STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345400	A. BUILDING _____ B. WING _____	C 08/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKYLAND CARE CENTER	193 ASHEVILLE HWY SYLVA, NC 28779

(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 The original recertification/complaint survey was conducted from July 24 - 28, 2011. Based upon management review, the survey dates were extended. The survey team reentered the facility on August 8, 2011 and notified the administrator of the IJ at F-323. The survey's exit date was extended to August 9, 2011 at which time the jeopardy was removed and tag F323 was left out of compliance at a lower scope and severity.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.	
F 272 SS=B	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures;	F 272	• **F272 483.20(b)(1)** 1) Resident #3, #74, and #98 had the CAAs portion of the Minimum Data Set (MDS) completed on August 15, 2011. MDS coordinator #2 was in-serviced on the importance of the CAAs section of the MDS and its relevance to completion of the MDS. 2) The facility has conducted a complete chart audit of all current residents as of August 15, 2011 to identify any residents who may have been affected by the deficient practice. Those MDSs identified as not having a CAAs were completed by the MDS coordinator by August 15, 2011. The facility will conduct chart audits monthly times one month and quarterly thereafter to identify any residents who did not have a CAAs section of their MDS completed. Residents who are identified as not having the CAAs section completed will have one completed by the MDS coordinators.	August 15, 2011 August 15, 2011

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mistie Cooley — TITLE: LNHA — (X6) DATE: 8/25/2011

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 272	Continued From page 1 Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete required Care Area Assessments for Annual and Admission Minimum Data Sets for three (3) of nine (9) sampled residents. (Resident #3, #74 and #98.) The findings are: 1. Resident #3 had an Annual Minimum Data Set (MDS) dated 6/9/11. Based on this MDS and the trigger legend, the areas of delirium, cognitive loss, activities of daily living skills, incontinence, mood, falls, nutritional status, dental care, pressure sores and pain required a comprehensive Care Area Assessment (CAA) of the resident's needs. Review of the medical record revealed there were no CAA of any of the triggered areas. During an interview on 7/28/11 at 3:02 PM, MDS Coordinator #2 revealed she had completed the MDS dated 6/9/11 but had not completed the CAAs yet. She stated she did not totally	F 272	Continued omissions of the CAAs section by the MDS coordinators will be addressed through the facility's progressive disciplinary action procedure up to and including termination of employment. 3) No systemic changes are needed. In the instance noted in the 2567 the former MDS coordinator (no longer employed) did not complete the CAAs for two of the identified residents who were missing the CAAs section on their respective MDS. MDS coordinator #2 was in-serviced on the importance of the CAAs section of the MDS and its relevance to completion of the MDS. The facility will conduct chart audits monthly for one month and quarterly thereafter to identify any residents who did not have a CAAs section of their MDS completed. Residents who are identified as not having the CAAs section completed will have one completed by the MDS coordinators. Continued omissions of the CAAs section by the MDS coordinators will be addressed through the facility's progressive disciplinary action procedure up to and including termination of employment. 4) The facility will monitor though the chart audits (for 3 months and quarterly thereafter) residents who did not have a CAAs section of their MDS completed. The results of these audits will be addressed through the facility's quality assurance program as necessary.	August 12, 2011 August 15, 2011

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F 272	Continued From page 2 understand the importance of the CAAs and the relationship of the CAAs to the care plans. 2. Resident #74 had an Admission Minimum Data Set (MDS) dated 1/26/11. Based on this MDS and the trigger legend, the areas of activities of daily living skills, incontinence, activities, falls, hydration, dental, pressure, and pain required a comprehensive Care Area Assessment (CAA) of the resident's needs. Review of the medical record revealed there were no CAAs of any of the triggered areas. During an interview on 7/28/11 at 2:00 PM, MDS Coordinator #2 revealed there were no CAAs because the previous MDS staff who was responsible for completing the initial MDS did not do one. MDS Coordinator #2 stated that she discovered that several residents were missing CAAS and when she discovered this, she placed the resident's name on a list to be sure the CAAs were completed at the next annual assessment or at a significant change assessment. Review of the list revealed Resident #74 was not on the list as needing a CAAs. 3. Resident #98 had an Annual Minimum Data Set (MDS) dated 3/3/11. Based on this MDS and the trigger legend, the areas of vision, activities of daily living skills, incontinence, psychosocial needs, activities, falls, nutrition, hydration, dental, pressure, and psychotropic medications required a comprehensive Care Area Assessment (CAA). Review of the medical record revealed there were no CAAs of any of the triggered areas. On 7/28/11 at 1:58 PM interview with the MDS Coordinator #1 revealed there was no CAAs	F 272	The administrator is responsible for overall compliance	

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F 272	Continued From page 3 because the previous MDS staff did not do one. MDS Coordinator #1 stated MDS staff were making a list of residents that needed CAAs when they found the CAAs were missing.	F 272		
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, resident interview, electrician interview, review of fire department reports and facility reports the facility failed to operate room air conditioners on single outlet circuits per the manufacturer recommendations to prevent overloading the electrical circuit to prevent a potential fire hazard, to ensure rooms were free of electrical extension cords and keep resident beds and bedding an acceptable distance away from baseboard heating units in nineteen (19) of thirty-nine (39) resident rooms and in one (1) of two (2) therapy rooms.(Rooms #1, #2, #5, #9, #10, #12, #14, #17, #18, #19, #20, #24, #27, #28, #30, #31, #32, #34, #35 and #41) Immediate jeopardy began on 7/24/11 when a fire occurred in one (1) resident room (Room #19) after a circuit was overloaded and sparks from the air conditioner wiring ignited the bedding in	F 323	• F323 483.25(h) 1) The fire that occurred on July 24, 2011 directly affected room #19 for residents # 18 and #93 however other residents were identified to be affected by the deficient practice due to the use of surge protectors/extension cord devices, the individual A/C units that were supposed to have dedicated receptacles but were plugged into the duel receptacles, and beds being too close to the baseboard heaters. Due to this fact the facility's POC for this Ftag will be focused on the entire facility rather than the residents who occupied room #19 on July 24, 2011. The facility conducted an audit of the facility's individual A/C units on July 26, 2011 to identify which units required a dedicated outlet. Upon completion of the audit and in discussions with life safety and the electrician, it was determined the most expedient way to ensure compliance is to remove the units that required an individual receptacle and to install units that would allow duel receptacles to be used. On August 13, 2011 the facility installed new individual A/C units that would allow them to be plugged into the duel receptacles. In addition, the facility has installed new receptacles that will accommodate new individual air conditioning units purchased by the facility.	August 18, 2011

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F 323	Continued From page 4 the room. Immediate jeopardy was removed on 8/09/11 when the facility provided and implemented a credible allegation of compliance. The facility remains out of compliance at a lower scope and severity of E (a pattern of deficient practice, no actual harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put into place and completion of employee training. The findings are: 1. During the initial tour of the facility on 7/25/11 at 1:34 PM, Room #19 (a room that was occupied by Residents #18 and #93) was observed cleared of furniture and in the midst of being painted. The wall outlet under the window had a solid silver plate cover with blackened area surrounding the outlet. The white painted window sill just above the outlet was also blackened but not charred. In addition, the electric baseboard heater running along the wall under the outlet had the cover removed. The wall just above the baseboard was observed slightly blackened. Review of the nurse's notes for Resident #93 revealed an entry dated 07/24/11 at 3:15 a.m. which specified that at approximately 2:00 a.m. the fire alarm sounded. A fire was noted in Room #19 which was Resident #93's room. The residents in this room were immediately evacuated. The fire was extinguished with fire extinguishers and no injuries were noted. An interview with Resident #93, who is considered alert and oriented by the facility, was conducted on 07/25/11 at 2:11 p.m. The resident stated on 07/24/11 she was awake and watching	F 323	The facility conducted rounds on August 17, 2011 and removed all extension cords and surge protectors and replaced all the surge protectors with UL rated 60601-1 surge protectors as approved by life safety on August 12, 2011. The facility's administrator and/or designee will make rounds weekly times 3 months and quarterly thereafter to ensure that residents are free from inappropriate surge protectors or extension cords. The maintenance supervisor has been in-serviced on August 3, 2011 regarding the importance of installing equipment to manufacturer specifications, not allowing extension cords to be used in the facility, and to review life safety guidelines before installing equipment. Failure by the maintenance supervisor to meet these requirements will be handled through the facility progressive disciplinary policy up to and including termination of employment. Facility employees were in-serviced on August 3-4, 2011 regarding extension cords and the adequate distance required of the beds to be separated from the baseboard heaters. In order to ensure the resident beds maintain an adequate distance from the baseboard heating units the facility administrator and/or her designee are conducting weekly rounds for 3 months and then monthly thereafter to ensure compliance.	

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F 323	Continued From page 5 television when she noticed the oxygen concentrator she was using had a "red" light on. She used her call light to summon facility staff. At that time she noticed sparks on the opposite side of her roommate's bed. She began yelling for help. As the room door opened, she stated she saw flames where the sparks had been. Resident #93 stated facility staff quickly pulled her and her roommate from the room and moved them to safety. A review of an incident report from the city fire department revealed that on 07/24/11 an alarm was received at 2:20 a.m. from the facility. The report described the ignition factor as electrical. The form of ignition was electrical short. Equipment involved in ignition was electrical wiring. The type of material ignited was fabric. The area of fire origin was patient room (bedroom). A review of the facility's investigation of the 07/24/11 fire which occurred in Room #19 revealed the County Fire Marshall reported that an air conditioner plugged into the receptacle in Room #19 caused the fire. The report continued the residents remained off the affected wing until the wiring was checked by a licensed electrician. The electrician's examination was in progress by 8:00 a.m. on 07/24/11. Further review of the facility's investigation revealed the electrician "noted a multi-plug surge protector had been used in this room (Room #19). and that with the recent hot weather and the room air conditioner running constantly that it probably over heated the sure (sic)-protector." The electrician recommended a higher capacity surge protector for this room. Further review of the investigation	F 323	2) The facility conducted an audit of the facility's individual A/C units on July 26, 2011 to identify which units required a dedicated outlet. Upon completion of the audit and in discussions with life safety and the electrician, it was determined the most expedient way to ensure compliance is to remove the units that required an individual receptacle and to install units that would allow duel receptacles to be used. On August 13, 2011 the facility installed new individual A/C units that would allow them to be plugged into the duel receptacles. In addition, the facility has installed new receptacles that will accommodate new individual air conditioning units purchased by the facility. The facility conducted rounds on August 17, 2011 and removed all extension cords and surge protectors and replaced all the surge protectors with UL rated 60601-1 surge protectors as approved by life safety on August 12, 2011. The facility's administrator and/or designee will make rounds weekly times 3 months and quarterly thereafter to ensure that residents are free from inappropriate surge protectors or extension cords. The maintenance supervisor has been in-serviced on August 3, 2011 regarding the importance of installing equipment to manufacturer specifications, not allowing extension cords to be used in the facility, and to review life safety guidelines before installing equipment.	August 18, 2011

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F 323	Continued From page 6 report revealed rounds were conducted by the maintenance director, housekeeping director, and administrator to assure beds were pulled away from walls that have electrical outlets. The report specified multi-plug surge protectors utilized throughout the building were identified by the maintenance director and replaced with a higher capacity surge protector by 07/25/11. Review of a letter, dated 07/26/11, that was written by the licensed electrician who performed the electrical check described the fire of Sunday, 07/24/11, in Room #19 specified that the fire was due to an "electrical incident". The electrician specified that "A multi-device splitter was installed in the duplex (two outlet) receptacle located under the exterior window. The combination of devices plugged into the splitter, the amount of current consumed by these devices, and the arrangement of the cords attached to the individual devices collectively led me to believe excessive heat and eventual fire took place due to a loose connection and/or an overloaded splitter." On 07/25/11 at 5:21 p.m. the Licensed Electrician, who declared the building's wiring was undamaged by the fire, was interviewed. The Electrician stated that he found a six (6) way adapter plugged into a duplex receptacle with multiple cords plugged into the adapter in Room #19. The electrical items plugged into the receptacle included an air conditioner and television. He stated the electrical adapter was melted when he examined it. The Electrician specified that the electrical receptacle that the adapter was plugged into was rated to allow fifteen (15) amps (measurement of electrical	F 323	Facility employees were in-serviced on August 3-4, 2011 regarding extension cords and the adequate distance required of the beds to be separated from the baseboard heaters. In order to ensure the resident beds maintain an adequate distance from the baseboard heating units the facility administrator and/or her designee are conducting weekly rounds for 3 months and then monthly thereafter to ensure compliance. 3) No systemic changes were necessary. In this instance the facility failed to install the individual A/C units according to manufacturer specifications, was using non-approved surge protectors and extension cords, and had the facility beds too close to the baseboard heaters that required in-servicing and physical corrections to the facility but no systemic changes. 4) The facility, through its quality assurance program, will be conducting QA rounds to ensure compliance. The facility's administrator and/or designee will make rounds weekly times 3 months and quarterly thereafter to ensure that residents are free from inappropriate surge protectors or extension cords.	August 3-4, 2011

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F 323	Continued From page 7 current). The air conditioner plugged into the adapter was rated to need 15 amps without adding the other devices plugged into the adapter. He added that too many items were plugged into that receptacle and that air conditioners should never be plugged into electrical adapters. An interview with the Maintenance Director on 07/25/11 at 3:07 p.m. revealed the fire was caused by a six (6) plug adapter plugged into a two (2) plug wall outlet. He stated the multi-port adapter was not like a surge protector with a reset button. The multi port plug had the air conditioner unit, radio, television, and telephone charger plugged into it. The heat generated in the plug melted the covers of the wires and the wires were next to the bed covers. The Maintenance Director stated he was not aware the six (6) plug adapter was in use in Room #19. Review of the Owner's Manual of the window air conditioner that was involved in the fire in Room #19 on 07/24/11 revealed it was to be operated on a dedicated circuit. The manual also specified that overloading the line could create a fire hazard. During an interview with the facility's Maintenance Director and Administrator on 08/08/11 at 3:25 p.m., the air conditioner that was involved in the fire which occurred in Room #19 was observed. Observations of the air conditioner revealed information written on the side of the air conditioner specified; "Use on Single Outlet Circuit Only". Inspection of the air conditioner revealed that its electrical cord was melted. The Maintenance Director stated he had not read the	F 323	In order to ensure the resident beds maintain an adequate distance from the baseboard heating units the facility administrator and/or her designee are conducting weekly rounds for 3 months and then monthly thereafter to ensure compliance. The administrator will ensure that all individual A/C units are installed according to manufacturer specifications. Results of these QAs will be reviewed during quality assurance meetings and corrective actions taken as necessary.	

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information that was on the side of the air conditioner and was unaware of when the unit was purchased or put into use.

2. Observations on 08/08/11 of window air condition units being utilized in the facility revealed the following units were not operating on single outlet circuits as specified by their manufacturer's:

a. Observations on 08/08/11 at 10:28 a.m. of Room #18 revealed a window air conditioner was in operation and plugged into a duplex (two outlet) electrical wall outlet along with a rechargeable phone. Review of information printed on the air conditioner specified; "Use on Single Outlet Circuit Only".

b. Observations on 08/08/11 at 10:31 a.m. of Room #34 revealed a window air conditioner was plugged into a duplex electrical outlet. A white plug was noted in second outlet attached to a white cord that went into the resident's closet. A television was observed on a shelf above the closet and was turned on. Review of information printed on the side of the air conditioner specified; "Use on Single Outlet Circuit Only".

c. Observations on 08/08/11 at 10:35 a.m. of Room #17 revealed a window air conditioner was in operation and plugged into a duplex electrical wall outlet which had a surge protector plugged into its second port. A television was observed plugged directly into the surge protector. Review of information printed on the air conditioner specified; "Use on Single Outlet Circuit Only".

d. Observations on 08/08/11 at 11:30 a.m. of

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F 323	Continued From page 9 Room #41 revealed a window air conditioner was plugged into a duplex outlet with a television plugged into the outlet's second port. Review of information printed on the side of the air conditioner specified; "Use On Single Outlet Circuit Only". e. Observations on 08/08/11 at 11:37 a.m. of Room #14 revealed a window air conditioner was in operation and plugged into a duplex electrical wall outlet along with a television. Review of information printed on the air conditioner specified; "Use on Single Outlet Circuit Only". f. Observations on 08/08/11 at 11:45 a.m. of Room #10 revealed a surge protector was plugged into a duplex electrical wall outlet. A window air conditioner, an oxygen concentrator and an extension cord were observed plugged into this surge protector. The other end of the extension cord was observed to be plugged into a another duplex electrical wall outlet in this room. Review of information printed on the air conditioner specified; "Use on Single Outlet Circuit Only". g. Observations on 08/08/11 at 11:45 a.m. of Room #28 revealed a window air conditioner was plugged into a surge protector along with a television and telephone charger. The surge protector was plugged into a duplex electrical outlet. Review of information printed on the side of the air conditioner specified; "Use on Single Outlet Circuit Only". h. Observations on 08/08/11 at 12:00 p.m. of Room #31 (Therapy Room) revealed a window air conditioner was plugged into a surge protector	F 323		

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along with an office printer and an exercise machine. The surge protector was plugged into a duplex outlet that had a television plugged into the outlet's second port. Review of information printed on the side of the air conditioner specified; "Use on Single Outlet Circuit Only".

i. Observations on 08/08/11 at 2:01 p.m. of Room #24 revealed a window air conditioner was plugged into a surge protector along with a television and an oxygen concentrator. The surge protector was plugged into a duplex outlet with an electric bed plugged into the outlet's second port. Review of information printed on the side of the air conditioner specified; "Use on Single Outlet Circuit Only".

Interviews with the Administrator and Maintenance Director on 08/08/11 at 3:10 p.m. revealed there was no written manufacturer's instructions or safety precautions available for any of the window air conditioning units that were being utilized in the facility to reference regarding proper installation or safe use. Both the Administrator and Maintenance director stated that they were unsure which in room window air conditioning units required dedicated electrical circuits in order to operate in a safe manner per their manufacturer's specifications.
The Administrator stated that the facility was in the process having dedicated electrical outlets installed, so that all window air conditioners requiring dedicated outlets would be able to operate in a safe manner per their manufacturer's specifications. The Administrator further stated that she was unsure how long it would take to have this electrical work performed.

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The Administrator was notified of the Immediate Jeopardy on 08/08/11 at 9:55 a.m. The facility provided a credible allegation of compliance on 08/09/11 at 5:10 p.m. The following interventions were put into place by the facility to remove the Jeopardy:

1) On 07/24/11 a fire occurred in Room #19. Both residents (Resident #18 and Resident #93) who resided in this room were immediately removed from the room by staff without injury on July 24, 2011 and were placed in another room. On 07/24/11 Room #19 was inspected by staff (administrator, maintenance director, DON), licensed electrician and the fire department to ensure that the room was safe and did not pose any potential fire hazards.

2) a. On 07/24/11 all residents who resided on the same wing (East) as Room #19, where the fire occurred were relocated in vacant beds within the facility until staff (administrator, maintenance director, DON) fire marshal, and licensed electrician could thoroughly investigate the origin of the fire. Based on the facility's investigation of this fire, staff determined that residents were safe and secure and no harm to any resident occurred. Residents, other than the two residents who resided in Room #19, (which needed repair) were moved back into their original beds on July 24, 2011 after the facility was declared safe by the County Fire Marshall and the licensed electrician who inspected the facility ' s wiring and determined that the facility was safe and the facility wiring was never penetrated by the fire.

b. On 7/24/2011 at approximately 8:30AM a

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licensed electrician inspected the electrical wiring in the facility including air conditioners (A/C) to ensure the electrical wiring was safe. The licensed electrician acknowledged the building's electrical supply was safe. The licensed electrician also wrote a conclusion to his investigation which stated a multi device splitter was installed in the duplex receptacle located under the exterior window. The combination of devices plugged into the splitter, the amount of current consumed by these devices and the arrangement of the cords attached to the individual devices collectively led me to believe that excessive heat and eventual fire took place due to a loose connection and/or an overloaded splitter.

c. On 07/24/11 at approximately 8:30AM the administrator and the facility's maintenance supervisor made rounds throughout the entire facility to identify any potential non-compliant forms of energy; including multi plug electrical outlet adaptors/splitters and extension cords. Through these rounds it was identified that multi device splitters, electrical outlet adaptors/splitters, and individual extension cords were being utilized in resident rooms. The electrical outlet adaptors/splitters and extension cords were immediately removed from resident rooms and were replaced with UL rated surge protectors on 07/24/11. During these rounds beds were moved away from the electric base board heaters, this is an ongoing process checked daily department manager rounds and each housekeeper signs off when they clean the room. These QA rounds also include checking for extension cords being brought into the building by family members.

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F 323	Continued From page 13 d. On 7/25/2011 the administrator wrote a letter to all family members and/or responsible parties requesting that they do not bring extension cords into the facility and that they get approval by the administrator if they had a request for additional electrical outlets to be placed in a resident ' s room. e. On August 3-4, 2011 the facility completed an in-service (completed by Administrator, DON, Maintenance Director, and Carolina Fire Protections) of all facility staff regarding the no extension cord policy and also for staff to check to ensure that all beds are at least 12 inches from wall mounted heaters. Any staff who did not attend this inservice, training will be in-serviced via phone by Administrator/DON before their next scheduled day to work. f. On 8/5/2011 the administrator and president (of the managing company) made the decision to install dedicated receptacles throughout the facility for air conditioner (A/C) units to ensure that receptacles are not overloaded and these receptacles will be brought up to current life safety code. On 7/27/2011 the Administrator and Maintenance Director conducted an audit of the whole facility to determine which a/c units in house require dedicated receptacles. g. On 8/8/2011 the licensed electrician, who assisted with the initial investigation of the fire, met with the administrator and will begin 8/9/2011 to install dedicated receptacles for all air conditioner units that require them. Installation of these dedicated electrical receptacles is estimated to be completed in 5 to 7 days.	F 323		

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h. On 08/08/11 at approximately 6:00PM the facility began requiring an employee who is dedicated to be on "fire watch" each shift to ensure the safety of all residents until all dedicated receptacles are installed in the facility. This employee is responsible for conducting continuous facility rounds on at least an hourly basis, to monitor and identify a potential fire or fire hazard in the facility. This employee is responsible for monitoring if they smell anything burning, if any equipment is hot to touch, if beds are 12 inches off base board heater, and assures there are no extension cords used in the rooms and recording this on a log. On 08/08/11 each employee, who will be functioning in this capacity, was in serviced by the Administrator/DON on the job's duties and responsibilities. These employees were instructed on how they are to monitor the facility, how they are to document on the fire watch log, and that they are to immediately report any problems involving resident safety to their supervisor and the administrator. Hourly Rounds will be documented on QA checklist by the fire watch safeguard and forwarded to administrator at the conclusion of their shift to ensure compliance. During the hours that the Administrator is not in the building the charge nurse will need to sign off that the rounds have been completed.

On 08/08/11 and 08/09/11 all staff were in serviced by the administrator/DON that electrical extension cords are not to be utilized in the facility and on the responsibilities of the "fire watch safeguard" and the fact that this individual is assigned to only do fire watch monitoring during their scheduled time. Any staff who was unable to attend this inservice training will be inserviced

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F 323	Continued From page 15 before being allowed to return to work. 3) On 07/26/2011 the facility began adding a form to its admission packet instructing family not to bring in their own extension cords, outlet adapters and such without facility approval. 4) a. On 08/08/11 daily monitoring of the facility was restarted by the administrator and all department managers to ensure that the facility is free of extension cords and non-approved surge protectors and electrical outlet adaptors/splitters. This monitoring will include daily rounds of the entire facility performed by the administrator and or her designees (maintenance director, other department staff, and administrative personnel) for 3 weeks, then on a monthly basis and then at least quarterly thereafter to ensure compliance. b. Once the dedicated receptacle outlets are installed in resident rooms the facility's maintenance director will perform monthly inspections to ensure that all air conditioners that require a dedicated receptacle are safely operating with a dedicated receptacle in place. Findings from these inspections will be reported at the facility ' s monthly safety meeting. Immediate Jeopardy was removed on 08/09/11 at 6:50 p.m. Observations of the facility confirmed no electrical adaptors/splitters or extension cords were being utilized in the facility. Observations revealed a staff member designated with "fire watch" duties was conducting continuous facility rounds on at least an hourly basis, to monitor and identify a potential fire or fire hazards in the facility. Staff interviews revealed they had	F 323		

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F 323	Continued From page 16 received inservice training on prohibiting the use of electrical adaptors/splitters and extension cords in the facility and on the responsibilities of the staff member who was assigned to be on "Fire watch". 3. Review of the facility's undated policy "Safety Guidelines" revealed the purpose of the policy was "to ensure a safe and comfortable living environment for the residents." Included in the guidelines was "12. Do not allow the use of extension cords in the building." Observations of the facility on 07/25/11 and 07/26/11 revealed electrical extension cords were being used by the facility in resident rooms due to inadequate accessible wall outlets as follows: *Room #9 on 7/25/11 at 4:40 p.m.: a television, located on a shelf above a closet, was plugged into a household extension cord which ran inside the closet and plugged into a large grey extension cord which plugged into a wall outlet. The Director of Nursing (DON) who accompanied the surveyor during this observations stated "I don't like it." *Room #10 on 7/25/11 at 4:44 p.m.: a window air conditioner was plugged into a surge protector which was plugged into a heavy extension cord which was plugged into the wall outlet. *Room #12 on 7/25/11 at 4:50 p.m.: an electric lounge chair was plugged into an orange extension cord which was plugged into a surge protector which plugged into a wall outlet. The Maintenance Director stated "I know it is safe."	F 323		

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F 323	Continued From page 17 *Room #5 on 7/25/11 at 5:00 p.m.: a television and window air conditioner unit was plugged into a surge protector which was plugged into a thick extension cord which was plugged into the wall outlet. *Room #34 on 7/25/11 at 5:23 p.m.: a television located above a closet was plugged into an extension cord which ran through the closet and into a wall outlet. *Room #2 on 7/26/11 at 9:11 a.m.: a television was plugged into a surge protector strip that was plugged into another surge protector strip which was plugged into the wall outlet. *Room #1 on 7/26/11 at 9:48 a.m.: an air conditioner was plugged into a household extension cord which was plugged into the wall outlet. On 7/26/11 at 8:25 a.m. a telephone interview with the fire marshal revealed extension cords should not be used in resident rooms. Further interview with the fire marshal on 7/26/11 at 11:20 a.m. revealed that connecting two surge protectors together, referred to as a daisy chain, was also not safe. Interview with the Maintenance Director on 7/25/11 at 4:49 p.m. revealed that there were not enough plugs in the rooms and extension cords had to be used sometimes so residents could have television, air conditioning, etc. He stated he was comfortable with using the extension cords and connecting surge protector cords together. He stated this was what he did in place of making any structural changes to the facility.	F 323		

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F 323	Continued From page 18 On 7/26/11 at 12:20 p.m., the Administrator stated that on Sunday, 7/25/11 after the fire, she instructed the maintenance staff to remove all extension cords. She stated that she was told by Maintenance staff yesterday 7/25/11 there were still some extension cords used due to televisions. On 7/26/11 at 2:29 p.m., Nurse Aide (NA) #4 stated she was unaware of instructions related to the use of extension cords. On 7/26/11 at 2:31 p.m., housekeeper #1 stated that extension cords were alright to use as long as they were not frayed and not on the floor in a place that created a fall hazard. On 7/26/11 at 2:40 p.m., NA #6 stated that extension cords were alright to use but should not be in the way of people who could trip or fall over them. On 7/26/11 at 4:01 p.m. an interview with the maintenance staff and administrator was conducted. The maintenance staff conducted weekly safety checks which he turned into the quality assurance committee monthly. Maintenance stated that surge protector strips connected to each other was alright. Maintenance staff further stated he tried not to use extension cords but that it could not be helped sometimes. The Administrator stated that during the quality assurance monthly meetings nothing was reported regarding extension cords because they did not know their use was unsafe. Further observations of the facility on 08/08/11	F 323		

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F 323	Continued From page 19 revealed that electrical extension cords were still being utilized in the following resident rooms: * Observations of Room #34 on 08/08/11 at 10:31 a.m. revealed a white extension cord plugged into a wall outlet that went into the resident's closet and was attached to a television set positioned on an upper shelf of the closet that was turned on. * Observations of Room #10 on 08/08/11 at 11:45 a.m. revealed an extension cord was plugged into an electric wall outlet and a surge protector that was plugged into an electrical wall outlet. A window air conditioner was plugged into the surge protector. Interview with the Administrator on 08/08/11 at 4:08 p.m. revealed that after the 07/24/11 fire she directed staff to remove all of electrical extension cords from the building because they were a safety hazard. The administrator stated that she thought all extension cords had been removed from the facility. 4. A review of a report of an Inspection conducted by the county Fire Marshal on 07/26/11 revealed the facility failed to provide a twelve (12) inch clearance between heating units and combustibles (bedding). An interview was conducted with the county Fire Marshall on 07/26/11 at 11:20 a.m. The Fire Marshall stated there should be a twelve (12) inch clearance between bed material and the heater per state regulation. The Fire Marshall added that bedding near the heater baseboards was a fire hazard even when the heaters were off. He stated that he had instructed this facility on a	F 323		

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previous inspection that beds were to be kept twelve (12) inches from the heater baseboards.

Observations on 07/26/11 and on 07/27/11 revealed beds and/or bedding were positioned in close proximity or directly on board heaters in the following resident rooms:

On 07/26/11 at 9:06 a.m. the B bed in Room #9 was positioned against the baseboard heater with bed's covers lying on the heater panel.

On 07/27/11 at 8:57 a.m. a bed in Room #2 was positioned in close proximity (less than twelve inches away) to a baseboard heater. Resident #32, who was lying in this bed, stated that he had been in this bed for over a year and it was always positioned close to the wall.

On 07/27/11 at 9:29 a.m. both beds in Room #30 were positioned against baseboard heaters. The blanket on the room's B bed was observed touching the heating panel.

On 07/27/11 at 9:35 a.m. the B bed in Room #32 was positioned against the baseboard heater with bedding touching the heating panel.

On 07/27/11 at 9:38 a.m. the B bed in Room #27 was positioned against the baseboard heater.

On 07/27/11 at 9:42 a.m. the B bed in Room #20 was positioned against the baseboard heater.

On 07/27/11 at 10:25 a.m. the B bed in Room #5 was positioned against the baseboard heater. A plastic bag was observed between the bed and the heater panel touching both.

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F 323	Continued From page 21 On 07/27/11at 4:04 p.m. the B bed in Room #35 was positioned against the heater baseboard. All baseboard heating units were turned off during the above observations. An interview with NA #2 on 07/28/11 at 10:50 a.m. revealed housekeeping staff was responsible to move the beds to the appropriate position away from baseboard heaters. She stated she was aware of this procedure and that staff were reminded every winter when heat is required. NA #2 demonstrated how the baseboard heaters in resident rooms were turned on by easily rotating a dial at the base of a switch. The switches to turn the room heaters on and off were observed positioned on the walls next to the doorway in resident rooms approximately in the same area where overhead light switches are usually located. NA #2 stated the heater control switch is readily accessible to ambulatory residents, family, and facility staff. At this time, NA #2 verified that both beds in Room #30 remained positioned against baseboard heaters as observed on 07/27/11 at 9:29 a.m. An interview with the Administrator on 07/27/11 at 11:20 a.m. revealed that she was aware resident beds should not be positioned against baseboard heaters at any time. She acknowledged that a bed against a baseboard heater was a safety hazard even when the heat was turned off. The Administrator added it was her expectation that beds remain at least twelve (12) inches away from baseboard heaters at all times.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371	• F371 483.35(i)	

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F 371	Continued From page 22 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 observations and staff interviews the facility failed to ensure kitchen freezers were operating at zero degrees Fahrenheit (F.) or below to maintain food products in a frozen state and ensure food service equipment and the fan in the walk in the refrigerator were clean. The findings are: 1. During the initial tour of the facility kitchen on 7/25/11 from 1:15 PM -1:55 PM the temperature of the walk in freezer was 30 degrees Fahrenheit (F). There were food products stored on shelving throughout the walk in freezer. Food products stored near the door of the freezer were noted to be thawed and or partially thawed and soft to touch. This included a two pound bag of sliced honey ham, five packages identified as bologna (written on foil on the outside of the package), a bag of cinnamon raisin biscuit dough, garlic bread, and a box of sausage patties. The Food Service Director (FSD) was present at the time of the observation and reported a service technician had been at the facility on 7/21/11 to address	F 371	1) In this instance, no one resident was identified to be affected by the deficient practice however facility residents could possibly be affected by the deficient practice. The facility obtained a temporary walk-in freezer on July 26, 2011 to ensure that frozen items were maintained at zero degrees Fahrenheit. The walk-in freezer is scheduled to be repaired on August 31, 2011 to ensure the freezer temperature maintains at the zero degree Fahrenheit requirement. In addition, the facility installed clear freezer door covers to assist with preventing the cold air for being affected by opening/closing of the door. The facility will continue to record freezer temperatures and record them on the temperature log. Staff has been in-serviced on ensuring proper temperatures for frozen foods on August 10, 2011 and to ensure that in the event that the freezer cannot maintain the temperature of zero degrees Fahrenheit, items requiring to be frozen will either be stored in a freezer that can maintain the required temperature or be discarded until repairs are complete. In addition, dietary staff has been in-serviced by August 10, 2011 on their cleaning schedules including the cleaning of the fans in dietary, the horizontal surface area of the clean dishware storage rack and the ladles/other cooking utensils.	August 22, 2011

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F 371	Continued From page 23 problems with the walk in freezer. The FSD stated the service technician had identified several concerns and the facility was awaiting a return visit to implement repairs. The FSD stated the temperature in the freezer should be zero degrees F. or below. Review of the July 2011 walk in freezer log revealed the following recorded temperatures: 7/20/11 20 degrees F. 7/21/11 30 degrees F. 7/22/11 30 degrees F. 7/23/11 22 degrees F. 7/24/11 20 degrees F. 7/25/11 15 degrees F. 7/26/11 30 degrees F. On 7/27/11 at 8:45 AM the FSD stated food that was stored in the walk in freezer was removed after partially thawed/thawed items were identified on 7/25/11. The FSD stated food from the walk in freezer was placed in other freezer units in the facility kitchen. A chest freezer (used to house ice cream) had items from the walk in freezer stored inside. The temperature of this chest freezer was 22 degrees F. and items stored on the very top of the chest freezer were completely thawed. This included a bag of meatballs, a package of roast beef, several packages of quiche mix and a box of sausage patties. The FSD stated the items had been frozen when place in the chest freezer. The thawed items in the chest freezer were removed and discarded by the FSD. 2. On 7/27/11 from 8:45 AM-9:20 AM the following concerns were identified in the presence	F 371	The Food Service Director (FSD) and/or her designee is responsible for conducting sanitation rounds weekly for 3 months and at least monthly thereafter to ensure proper sanitation of the kitchen. 2) In this instance, no one resident was identified to be affected by the deficient practice however facility residents could possibly be affected by the deficient practice. The facility obtained a temporary walk-in freezer on July 26, 2011 to ensure that frozen items were maintained at zero degrees Fahrenheit. The walk-in freezer is scheduled to be repaired on August 31, 2011 to ensure the freezer temperature maintains at the zero degree Fahrenheit requirement. In addition, the facility installed clear freezer door covers to assist with preventing the cold air for being affected by opening/closing of the door. The facility will continue to record freezer temperatures and record them on the temperature log. Dietary Staff has been in-serviced on ensuring proper temperatures for frozen foods on August 10, 2011 and to ensure that in the event that the freezer cannot maintain the temperature of zero degrees Fahrenheit, items requiring to be frozen will either be stored in a freezer that can maintain the required temperature or be discarded until repairs are complete.	August 22, 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345400	A. BUILDING _____ B. WING _____	C 08/09/2011

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F 371	Continued From page 24 of the FSD: a) A thick layer of dust was observed on top of the fan in the walk in refrigerator. The dust was easily removed when wiped with a paper towel. The FSD was present at the time of the observation and stated the fan was cleaned one time a month. The FSD was not sure when the last time the fan had been cleaned. b) Three rolling carts (approximately 12" high) housing racks of clean dishware were observed to have particles of food and debris covering a significant portion of the horizontal surface area (which the clean racks sat on). The FSD stated the carts were supposed to be cleaned three times a week. c) Two ladles stored in clean dish storage were noted to have a significant amount of caked on debris on the interior portion of the ladle. The FSD stated dishware was supposed to be inspected prior to storing in clean storage.	F 371	In addition, dietary staff has been in-serviced by August 10, 2011 on their cleaning schedules including the cleaning of the fans in dietary, the horizontal surface area of the clean dishware storage rack and the ladles/other cooking utensils. The Food Service Director (FSD) and/or her designee is responsible for conducting verification of freezer temperatures and conduct sanitation rounds weekly for 3 months and at least monthly thereafter to ensure proper sanitation of the kitchen. The administrator is responsible for overall compliance. 3) The facility already has in place the recording of temperatures for the freezer and cleaning schedules. Dietary Staff has been in-serviced on ensuring proper temperatures for frozen foods on August 10, 2011 and to ensure that in the event that the freezer cannot maintain the temperature of zero degrees Fahrenheit, items requiring to be frozen will either be stored in a freezer that can maintain the required temperature or be discarded until repairs are complete. In addition, dietary staff has been in-serviced by August 10, 2011 on their cleaning schedules including the cleaning of the fans in dietary, the horizontal surface area of the clean dishware storage rack and the ladles/other cooking utensils.	August 10, 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 25	F 371	The Food Service Director (FSD) and/or her designee is responsible for conducting freezer temperature and conduct sanitation rounds weekly for 3 months and at least monthly thereafter to ensure proper sanitation of the kitchen. The administrator is responsible for overall compliance. 4) The facility will review the results of the FSD's quality assurance rounds though the facility quality assurance program to ensure compliance. Items found not complying will be reviewed and corrected as necessary to ensure compliance is maintained. The administrator is responsible for overall compliance.	