STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	04/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTHCARE OF FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation conducted on 4/25/2011 through 4/28/2011. Event ID ZLVD11	F 000		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure that housekeeping and maintenance services were provided to maintain a sanitary, orderly and comfortable environment for 3 of 20 bedrooms with broken closet doors, for 1 of 20 bedrooms with exposed foam insulation, scratched walls and brown discolored areas on the walls and for 1 of 9 resident bathrooms with a rust stained sink and floor and odors throughout the bathroom. Resident bedroom # 2, #4, #9, #17 and Resident Bathroom #8/9. The Findings Included: 1. An environmental tour and observation was conducted on 4/27/2011 at 4:00PM. 2. An observation of resident bedroom #2, noted the closet door was in disrepair. The door was an accordion type style door, and it was noted to be off the hinges, and had a splint in the door midway through. Additionally this closet door did not fit the width of the door, so it was unable to be completely closed.	F 253	Your #5 Facility will replace foam insulation around with trimmed casing around 26 air conditioners. This will satisfy not only the exposed area in room #17 but will maintain a sanitary, orderly and comfortable interior in all 20 patient rooms and deny access to insects and vermin. To assure no reoccurrence, fit and esthetics of heat/ac pumps has been added by P.I. committee (May 2011) to monthly rounds by Maintenance Director. Deficiencies will be noted no rounds form and submitted to Administrator, along with report of corrective action need. Inspection of air/heat units will be Safety committee Rounds and report also, and consolidated into main committee report. This will continue for one year.	Completion date Room 17 5/26/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Linda G. Loeder — TITLE: Administrator — (X6) DATE: 5/13/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 253	Continued From page 1 3. An observation of resident bedroom #4, noted the closet door was in disrepair. The door was an accordion type style door, and it was noted to be off the hinges and had a split at the top of the door that extended all the way to the bottom of the door. 4. An observation of resident bedroom #9, noted the closet door was in disrepair. The door was an accordion type style door, and it was noted to have a split in the door at the top and also noted to be off the hinges. 5. An observation of resident bedroom #17, revealed a foam insulation type material coming out of the wall around the air conditioner unit. Additionally, this room was noted with multiple scrapes and scratches on the walls around the air conditioner unit. The wall paper on the wall behind the resident's beds and on the wall across from the beds was noted to be very discolored with heavy brown discolored areas on the wallpaper. 6. An observation of the resident bathroom between bedrooms 8 and 9, revealed rust discolored areas on the tile all the around the toilet. Additionally, the inside of the sink had rust discolored areas on the inside of the sink. Throughout the bathroom on tile areas around the tub and under the sink, were also noted with rust discolored areas. This resident bathroom also had a very strong foul odor. A second observation of this room on 4/28/2011 at 8:20AM revealed the bathroom continued to have the strong foul odor as noted the day before.	F 253	Your #2,3, &4 Facility will replace broken closet doors with solid doors for rooms 2, 4, 8 & 9. That will close off the entire width New door slide tracks will be installed on each of the above. This will correct any sanitary or orderly deficiencies with closet doors. Monitors to correct any future door failures have been added to PI and Safety committee as above for one year Your #5 Facility will remove wall covering in Room 17. Walls will be scrubbed down including sanitized. Any surface distortion will be leveled using "Mud", and then sealer applied in up to 3 coats as necessary and up to 3 coats of paint applied. This will correct scrapes and scratches, plus new cove base installed and all door frames stripped and repainted. Floors will be stripped and waxed. This will correct any sanitary or orderly deficiencies as cited. Monitor to correct any future wall surface problems have been added to PI rounds and Safety Committee inspections as above relating to this tag.	Completion date Rooms 2, 3, 4 5/26/2011

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F 253	Continued.From page 2 7. An interview was conducted with the Maintenance Supervisor on 4/27/2011 at 5:24pm. During this interview he stated he was aware of the broken accordion style type doors and stated they all needed to be replaced. 8. An additional interview with the Maintenance Supervisor was conducted on 4/28/2011 at 8:30AM. During this interview, the Maintenance Supervisor stated the exposed insulation type material in bedroom #17 was a spray foam material that was put there to keep rodents out of the facility. He additionally stated that the rust in bathroom 8/9 would need to be cleaned up and or repaired. 9. An interview with the Administrator was conducted on 4/28/2011 at 10:23AM. During this interview the Administrator stated he expected the accordion doors in resident bedrooms to be repaired and or replaced. He additionally stated the foam spray material, scratched walls and the brown colored areas in bedroom #17 needed to be cleaned up. He also stated the tiles in resident bathroom 8/9 needed to be replaced and cleaned up.	F 253	Your # 6 Facility will clean then cover the floor tile in the bathroom between rooms #8 and #9. We will also replace the toilet and sink, plus clean the walls around the toilet and sink and repaint them. Plumbing such as faucets, drain pipes, water supply lines will also be replaced, including handles, traps and strainers. This will correct esthetics and odors plus eliminate any sanitation problems. Monitors to correct any future sanitary deficiencies as cited have been added to PI rounds and Safety Committee inspections as in above relating to this tag.	Completion date Bathroom 8-9 5/26/2011
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by	F 274	Your #1 & 2 All hospice patients at time of survey plus subsequent admissions have been reviewed for significant changes and, as needed, assessments have been completed. Going forward we have as of 5/13/2011 completed a 100% audit of assessments due, to include looking for significant changes, these will be updated and transmitted imputed daily, as due until completion date May 26, 2011.	

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F 274	Continued From page 3 implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to initiate a significant change for a resident placed on Hospice services for 1 of 1 (Resident # 30) residents requiring a change in status. Resident #30 was admitted to the facility on 6/25/10 with cumulative diagnoses of Alzheimer ' s dementia, dysphasia and weight loss. The most recent Quarterly Resident Minimum Data Set (MDS) Assessment dated 3/15/11 revealed Resident #30 had a deficit with long and short term memory. The resident required extensive to total assistance from staff for Activities of Daily Living (ADL) including eating, bathing and toileting. Record review showed a Quarterly MDS was completed on 12/17/10 and then a second Quarterly MDS was done on 3/15/11. Resident #30 was placed on Hospice services on 1/11/11 which was a decline in the resident ' s condition and he required additional support from staff for his ADLs. A Significant Change MDS was due within fourteen (14) days when the resident was placed on Hospice services. Observation on 4/25/11 at 12:00 noon Resident #30 was in his bed with his wife at the bedside.	F 274	Corporate reimbursement transmits batches every week. Ongoing audits will be done weekly, reviewed by the administrator and discussed at weekly CMI meeting to assure goal is being met. PI Committee will also follow for three months. The 14 day deadline for the comprehensive assessment of significant change will thus be met, and this type of deficiency will be permanently corrected. Weekly reminders that the dates for scheduled assessments to be turned in to the CMD must be met. Disciplinary action will be taken as necessary to enforce this.	

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F 274	Continued From page 4 The facility beautician was in the room and was trimming Resident #30 ' s hair. The beautician stated the resident was no longer able to sit up in the chair to get his hair trimmed and she now does it with him in the bed. Interview with Licensed Practical Nurse (LPN) #1 on 4/26/11 at 8:40AM stated the resident is on routine pain medication to help him rest. She stated he is not able to ask for pain medication but the staff knows when he needs additional medication for pain because he will become restless in bed. Interview with the Nursing Aid (NA) from the Hospice services on 4/26/11 at 4:49PM stated she does come twice a week to see Resident #30. She stated she provides personal hygiene and range of motion. She stated if dinner is out while she is visiting she will feed the resident. The NA stated she gives comfort care and spends about an hour each visit with Resident #30. She stated the Registered Nurse (RN) with Hospice services will visit weekly but if she assesses any change in Resident #30 while visiting she will call the RN and she will come and check on the resident immediately. Interview with the MDS nurse on 4/26/11 at 3:00PM stated a Significant Change of Condition MDS was not done for Resident #30. She stated it was reviewed at the corporate office and was notified of the missing Significant Change MDS. Interview with the Director of Health Services (DHS) on 4/28/11 at 9:10AM stated the MDS nurse does attend daily stand up meetings where information about resident ' s status, new	F 274		

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F 274	Continued From page 5 admissions or discharges are shared. The DHS stated if a resident was placed on Hospice this information would be shared at the daily meeting. Interview with the MDS nurse on 4/28/11 at 10:00AM stated she does a monthly calendar for when each resident is due their MDS that month. She stated she gives it out to the staff that is responsible for getting the information and assessments completed. The MDS nurse stated she will up-date the calendar throughout the month if necessary for new admissions, discharges and significant changes. She stated she does attend daily stand up meetings but was not aware that Resident #30 was placed onto Hospice until after he was on Hospice for two (2) days. An interview with the Facility Administrator on 4/28/11 at 10:10AM stated the process for getting MDS ' completed is a monthly calendar is prepared by the MDS nurse and distributed to each person responsible for a particular section of the MDS. He stated if changes need to be made to the calendar the MDS nurse will make the changes and re-distribute the new calendar. The Administrator stated that sometimes staff, that is responsible for particular sections of the MDS, will be late in getting the information to the MDS nurse so it can be put into the system. He stated when this occurs the MDS nurse is to notify him and he will get the staff to get the information to her that day. The Administrator stated the facility does get reports from the corporate office about MDS ' that are rejected or late. He stated, ' I was not aware that the Significant Change MDS was missed. "	F 274		
F 287	483.20(f) ENCODING/TRANSMITTING	F 287		

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F 287 SS=D	Continued From page 6 RESIDENT ASSESSMENT (1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. (2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. (3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death.	F 287	CMD will follow her weekly schedule for completion and submission to assure that the seven day deadline for encoding and transmitting is met. Compliance with the weekly schedule will be monitored weekly by the administrator and compliance report made to monthly PI meeting. Assistance will be requested weekly as required from Regional CMD consultant for transmission problems other than requirement. Your #3 Our corporate reimbursement office electronically transmits by batches of encoded assessments weekly, once our CMD has electronically sent the assessment to them. Thus timely submission for this facility will be processed there in a timely fashion. CMD will advise Administrator daily if she encounters any problems at that level. That he will assist with a back up assistant will be trained to help CMD stay on schedule and collect assessments from various disciplines, and keep track of events in her absence.	Completion date 5/26/2011

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F 287	Continued From page 7 (viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment. (4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to transmit quarterly Minimum Data Set (MDS) assessments for 4 (Resident #4, #5, #14, #49) of 14 residents within seven days of completion. Findings included: 1. Resident #4 was admitted to the facility on 11/18/10. Cumulative diagnoses included anemia, coronary heart disease, osteoporosis, congestive heart failure, and diabetes mellitus. On 04/28/11 at 9:15 AM, a request was made to the MDS coordinator for Resident #4 most recent quarterly MDS. On 04/28/11 at 10:45 AM, the MDS coordinator presented a printed copy of an MDS for resident #4 with an Assessment Reference Date (ARD) of 02/18/11 and the RN Assessment Coordinator (RAC) signature verifying assessment completion with a date of 04/28/11. An interview, on 04/28/11 at 11:00 AM, was conducted with the MDS Coordinator. She stated	F 287		

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F 287	Continued From page 8 she was behind in her work load; was unable to get the MDS imputed; and, therefore, unable to complete the transmission timely. The MDS Coordinator relayed she was also dependent on other staff to get information to her and that put her behind. She indicated she was aware the MDS ' s had not been imputed or transmitted as required. An interview, on 04/28/11 at 10:30 AM, was conducted with the Director of Nursing (DON). The DON relayed she would expect the MDS to be completed when due and submitted within the timeframe required. 2. Resident #5 was admitted to the facility on 02/16/11. Cumulative diagnoses included chronic pain syndrome, hyperthyroidism, chronic kidney disease, degenerative disc disease, and sleep apnea. Review of Resident #5 ' s admission MDS assessment revealed an ARD of 02/23/11 and a RAC signature verifying assessment completion with a date of 03/17/11. An interview, on 04/28/11 at 11:00 AM, was conducted with the MDS Coordinator. She stated she was behind in her work load; was unable to get the MDS imputed; and, therefore, unable to complete the transmission timely. The MDS Coordinator relayed she was also dependent on other staff to get information to her and that put her behind. She indicated she was aware the MDS ' s had not been imputed or transmitted as required. An interview, on 04/28/11 at 10:30 AM, was	F 287		

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F 287	Continued From page 9 conducted with the Director of Nursing (DON). The DON relayed she would expect the MDS to be completed when due and submitted within the timeframe required. 3. Resident #14 was admitted was admitted to the facility on 09/11/09. Cumulative diagnoses included end stage renal disease, hypertension, diabetes mellitus, and depression. On 04/28/11 at 8:55 AM, a request was made to the MDS Coordinator for the most recent quarterly for Resident #14. The MDS Coordinator stated she had not imputed the MDS into the computer; but, it was completed on paper and she would put it into the computer and print it. On 04/28/11 at 10:05 AM, the MDS Coordinator presented the quarterly MDs for Resident #14 with an ARD of 03/28/11 and the RAC signature verifying assessment completion with a date of 04/28/11. An interview, on 04/28/11 at 11:00 AM, was conducted with the MDS Coordinator. She stated she was behind in her work load; was unable to get the MDS imputed; and, therefore, unable to complete the transmission timely. The MDS Coordinator relayed she was also dependent on other staff to get information to her and that put her behind. She indicated she was aware the MDS ' s had not been imputed or transmitted as required. An interview, on 04/28/11 at 10:30 AM, was conducted with the Director of Nursing (DON). The DON relayed she would expect the MDS to be completed when due and submitted within the	F 287		

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F 287	Continued From page 10 timeframe required. 4. Resident #49 was admitted to the facility on 03/24/09 and readmitted 08/10/09. Cumulative diagnoses included dementia, chronic pain syndrome, congestive heart failure, osteopenia and osteoarthritis. On 04/26/11 at 2:00 PM, a request for a quarterly MDS was made to the MDS Coordinator. She stated Resident #49 ' s quarterly MDS was completed but had not been imputed into the computer and therefore could not be printed. The MDS Coordinator relayed she would impute the MDS and then print a copy. On 04/27/11 at 9:15 AM, the MDS Coordinator presented a printed copy of a MDS for Resident #49 with an ARD of 02/18/11 and a RAC signature verifying assessment completion with the date of 04/27/11. An interview, on 04/28/11 at 11:00 AM, was conducted with the MDS Coordinator. She stated she was behind in her work load; was unable to get the MDS imputed; and, therefore, unable to complete the transmission timely. The MDS Coordinator relayed she was also dependent on other staff to get information to her and that put her behind. She indicated she was aware the MDS ' s had not been imputed or transmitted as required. An interview, on 04/28/11 at 10:30 AM, was conducted with the Director of Nursing (DON). The DON relayed she would expect the MDS to be completed when due and submitted within the timeframe required.	F 287		

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F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure four (4) dry food storage bins were free of grease/food debris, food preparation was not exposed to dirty dish washing area in the kitchen; and that the inside of the microwave was free of rust and peeling paint. The findings included: A tour of the kitchen was conducted on 4/25/11 at 10:50 a.m., along with the Dietary Manager (DM). The Dietary Aide #1 was preparing the plates, cups, glasses, and eating utensils for dishwashing. She was taking trays from the food cart and removing uneaten foods and beverages from the breakfast meal. This involved scraping foods and emptying liquids in the sink disposal. The food cart was parked approximately 1 foot away from the steam table, the sink disposal and dishing machine was approximately 5 feet from the steam table. There was a full cake sheet pan of uncovered unbaked rolls resting on the steam table to aid in the raising process. The steam table had an open space of approximately 6 inches which exposed the uncovered rolls to the	F 371	We have cleaned the greasy, food encrusted four dry food storage bins; taken measures to eliminate exposure of food prep area to dirty dish washing fall out, and bought a new microwave free of rust and peeling paint. Specifically food carts will no longer be parked within 3 feet of steam table. The steam table will be relocated 6 feet from the sink disposal and dish machine. All rolls in the rising mode will: First choice: Be placed in a warm oven until up, if an oven is not in use. Second choice: covered with clean towel and placed on the steam table. Third choice: covered with clean tray and place on the steam table. The following items are a daily check list by dept. head to make rounds each week day and return sheet to administrator for follow up. 1. Food storage bins and rest of pantry is also clean. 2. No food carts are within 3 feet of steam table. 3. No rising rolls exposed to dish scraping or washer splash. Administrator will spot check at least weekly and keep record for presentation to P.I. committee monthly.	Completion date 5/26/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	04/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTHCARE OF FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

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F 371	Continued From page 12 dirty area of the kitchen. On 4/26/11 at 9:40 a.m. again a full sheet pan of uncovered rolls were observed resting on the steam table with exposure to a dirty area of the kitchen while dishwashing preparation was being done. The DM stated that was where they always placed the rolls to rise. During an interview with the Registered Dietician and the DM on 4/26/11 at 11:45 a.m., they verified that the uncovered rolls placed on the steam table to rise were exposed and too close to the dishwashing/processing area. On 4/28/11 at 9:20 a.m. while touring the kitchen with the DM the following items were observed and verified with the DM: The microwave had chipped peeling paint and rust on the inside top and sides; and burn stains on the side walls. The following dry storage bins had a heavy build up of grease/dust debris on the tops and outsides of the bins: 2-5 gallon loose flour and sugar containers 1-8 quart grits container 1-4 quart dry noodle container	F 371		
F 461 SS=C	483.70(d)(1)(vi)-(vii), (d)(2) BEDROOMS - WINDOW/FLOOR, BED/FURNITURE/CLOSET Bedrooms must have at least one window to the outside; and have a floor at or above grade level. The facility must provide each resident with-- (i) A separate bed of proper size and height for the convenience of the resident; (ii) A clean, comfortable mattress; (iii) Bedding, appropriate to the weather and climate; and (iv) Functional furniture appropriate to the resident ' s needs, and individual closet space in	F 461	The facility will provide each resident with designated closet space; indicated by use of divider inserts in each rooms closet area. All 20 closets are being fitted with divider inserts that provide equal space, with sanitary separation. Housekeeping will report daily any dividers that appear missing or damaged to the administrator who will be sure that repair or replacement occurs as soon as possible.	Completion date 5/26/2011

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F 461	Continued From page 13 the resident ' s bedroom with clothes racks and shelves accessible to the resident. CMS, or in the case of a nursing facility the survey agency, may permit variations in requirements specified in paragraphs (d)(1)(i) and (ii) of this section relating to rooms in individual cases when the facility demonstrates in writing that the variations-- (i) Are in accordance with the special needs of the residents; and (ii) Will not adversely affect residents' health and safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure individualized closet space for 18 of 20 resident bedrooms. (Resident bedroom #1, #3, #4, #5, #6, #7, #8, #9, #10, #11, #13, #14, #15, #16, #17, #18, #19 and #20) The findings included: An environmental tour and observations of resident bedrooms was conducted on 4/27/11 from 4:00pm until 4:45pm. During the observations the following bedrooms were noted without individualized closet space: Resident bedroom #1 (which 2 residents occupied) was noted with one closet area for both residents. There was no separation noted between the two resident's clothes. A plastic bag	F 461		

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F 461	Continued From page 14 was noted wrapped around the closet bar towards the center. The plastic bag was tied into a knot onto the closet bar. The plastic bag appeared to attempt to separate the clothing in the closet. Resident bedroom #3 (which 2 residents occupied) was noted with one closet area for both residents. There was no separation noted between the two resident's clothes. A black piece of elastic was noted wrapped around the closet bar towards the center. The piece if elastic appeared to attempt to separate the clothing in the closet, but the elastic was broken and falling off of the closet bar. Resident bedroom #4 (which 2 residents occupied) was noted with one closet area for both residents. There was no separation noted between the two resident's clothes. A black piece of elastic was noted wrapped around the closet bar towards the center. The piece if elastic appeared to attempt to separate the clothing in the closet, but the elastic was broken and falling off of the closet bar. Resident bedroom #5 (which 3 residents occupied) was noted with one closet for all three residents. There was no separation noted between the three resident's clothing in the closet. Resident bedroom #6 (which 3 residents occupied) was noted with one closet for all three residents. There was no separation noted between the three resident's clothing in the closet.	F 461		

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F 461	Continued From page 15 Resident bedroom #7 (which 3 residents occupied) was noted with one closet for all three residents. There was no separation noted between the three resident's clothing in the closet. There were 2 metal pieces screwed onto the closet bar. The metal pieces appeared to attempt to separate the clothing in the closet. Resident bedroom #8 (which 3 residents occupied) was noted with one closet area for all three residents. There was no separation noted between the resident's clothes. A plastic bag was noted wrapped around the closet bar towards the center. The plastic bag was tied into a knot onto the closet bar. The plastic bag appeared to attempt to separate the clothing in the closet. Resident bedroom #9 (which 3 residents occupied) was noted with one closet area for all three residents. There was no separation noted between the resident's clothes. Two clean adult incontinent briefs were noted wrapped around the closet bar. The adult incontinent briefs were noted to be tied into a knot over the bar. The adult incontinent briefs appeared to attempt to separate the clothing for the 3 residents in the room. Resident bedroom #10 (which 3 residents occupied) was noted with one closet area for all three residents. There was no separation noted between the resident's clothes Resident bedroom #11 (which 2 residents occupied) was noted with one closet area for both residents. There was no separation noted	F 461		

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F 461	Continued From page 16 between the two resident's clothes. Resident bedroom #13 (which 3 residents occupied) was noted with one closet area for all three residents. There was no separation noted between the resident's clothes Resident bedroom #14 (which 3 residents occupied) was noted with one closet area for all three residents. There was no separation noted between the resident ' s clothes	F 461		
	Resident bedroom #15 (which 3 residents occupied) was noted with one closet area for all three residents. There was no separation noted between the resident's clothes. Resident bedroom #16 (which 2 residents occupied) was noted with one closet area for both residents. There was no separation noted between the two resident's clothes. Resident bedroom #17 (which 3 residents occupied) was noted with one closet area for all three residents. There was no separation noted between the resident's clothes Resident bedroom #18 (which 3 residents occupied) was noted with one closet area for all three residents. There was no separation noted between the resident's clothes Resident bedroom #19 (which 3 residents occupied) was noted with one closet area for all three residents. There was no separation noted between the resident's clothes Resident bedroom #20 (which 3 residents			

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F 461	Continued From page 17 occupied) was noted with one closet area for all three residents. There was no separation noted between the resident's clothes. An interview was conducted with the Director of Nursing, Housekeeping Supervisor and Maintenance Supervisor on 4/28/11 at 8:30 AM. During this interview the Housekeeping supervisor stated that her staff take the clothes to resident rooms and place them into the closet. She stated that her attempt to put each resident ' s clothes on their side of the closet. She acknowledged that the closets had no individualized space for each resident ' s clothes. The Director of Nursing stated that she was aware of there being no separation or individualized closet space in the resident's bedrooms. When showed the plastic bags tied into knots on the closet bars in some of the rooms, she stated that she was not aware who did that, but that she felt staff did it in order to identify each resident ' s clothes and to separate the residents clothing in the closet. An interview was conducted with the administrator on 4/28/2011 at 10:23 AM. During this interview he stated that he does not allow the adult incontinent briefs and plastic bags to be used as a separator for clothing in resident ' s closets. He stated that he expected the residents to have individual closet space. He additionally stated that he felt some type of partition to separate the residents clothing would be an appropriate way to separate and individualize resident's closet space.	F 461		

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			ADDENDUM: F-253 In-Service training was given to our Housekeeping and Maintenance by Environmental Service Consultant 5/12/11 on essentiality of daily rounds to maintaining a sanitary, orderly and comfortable environment. These rounds, at least one room daily will be recorded to reflect any conditions or findings of unmet standards. The narrative portion should note on the spot corrections and include all actions needing immediate action. The rounds will be turned into the administrator personally, or partner acting in absence. Administrator or designee must be immediately notified of any conditions posing jeopardy or possible jeopardy to a patient. Deficiencies not corrected for administrative reason will continue to be reported until corrected. The use of foam to seal air conditioning has been discontinued.	

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			F-253 Housekeeping personnel were in serviced regarding observing physical damage or broken furnishing or fixture that may do physical harm to the resident, and once observed, to report it to their supervisor, and enter the needed repair in the maintenance director's repair log. Unrepaired items should continue to be reported until repaired or replaced. Housekeepers were further instructed to attempt to clean off rust and similar stains including dried urine using chemicals stocked by the corporate approved vendor. If these fail the housekeeping director is to seek guidance from the Uni-choice Consultant and if that fails the Administrator will request for contract services from an approved vendor. Stains included are those on plumbing, sinks, lavatories, toilets, tubs, various tile floors as well as walls. Chemicals will be used to eliminate odors, but not to cover them up. Housekeeping aide will follow the same protocol to eliminate odors as they did in the three preceding sentences regarding stains.	
			F 274 & F287 The CMD received one-on-one training from the Region Corporate consultant on RAI compliance, including a plan to catch up the completion of those assessments that are late and to avoid new ones.	May 12 & 13 2011

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			The CMI team was in-serviced on Medicare skilled services criteria, plans of correction and date of compliance. This was followed by a separate in-service given to the CMD and Social Services Director on elements of the physician certification and importance of timely completion. SEE EXCERPTS FROM CONSULTANT VISIT reports following POC as addendum 1. PI (performance Improvement) referenced in this Plan of correction is the arm of our Quality Assurance Program that identifies problems, and based on data analysis sets goals and monitors to measure progress towards goals. Monitors are discontinued when goals are achieved. Our goal is to eliminate late and missed assessments. Weekly review of status of assessment us schedule at the CMI meeting portion of our QA (Wednesdays) meeting will serve that purpose. Our key to success is daily communication by all players in the assessment process concerning changes in the patient's condition with the CMD; to keep to the schedule or vary as necessary and permissible. Our staff is stepping up to meet this challenge.	

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			In-service and QA Addendum F371 Not covering the rising roll dough was presented through an inservice by the Dietary Consultant, present during day 2 of survey, on the afternoon of April 26, 2011. Another in-service on sanitation for Dietary partners, covering sanitation included cleaning the new microwave; assuring 5 or more feet between the sink disposal and the steam table and the pre-wash swiveling faucets; not parking carts with dirty trash, tableware or dishes contiguous to the steam table; clearing food storage areas (particularly the pantry) to include sanitizing food storage bins. Using a vacant oven section to place dough for rising phase was taught as the preferred location.	5/9/2011
			QA committee in PI session could not come up to any better solutions than those recommended by the Dietary Consultant and were pleased with the record or rounds in place.	5/10/2011
			F461 When the closets partitions are installed; housekeeping and C.N.A.'s will be inserviced on marking clothes and hanging them. Families will be advised of space limitation and some items will have to be removed to maintain an orderly environment. QA monitors for neatness will begin as a 3 month priority item.	5/26/2011

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	345384	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/24/2011

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K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. RECEIVED JUN 13 2011 CONSTRUCTION SECTION This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 5/24/11 at approximately noon the following corridor door was non-compliant, specific findings include shower room converted to storage room next to bedroom 20 did not have positive latching.	K 018	a.) Signage was replaced b.) Maintenance Director will audit one year of Sprinkler Inspections completed by outside contractor, BFPE, to ensure that all issues identified by BFPE have been corrected and system is currently compliant. c.) Outside contractor, BFPE, will be notified of the noted absence of FDC signage and its replacement as well as the findings of the audit. Any issues noted in the audit as not currently compliant will be corrected by either BFPE or Maintenance Director. d.) Maintenance Director and BFPE will ensure compliance through quarterly sprinkler system inspections. Inspection findings will be reported in facility monthly Safety Committee meetings to monitor compliance. Any issues found out of compliance during inspections will be corrected and reported to administrator and any deficient practice will be worked through facility Performance Improvement Process.	6/2/11 6/11/11 6/11/11 Currently and Ongoing
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 6-9-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	345384	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/24/2011

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K 062	Continued From page 1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 5/24/11 at approximately noon the following sprinkler system was non-compliant, specific findings include signage of Fire Department Connection (FDC) near siamese connection was not posted.	K 062	a.) Replaced positive latching b.) Facility staff conducting daily Quality Assurance Compliance Rounds. In addition to daily QA Compliance Rounds, the Maintenance Director will conduct monthly rounds to inspect facility for maintenance issues, including positive latching devices. c.) Any positive latching found to not be working properly during QA Compliance Rounds or during Maintenance's monthly rounds will be repaired and or replaced by the Maintenance Director. e.) Inspection findings will be reported in facility monthly Safety Committee meetings to monitor compliance. Any issues found out of compliance during inspections will be corrected and reported to administrator and any deficient practice will be worked through facility Performance Improvement Process.	6/7/11 Currently and Ongoin Currently and Ongoin Currently and Ongoin