed that she was appropriate behavior of s Resident # 123 on 7/1/13, and moved Resident #102 to by from Resident #102 to by from Resident #123. She as not aware of his ehavior towards the staff. In the incident on 7/20/13, placement and she found at the staff of the further stated that	F3	The statements made on this P are not an admission to and do agreement with the alleged de To remain in compliance with a regulations, the Center has tak actions set forth in the followir Correction. The Plan of Correc Center's allegation of complian alleged deficiencies cited have corrected by the date or dates	o not constitute an ficiencies herein. all Federal and State en or will take the ng Plan of tion constitutes the ace such that all been or will be	2.5.3

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345286	B. WING _		i	C /30/2013
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		BE	(X5) COMPLETION DATE
F 323	On 8/28/13 at 1:50 PN She stated that Resid questions which were further stated that nur were aware of his beh. On 8/28/13 at 1:55 PN She stated that Resid verbally abusive. He and showed her his p that nurses were awa. On 8/28/13 at 1:58 PN She stated that she hasking other resident added that the nurses behavior.  On 8/28/13 at 2:15 PN She stated that Resid around the residents area and was asking that added that his behavior added that his behavior.  On 8/30/13 at 10:05 A was interviewed. She aware of the sexually Resident #102. She s been discussed in the far as she could reme changes. She added dated 7/20/13, the res supervision, was sent social worker started to	M, NA # 4 was interviewed.  Ient #102 had asked her sexually inappropriate. She ses and administrative staff navior.  M, NA # 3 was interviewed. Ient #102 was physically and had hit her on her buttocks rivate area. She indicated re of his behavior.  M, NA # 5 was interviewed. ad heard Resident #102 to have sex with them. She sewere aware of his  M, NA # 2 was interviewed. Ient #102 should not be He was showing his private for sex from her. She or had been reported to the  MM, administrative staff # 2 stated that she was made inappropriate behaviors of tated that his behavior had a care plan meeting and as mber they had made room that after the 2nd incident sident was placed on 1:1 to the hospital and the to look for placement. She no training provided to the	F3	The statements made on this Plan of C are not an admission to and do not cor agreement with the alleged deficiencies. To remain in compliance with all Feder regulations, the Center has taken or w actions set forth in the following Plan of Correction. The Plan of Correction cor Center's allegation of compliance such alleged deficiencies cited have been or corrected by the date or dates indicated.	stitute an herein. I and State take the titutes the that all will be	2.55.13

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		E SURVEY PLETED
		345286	B. WNG		i	C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147		/30/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	1. On 8-27-13, Res immediate first aid an of Nursing pending transferred by low Resident #58's attend by the Assistant Direct 8-27-13 at 5:25 PM of directives to her care send the resident to the evaluation. Responsincident on 8-27-13 at 11:00 PM at Emergency Department 58 was research #58 was research #58 was research #58 was research private and plan of care updared plan by eliminating fact chair and care of stap Driver and Nursing As 8-27-13 pending investigation. Resident #102 was distinct the properties of practice. Residents that have ever physical behaviors review of the MDS and Inter-Disciplinary Teams 1.	the following Credible nce on 8/30/13 at 12:17 PM. ident # 58 was provided d assessed by the Director ensportation to the local ent for assessment and 13 @ 5:25PM, Resident #58 cal EMS per stretcher. ling physician was notified efter of Nursing (ADNS) on if the incident and provided by providing an order to the Emergency Room for tible Party was notified of is 5:30 PM by ADNS. furned to the building on after treatment at the local ent. Upon return Resident # the Registered Nurse (RN) ted to include: falls care cillity transportation via Geri ties. sistant were suspended on stigation. Resident the ending completion of the scharged as of 7-25-13 terventions are possible, sported in the Center's van the affected by this deficient whibited verbal, sexual and thave been identified by a the staff interviews by the in (IDT) on 8-28-13. IDT tesentative from Nursing,	F3	The statements made on this Plaare not an admission to and do agreement with the alleged defit To remain in compliance with al regulations, the Center has take actions set forth in the following Correction. The Plan of Correcti Center's allegation of compliant alleged deficiencies cited have be corrected by the date or dates in	not constitute an iclencies herein. I Federal and State in or will take the galan of ion constitutes the se such that all been or will be	£ 55.13

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	X3) DATE SURVEY COMPLETED	
		345286	B, WING				C (20/2042
	ROVIDER OR SUPPLIER			71	FREET ADDRESS, CITY, STATE, ZIP CODE 10 JULIAN ROAD ALISBURY, NC 28147	00/	/30/2013
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	Technician, Receptior that provide transport on the safe loading ar 8-27-13 by Maintenar Administrator. Trainir wheel chair (w/c) in control of wich in van, securing placement of seatbelt position prior to unload demonstration of command unloading of resideral interactions are ded for all staff Maintenance Director. 2 operations manual a instructions) recommend incorporated into train member will provide the without completing tracompetency. The Admensure all training is composed in training is composed in the prior to authorizing to and transport resident Maintenance Director visually validate each including weekends for days to ensure competency. The Admensure all training is composed in the content of the content	ce Director, Maintenance hist and 3 Activities Staff) ation services were trained and unloading of residents on one Director and ag included: positioning of enter of lift, when to lock ering of lift gate, positioning of the w/c to the floor, and validation of lift gate ding. Staff provided return petency for safe loading lents. Competency and ed annually, upon hire and transporting residents by Manufacturer's (Century and Q-traint user andations have been ing material. No staff transportation services inling and demonstration of hinistrator will validate and completed and documented operate the center's vehicle s. and or Administrator will trained driver weekly ar 30 day and monthly for 90 tencies. Was posted in the rear of ting a visual cue to "e UPRIGHT position prior iced in the front of the cle Safety Inspection Maintenance Director will rement of signs on a weekly monthly thereafter.	F	323	The statements made on this Plan of Correct are not an admission to and do not constitution agreement with the alleged deficiencies here. To remain in compliance with all Federal and regulations, the Center has taken or will tak actions set forth in the following Plan of Correction. The Plan of Correction constitution Center's allegation of compliance such that alleged deficiencies cited have been or will corrected by the date or dates indicated.	ite an rein. d State te the tes the all	5.25.3

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		СОМ	(X3) DATE SURVEY COMPLETED	
		345286	B. WING _			C /30/2013	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
F 323	transportation in Geri Staff to include Licen Assistants, therapist, maintenance, social provided training by the Assistant Director of Coordinator and Nurand 8-29-13. Training resident to resident in inappropriate behavior incident report, care updating and how to behaviors. Behavior separate residents a by: talking, offering and on one supervision, cause of the behavior review and psycholo interventions. As of have completed train to work without first of Incident/Accident report daily Monday the sexually inappropriate effective intervention daily reviews (M-F) weekly thereafter. An altercation will be reafter implementation Director of Nursing and Director of Nursing and Socivisually monitor resident safety. Assign provide back up after hours, holiday of Nursing and Socivisually monitor residents.	schairs effective 8-27-13. sed Nurses, Nursing dietary, housekeeping, and business services was the Director of Nursing and or Nurses, Nurse Practice sing Supervisor on 8-28-13 ag included the reporting of incidents (including sexually or) by the completion of an plan interventions and manage residents' al interventions included: to and ensure safety, redirection nacks, checking for physical ernative activity, provide one attempt to identify the root or, medication reviews, lab	F3	The statements made on this Plan of are not an admission to and do not agreement with the alleged deficien. To remain in compliance with all Fe regulations, the Center has taken on actions set forth in the following Placorrection. The Plan of Correction Center's allegation of compliance stalleged deficiencies cited have been corrected by the date or dates indicated the corrected by the date or dates.	constitute an ncies herein. deral and State r will take the an of constitutes the ach that all nor will be	6.25.13	

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	PLE CONSTRUCTION G		ATE SURVEY OMPLETED
	345286	B. WING _			C 08/30/2013
(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147  PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	RRECTION (X5) 4 SHOULD BE COMPLETION	
safety of residents.  4. The Administrato will review Safe Unloci incident/accidents regulated incident/accidents regulated incident/accidents regulated incident/accidents regulated incident/accidents regulated incident/accidents regulated incidents incide	or and or Director of Nursing adding audit tool, corts and the result of the a daily basis Monday thru eekly for 90 days and The results of this reviewed ty Assurance committee on days and monthly  on was validated on 8/30/13 of interviews revealed training ment and reporting abers were able to verbalize fort and to whom and when haviors.  Industry the position of the interviews during resident is ualizing the position of the national residents.  It were observed posted of the van and the interior of site the passenger door lift gate is in the UPRIGHT adding."  DEF MEDICATION ERROR LIGRES	F3	are not an admission to and do not agreement with the alleged deficient or remain in compliance with all Fe regulations, the Center has taken of actions set forth in the following Placorrection. The Plan of Correction Center's allegation of compliance shalleged deficiencies cited have been corrected by the date or dates indiction and the provided an opport of the provided an opport of the provided and as was obtained by the Director of Nursing on 8-29-13.  Nurse #2 was provided the Director of Nursing Medication Administration Administration and the resident's mouth after administration of inhale return demonstration of competency.	constitute an incies herein. deral and State r will take the an of constitutes the uch that all in or will be cated.  ent #122 cunity to pulse rate rector of craining by on clion on 8-29-ning of pulse hysician's prior to rinsing of a lers with of cethe ed by the	. 2. 2. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING_		COMPLETED	
					С		
		345286	B. WING	B. WING			/30/2013
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SALISBU	RY CENTER			71	10 JULIAN ROAD		
				S	ALISBURY, NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROMDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 332	policy review, manufa staff interview, the face medication error rate evidenced by two (2) opportunities resulting findings included:  1. Resident #122 was 8/2/13. Cumulative d (chronic obstructive p Hypertension.  Physician's orders da (inhalation medication mg. one puff daily.  Manufacturer's instructin part, to shake the in before using. Rinse run on 8/29/13 at 8:14 Alturing medication pas Resident #122 the inhalter inhaler prior to give inhaler. Nurse #2 #122 to rinse her mound on 8/29/13 at 8:32 Alta should have shaken the Resident #122 to rinse administration of the run on 8/29/13 at 4:00 PM	ew, observation, facility of interest in specifications and stillity failed to ensure that the was 5% or less as errors of thirty-one (31) in a 6.45% error rate. The sadmitted to the facility on interest in interest in a sadmitted to the facility on interest in a sadmitted to sadmitted the sadmitted in a sadmitted in	F	332	3. Reeducation on medication administration including monivital signs as required by the medication and the administrator of inhalers was provided by the Nurse from Omnicare Pharma 9-12-13. Further reeducation a provided on September 23,24 by Director of Nursing or Assis Director of Nursing on medica administration. Licensed nurse have had a medication administration pass observed nurse from Omnicare Pharmac Nurse Practice Educator or Assibirector of Nurses on Septembrace 8, 12, 21,22,23,24 2013 After the initial medication administration observation the Director of Nurse Practice Educator and Assistant Director of Nursing we conduct 3 medication pass observation weekly for a month then 3 observations monthly thereafter.  The statements made on this Plan of Corrector are not an admission to and do not constitution agreement with the alleged deficiencies here to remain in compliance with all Federal and regulations, the Center has taken or will tak actions set forth in the following Plan of Correction. The Plan of Correction constitutions constitution and deficiencies cited have been or will center's allegation of compliance such that alleged deficiencies cited have been or will corrected by the date or dates indicated.	ecy on was 2013 tant tion es by the cy, sistant per 4, he on ursing, will the and distant te an ein. d State e the testhe all	9.25.13

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				<u> Uni Binic</u>	<u>. บรงด-บงษ [</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		345286	B, WING			08/:	30/2013
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		0012010
SALISBLE	RY CENTER			71	10 JULIAN ROAD		
OALIODOI	() OCIVICIO			S.	ALISBURY, NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
	for the administration  2. Resident #122 was 8/2/13. Cumulative of (chronic obstructive properties).  Physician orders date Tartrate (a medication (milligrams) po. (by m (systolic blood pressure heart rate < 65.  On 8/29/13 at 8:17 A during the medication administered the Methad obtained a blood did not obtain Reside On 8/29/13 at 11:00 a should have taken the administration of the On 8/29/13 at 4:00 P nursing staff should fobtain the pulse prior administration.  483.30(e) POSTED MINFORMATION  The facility must post a daily basis: o Facility name. o The current date. o The total number a by the following categunlicensed nursing staff shoulds.	of Symbicort.  s admitted to the facility on liagnoses included COPD culmonary disease) and and ad 8/2/13 stated Metoprolol in for hypertension) 50 mg. mouth) daily. Hold for SBP ure) < (less than) 100 or  M., Nurse #2 was observed in pass. Nurse #2 oprolol Tartrate after she pressure of 142/68. She int #122's pulse rate.  AM., Nurse #2 stated she is pulse prior to medication.  M., Nurse #1 stated the ollow physician's orders to into medication.  NURSE STAFFING  If the following information on and the actual hours worked gories of licensed and laff directly responsible for		332	4. Director of Nursing will analyze valuate the data gathered ablooking for patterns and trend The results of this evaluation reported monthly for 90 day at then quarterly to the Quality Assurance and Process Improvement (QAPI) committed QAPI committed will review at make recommendations or modification as needed to assecontinued compliance.  The statements made on this Plan of Correare not an admission to and do not constituted agreement with the alleged deficiencies here to remain in compliance with all Federal arregulations, the Center has taken or will tall actions set forth in the following Plan of Correction. The Plan of Correction constituted to the plan of compliance such that alleged deficiencies cited have been or will corrected by the date or dates indicated.  F356 C  1. The daily staffing sheet was complete and posted 8-30-13 Scheduling Manager in the Common Administrative Hally	cove ds. will be and dee. nd sure ection ute an erein. nd State ke the utes the t all l be	2.2.13
	resident care per shif	t:	- 1				

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SU		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	(X3) DATE	
		345286	B. WNG_				C  30/2013
NAME OF P	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		90,8015
SALISBU	RY CENTER				JULIAN ROAD LISBURY, NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 356	- Registered nurse - Licensed practic vocational nurses (as - Certified nurse a o Resident census.  The facility must post specified above on a of each shift. Data m o Clear and readable o In a prominent place residents and visitors.  The facility must, upo make nurse staffing d for review at a cost no standard.  The facility must main staffing data for a min required by State law,  This REQUIREMENT by: Based on observation interview, the facility f information that was a that was accessible to five consecutive days included:  On 8/26/13 at 3:00PM was noted to be on a nursing station. Staff resident census was b	es. cal nurses or licensed defined under State law). aides.  It the nurse staffing data daily basis at the beginning nust be posted as follows: format. e readily accessible to diata available to the public out to exceed the community  Intain the posted daily nurse nimum of 18 months, or as diata whichever is greater.  It is not met as evidenced and, resident and staff failed to post daily staffing accurate and in a location or residents and visitors on or of the survey. The findings  A., staff posting information bulletin board behind the posting for day shift and the blank.  A., staff posting information	F3	356	<ol> <li>Residents residing the center potential to be affected by the alleged deficient practice.</li> <li>The Manager of Clinical Opera provided re –education to the Director of Nursing, the Assist Directors of Nursing and schemanager on 9-4-13. The education included the requirement to public view, completing with the number of nursing staff on dureach shift and correct census each shift. The Director of Nursing of Scheduling Manager will conduct a dudit on Monday thru Friday the ensure posting was completed daily basis and is accurate. The Manager on Duty will complete audit on weekends to ensure the staffing sheet is posted and complete.</li> <li>The statements made on this Plan of Correction are not an admission to an not constitute an agreement with the deficiencies herein. To remain in comwith all Federal and State regulations Center has taken or will take the action forth in the following Plan of Correction are not constitutes the Cerallegation of compliance such that all deficiencies cited have been or will be corrected by the date or dates indicated.</li> </ol>	e ations e tant duling ration cost in the rity for rsing, or luct an to d on a ne te that nd and do e alleged npliance is, the ons set ion. The nter's lalleged e	2.55.13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (	CONSTRUCTION	(X3) DATE	SURVEY LETED
		345286	B. WING		1	0
	ROVIDER OR SUPPLIER  RY CENTER  SUMMARY STA	NTEMENT OF DEFICIENCIES	STI 710	REET ADDRESS, CITY, STATE, ZIP CODE  D JULIAN ROAD  LISBURY, NC 28147  PROVIDER'S PLAN OF CORRECTION	1 08/	30/2013
PREFIX TAG	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 356	nursing station on A h On 8/27/13 at 5:00PM was observed with da information blank. On 8/28/13 at 9:00AM was observed with da On 8/30/13 at 8:45AM was observed. The n day shift was complete and the actual hours w himself, another assis the scheduling manag information was comp shift with the number of census information; th completed at the end the staffing information station A nursing station station A nursing station on 8/30/13 at 8:47 Af President stated that is staff posting informatio On 8/30/13 at 8:55AM stated the assistant di the form information for supervisors for second the information for the stated there were blan station and the night s	all and day shift was blank.  I., staff posting information y shift and evening shift  I., staff posting information y shift information blank.  I., staff posting information umber of staff working the ed. The census was blank worked was blank.  I., Nurse #1 stated the as usually completed by tant director of nursing or er. He stated the leted at the beginning of the of nursing staff and the e actual hours were of the shift. Nurse #1 said in was always posted at on on the bulletin board ion.  II., the Resident Council he did not know where the on was located.  II., the scheduling manager rector of nursing completed or first shift and the did and third shifts filled out in respective shifts. She k forms at the nursing upervisor put up the board. She stated she	F 356	4. The Director of Nursing will and evaluate the data gathe above looking for patterns a trends. The results of this evaluation will be reported to for 90 day and then quarterl Quality Assurance and Proce Improvement (QAPI) commit QAPI committee will review make recommendations or modification as needed to accontinued compliance.  The statements made on this Plan of Corare not an admission to and do not constagreement with the alleged deficiencies. To remain in compliance with all Federal regulations, the Center has taken or will actions set forth in the following Plan of Correction. The Plan of Correction constituted deficiencies cited have been or we corrected by the date or dates indicated.	red nd monthly y to the ess ttee. and ssure rection itute an herein, and State take the itutes the	9.55.13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		INTERPREDATION AND HOUSE		X2) MULTIPLE CONSTRUCTION A. BUILDING			Survey Leted
		345286	B. WING	B. WNG0			
	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	71 SA X	REET ADDRESS, CITY, STATE, ZIP CODE  0 JULIAN ROAD  ALISBURY, NC 28147  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 356 F 356	assignment sheets to On 8/30/13 at 9:15 / forms for 8/26/13 the with Administrative sand evening shift ce staff and actual hour night shift had a cen assisted living reside and evening shift ce staff and actual hour 8/28/13, the census evening shift was not assisted living reside and evening shift ce which included assisted the nursing sinformation at the bochanges were made the staffing form harmursing station  On 8/30/13 at 9:15/2 stated the staffing form harmursing station  On 8/30/13 at 9:15/2 stated the staff post place and all of the census information each shift and adjust census information skilled nursing residents listed sep 483.35(i) FOOD PESTORE/PREPARE.	ious day, attached the other and filed the forms.  AM., the daily nurse staffing rough 8/30/13 were reviewed staff #2. On 8/26/13, the day insus information, number of res worked were blank. The sus of 158 that included ents. On 8/27/13, the day insus information, number of res worked were blank. On information for day and otted as 157 which included ents. On 8/29/13, the day insus information was 159 sted living residents.  AM., Administrative staff #2 upervisor filled out their shift end as needed. She indicated a laways been posted at the as needed. She indicated the should be completed prior to sted as needed. Also, the should be separated with lents and assisted living arately on the form.		356	The statements made on this Plan of Correare not an admission to and do not constit agreement with the alleged deficiencies have compliance with all Federal a regulations, the Center has taken or will the actions set forth in the following Plan of Correction. The Plan of Correction constit Center's allegation of compliance such the alleged deficiencies cited have been or will corrected by the date or dates indicated.  F371 E  1. The potatoes were removed the tray line by the Dietary Manager and brought to temperature the correct of 14 degrees on 8-29-13. The mean plates with low temperature potatoes were removed and items discarded by Dietary Mon 8-29-13. The wet dome lideremoved from services by Diemoved from services by the Emay have the potential to be affect this alleged deficient practice audit was completed by the Emay have received potatoes allow temperature and who may have received meal tray were dome lid. No resident received at a temperature be 140 degrees or meal plate services with a wet dome lid.	tute an erein. Ind State oke the utes the utes the it all it be  from food anager is were etary  Interpleted by it an olietary is who at a any with a ceived elow	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345286	B. WING		1	C /30/2013	
NAME OF PROVIDER OR SUPPLIER  SALISBURY CENTER  (X4) ID  PREFIX  TAG  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY, NC 28147  PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	N DBE	(X5) COMPLETION DATE		
	authorities; and (2) Store, prepare, d under sanitary condit  This REQUIREMEN' by: Based on observation facility failed to main above 140 degrees a dome lids were not a included:  1. On 8/29/13 at 12:0 line in the dining roof temperature of the for dietary aide prior to a the mashed potato w checking the temperature observed to start the mashed potato to the brought to the attenti #6 who immediately from the line. At 12:3 interviewed. She sta hot food should be m and above but she di why she served the in degrees temperature  2. On 8/29/13 at 11:5 were observed bringi	istribute and serve food tions  It is not met as evidenced on and staff interview, the fain the hot food temperature and failed to ensure that tacked wet. Findings  If is not met as evidenced on and staff interview, the fain the hot food temperature and failed to ensure that tacked wet. Findings  If of PM, operation of the tray in was observed. The od was checked by the erving. The temperatures of cove 140 degrees except for hich was 130 degrees. After fatures, the dietary aide was tray line and served the residents. This was on of the administrative staff fremoved the mashed potato for PM, the dietary aide was ted that the temperature of aintained at 140 degrees do not provide an explanation hashed potato with 130	F3	<ul> <li>3. Reeducation for Dietary Sta provided by the Dietary Ma on 9-10-13 to include but no limited to: proper temperat food service and how to remproper drying techniques for including dome lids.  Dietary Manager or Assistant Manager will conduct audits temperatures and wet stacked dishes for 5 meals a week for days and then at least weekly randomly thereafter.</li> <li>4. The Dietary Manager or Administrator will analysis a evaluate the data gathered looking for patterns and trent The results of this evaluation reported monthly for 90 day Quality Assurance and Proceed Improvement (QAPI) commit QAPI committee will review make recommendations or modification as needed to accontinued compliance.</li> <li>The statements made on this Plan of Corare not an admission to and do not constagreement with the alleged deficiencies. To remain in compliance with all Federal regulations, the Center has taken or will actions set forth in the following Plan of Correction. The Plan of Correction constituted of the plan of Correction constituted alleged deficiencies cited have been or we corrected by the date or dates indicated.</li> </ul>	nager pt ure for nediate, r dishes  of food d 60 and  above nds. n will be ss to the ss ttee. and ssure ection itute an nerein. and State ake the tutes the at all	9.55.3	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345286	B. WING		C 08/30/2013	
	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE  710 JULIAN ROAD  SALISBURY, NC 28147  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) E COMPLETION	
F 497 SS=B	61 dome lids observe other wet in 2 dining rattention of the admin immediately removed tray line on the 2 dinir On 8/30/13 at 9:30 AM was interviewed. He was changed 6 month machine which made further stated that the dishes but there was a prior to meal time. He enough dry dishes to yesterday (8/29/13) hat the racks and stacked obviously they were shad already retrained dome lids and the pro 483.75(e)(8) NURSE AREVIEW-12 HR/YR IN The facility must compose of every nurse aide at months, and must proeducation based on the reviews. The in-service sufficient to ensure the nurse aides, but must per year; address are address the sa determined by the aides providing service.	d stacked on top of each coms. When brought to the istrative staff # 6, he the wet dome lids from the ag rooms.  A, administrative staff #6 stated that the dish machine as ago to a low temperature the dishes to dry slowly. He are the dishes to dry the mot enough time to dry them to enough time to dry them to indicated that they had use but the dietary aide and pulled the dome lids from them together and till wet. He stated that he the dietary aide on the wet per food temperature.  AIDE PERFORM ISERVICE  Delete a performance review least once every 12 vide regular in-service are outcome of these are training must be a continuing competence of the no less than 12 hours as of weakness as as des' performance reviews special needs of residents facility staff; and for nurse as to individuals with also address the care of	F 49	agreement with the alleged deficiencies he To remain in compliance with all Federal al regulations, the Center has taken or will ta actions set forth in the following Plan of Correction. The Plan of Correction constitutions alleged deficiencies cited have been or will corrected by the date or dates indicated.  F 497 B  1. No resident was identified in tag.  2. Resident residing the center h potential to be effected by the alleged deficient practice.  3. The Director of Nursing and N Practice Educator were reedu-	tute an erein. Ind State ke the utes the tall libe  this have a e cated ing are to a year, te. It the in e or be o	

PRINTED: 09/11/2013 FORM APPROVED

OLIVELI	OF OR WEDICARE &	MEDICAID SEKVICES				OMR M	O. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345286	B. WING				C /30/2013
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	100/2010
			ı	10 JULIAN ROAD			
SALISBU	RY CENTER			s	ALISBURY, NC 28147		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	L	PROVIDER'S PLAN OF CORRECTION		1
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COMPLETION DATE
					Regulated and Regular Waste		
F 497			F	497	Management, Dementia Train	ing-	
	This REQUIREMENT	is not met as evidenced			Communication, Successful		
	by:				Strategies for Difficult Behavio	rs,	
		ew and staff interview, the			Resident Wandering, Tubercu	losis,	
		that 3 of 3 nurse aides			Caring for Residents with COP		
		& #3) acquired 12 hours of			Age Related Changes, Cultural		
	in-services annually.				Competency, Handling and Di		
	The findings included				of Hazardous Drugs, Caring fo	•	
	The intalings included.	•			Residents with Sickle Cell Dise		
	On 8/30/13 at 10:45 a	ım, a record review was			the Administrator on Septemb		
		rse aide 's personnel files.			20 2013. Education hours will		
					logged on the Individual In ser		
	1. Nurse Aide #1 was	hired on 5/14/02. In 2013,			record by the Nurse Practice	VICC	
		coursework recorded in			Educator after each education		
		s noted that she attended			session. The Nurse Practice	•	2.5 2.5 2.5
		ver the time allotted for the					6.3
	courses was not spec	inea,			Educator has developed an		V
	A record review revea	led that the Administrator			education calendar for the		್ಳ
		le shared in an interview on			completion of this year and ye	-	1
		hat as a new employee, he			thereafter to ensure that educ	cation	
	was still learning the o	organizations ' policies and			hours are provided to nursing		
į	procedures.	•			assistants. The Director of Nu	sing	
					will monitor the Individual In-		
		n, Administrative Staff #1			service log monthly to ensure		
		stated that the human			the nursing assistants are rece	_	
		could not find sufficient		1	the required 12 hours of educ	ation	
		2 in-services and many of not specify the length of			prior to their anniversary date	<b>:.</b>	
		1-services were calculated		ļ			İ
	per calendar year. She	shared that many of their			The statements made on this Plan of Corre		
	required in-services w	ere done independently			are not an admission to and do not constitu		
	online, instead of in a	classroom setting and she			agreement with the alleged deficiencies he To remain in compliance with all Federal ar		
	couldn't verify that sta	aff were logging in to sign			regulations, the Center has taken or will ta		
	up for courses.	_			actions set forth in the following Plan of		[
	<b>Table 4.4.</b> 4.5				Correction. The Plan of Correction constitu		
		iff #1 further stated that the			Center's allegation of compliance such that		ł
-	Staff Development Co	ordinator had been in place			alleged deficiencies cited have been or will corrected by the date or dates indicated	ne	
	since November, 2012	but was on vacation and			corrected by the date of dates indicated		

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONS	TRUCTION		E SURVEY IPLETED	
		345286	B. WNG				C	
NAME OF PROVIDER OR SUPPLIER SALISBURY CENTER			STREET.	ADDRESS, CITY, STATE, ZIP CODE IAN ROAD BURY, NC 28147	08	3/30/2013		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	was unavailable for in  2. Nurse Aide #2 was she had 2.5 hours of file. In 2012, she atter of the classes had a r the length of program not be determined.  A record review revea was hired last week. H 8/26/13, at 11:13 am t was still learning the corocedures.  On 8/30/13 at 2:35 pm was interviewed. She resources department documentation for 201 the courses on file did time of the program. In per calendar year. She required in-services w online, instead of in a couldn't verify that strup for courses.  The Administrative Sta Staff Development Cosince November, 2012 was unavailable for interviewed at the classes had a recording the course of the course of the course of the classes had a recordinate of the classes had a	hired on 8/20/92. In 2013, coursework recorded in her nded three in-services. One ecorded length of 7.5 hours, for the other classes could alled that the Administrator he shared in an interview on that as a new employee, he organizations ' policies and an Administrative Staff #1 stated that the human a could not find sufficient 12 in-services and many of not specify the length of not specify the length of not specify the length of neservices were calculated as shared that many of their ere done independently classroom setting and she aff were logging in to sign	F	Ti ai ai Tr re ai Cr Cr ai	the results of the monitor Individual in-service log to Quality Assurance Commi monthly for 90 days. The statements made on this Plan of the statements made on this Plan of the not an admission to and do not congreement with the alleged deficiencity or remain in compliance with all Federgulations, the Center has taken or work to the statement of the plan of Correction congenter's allegation of compliance such lileged deficiencies cited have been of the plan	ing of the thee  Correction institute an es herein ral and State fill take the of institutes the that all r will be	\$ de	

PRINTED: 09/11/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING\_ C 345286 08/30/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 710 JULIAN ROAD SALISBURY CENTER SALISBURY, NC 28147 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 497 Continued From page 33 F 497 not be determined. A record review revealed that the Administrator was hired last week. He shared in an interview on The statements made on this Plan of Correction 8/26/13, at 11:13 am that as a new employee, he are not an admission to and do not constitute an was still learning the organizations 'policies and agreement with the alleged deficiencies herein. procedures. To remain in compliance with all Federal and State regulations, the Center has taken or will take the On 8/30/13 at 2:35 pm, Administrative Staff #1 actions set forth in the following Plan of was interviewed. She stated that the human Correction. The Plan of Correction constitutes the Center's allegation of compliance such that all resources department could not find sufficient alleged deficiencies cited have been or will be documentation for 2012 in-services and many of corrected by the date or dates indicated. the courses on file did not specify the length of time of the program. In-services were calculated per calendar year. She shared that many of their required in-services were done independently online, instead of in a classroom setting and she couldn't verify that staff were logging in to sign up for courses. The Administrative Staff #1 further stated that the Staff Development Coordinator had been in place since November, 2012 but was on vacation and was unavailable for interview.

OCT 08 2013

RINTED: 09/22/2013 FORM APPROVED CONSTRUCTION SECTION NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01 (X3) DATE SURVEY COMPLETED

345286

B. WING

09/17/2013

NAME OF PROVIDER OR SUPPLIER

710 JULIAN ROAD

STREET ADDRESS, CITY, STATE, ZIP CODE

SALISBURY CENTER				SALISBURY, NC 28147			
(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)	(X6) COMPLETION DATE		
SS≒E	INITIAL COMMENTS  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 facility is Type III (211) protected construction and is equipped with a complete automatic sprinkler system.  CFR#: 42 CFR 483.70 (a)  NFPA 101 LIFE SAFETY CODE STANDARD  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 the observations and staff interview during the tour on 9/17/2013 following exit discharge illumination was observed as noncompliant as the specific findings include there were no exit discharge lighting on the path of egress to the public way from the 500 hallway to the 600 hallway.	K 04	55	A. Contact Electrical contractor on 10/01/2013 to measure and get quote on materials needed to install emergency lighting at the ends of 500 and 600 halls.  B. Maintenance Director completed an Audit on 10/01/2013 of the Center's exit discharge illumination. There were no other negative findings.  C. Identified emergency lighting will be installed by 10/31/2013 by contractor. Maintenance Director will inspect project at completion to ensure compliance with Life Safety Code Standards, Maintenance Director and/or Maintenance Technician will complete an audit weekly for 30 days and monthly thereafter ensuring illumination of the means of egress, including exit discharge are operating as designed. Any negative findings will be addressed.  D. Maintenance Director will collect and analyze the data collected looking for patterns and trends. The result of the analysis will be reported monthly for	10.31.13		

LABORATORY DIRECTORS OR PROVIDEN/SUPPLIER REPRESENTATIVE'S SIGNATURE

CFR#: 42 CFR 483.70 (a)

TITLE

compliance

(X6) DATE

10443 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.

. 90 days and quarterly thereafter to the

Quality Assurance and Process Improvement (QAPI) committee. The QAPI committee will review and make recommendations or modifications as needed to assure continued

If continuation sheet Page 1 of 1