STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FORREST OAKES HEALTHCARE CENTER	620 HEATHWOOD DRIVE ALBEMARLE, NC 28001

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F 159 SS=C	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the	F 159	This Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alledged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by State and Federal law. F-159 C #1 Residents #69, #72, #6, and #57 funds have been reduced to within the SSI (Supplemental Security Income) resource limit. Residents #14, #12, and #37 have been provided quarterly statements for their respective Resident Fund Account by the Business Office Manager. #2 A review of current resident accounts has been completed by the Business Office Manager to identify any residents with funds reaching $200.00 within SSI resource limit with no corrective action needed. Quarterly statements were reviewed and delivered by the Business Office Manager to alert and oriented residents as determined by review of the Minimum Data Set for those residents assessed as alert and oriented.	8/23/12

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

TITLE

(X6) DATE

Administrator

8-22-12

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 159	Continued From page 1 resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interview, the facility failed to notify 4 of 4 sampled residents, (Residents #69, #72, #6, and #57) and/or their responsible party of resident's funds reaching $200.00 within the SSI (Supplemental Security Income) resource limit and failed to provide quarterly statements to alert and oriented residents with Resident/Personal Fund Accounts for 3 of 3 residents (Residents The findings include: 1a. During a review of a list of resident's whose funds were managed by the facility, the list revealed that Resident #69 had an account balance of $1880.30 as of 3/26/12. Further review of Resident #69's financial record revealed that the resident received $418.00 per month on 4/4/12, 5/7/12, 6/6/12 and 7/6/12 with an ending balance (after the monthly cost of care was debited) of $2,000.60 on 7/26/12, which exceeded the resource limit. The record indicated that Resident #69 had not spent any money for personal expenses. During an interview with the Business Office Manager on 7/26/12 at 11:39 AM she stated that	F 159	Continued from Pg 1 F-159 #3 The Business Office Manager has been re-educated by the Nursing Home Administrator regarding the requirements in facility management of personal funds for skilled nursing home residents specifically that when the amount in the resident's account reaches $200 less than the SSI resource limit notification to the resident and/or responsible party must be done; and, quarterly statements are to be provided in writing to the resident and/or the resident's representative within 30 days after the end of the quarter. Quarterly statements will be delivered to all residents and responsible party within 30 days after the end of the quarter by the Business Office Manager. A letter with a copy of the resident's trust fund account, will be mailed to the resident/or the designated responsible party indicating that the resident's fund balance is within $200 or the resource limit allowed by Medicaid, and that Medicaid eligibility could be jeopardized if the trust fund balance exceeds the limit by the Business Office Manager. A copy of this letter will be provided to the Social Services Director and a copy filed in the resident's financial file. The Social Services Director has been re-educated by the Nursing Home Administrator to note in the resident's chart when conversations are held with residents and/or responible party regarding funds reaching the resource limit and the plan to spend down. A Quality Improvement tool will be completed weekly x 12 weeks, then monthly x 9 months to identify notification of residents and/or responsible party if funds reaching within $200 of the resource limit and alert and oriented residents receive quarterly statements for their respective Resident Fund Account by the Business Office Manager or Nursing Home Administrator. #4 The Business Office Manager or Nursing Home Administrator will report the results of the Quality Improvement tool to the Performance Improvement committee monthly x 12 months to identify trends and need for further education and/or monitoring.	

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F 159	Continued From page 2 she notified the responsible party by telephone of the balance being within $200.00 of the spending limit but did not document this. She also indicated that she notified the Social Worker to start working with the families on spending down the funds for the resident. During an interview with the Social Worker on 7/26/12 at 12:30 PM she indicated that she did work with families to spend down funds within $200.00 of the spending limit on things such as pre burial need but did not have any documentation of this for resident #69. 1b. During a review of a list of resident's whose funds were managed by the facility, the list revealed that Resident #87 had an account balance of $1874.94 as of 3/26/12. Further review of Resident #72's financial record revealed that the resident received $418.00 per month on 4/4/12, 5/7/12, 6/6/12 and 7/6/12 with an ending balance (after the monthly cost of care was debited) of $1858.22 on 7/26/12, which remained within $200.00 of the spending limit. The record indicated that Resident #72 had withdrawn a total of $137.00 from 3//26/12 - 7/17/12 as " resident advance cash " , no other personal spending was evident. During an interview with the Business Office Manager on 7/26/12 at 11:39 AM she stated that she notified the responsible party by telephone of the balance being within $200.00 of the spending limit but did not document this. She also indicated that she notified the Social Worker to start working with the families on spending down the funds for the resident.	F 159		

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F 159	Continued From page 3 During an interview with the Social Worker on 7/26/12 at 12:30 PM she indicated that she did work with families to spend down funds within $200.00 of the spending limit on things such as pre burial need but did not have any documentation of this for resident #72. 1c. During a review of a list of resident's whose funds were managed by the facility, the list revealed that Resident #6 had an account balance of $1,997.21 as of 3/26/12. Further review of Resident #6's financial record revealed that the resident received $633.00 per month on 4/4/12, 5/7/12, 6/6/12 and 7/6/12 with an ending balance (after the monthly cost of care was debited) of $2,117.53 on 7/26/12, which exceeded the resource limit. The record indicated that Resident #6 had not spent any money for personal expenses. During an interview with the Business Office Manager on 7/26/12 at 11:39 AM she stated that she notified the responsible party by telephone of the balance being within $200.00 of the spending limit but did not document this. She also indicated that she notified the Social Worker to start working with the families on spending down the funds for the resident. During an interview with the Social Worker on 7/26/12 at 12:30 PM she indicated that she did work with families to spend down funds within $200.00 of the spending limit on things such as pre burial need but did not have any documentation of this for resident #6. 1d. During a review of a list of resident's whose funds were managed by the facility, the list	F 159		

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F 159	Continued From page 4	F 159		

revealed that Resident #57 had an account balance of $583.05 as of 3/26/12. Further review of Resident #57's financial record revealed that the resident received $368.00 per month on 4/4/12, 5/7/12, 6/6/12 and 7/6/12 with an ending of $2055.21 on 7/26/12, which exceeded the resource limit. No debits for care costs were listed for the period 3/26/12 - 7/6/12. The record indicated that Resident #57 had not spent any money for personal expenses.

During an interview with the Business Office Manager on 7/26/12 at 11:39 AM she stated that she notified the responsible party by telephone of the balance being within $200.00 of the spending limit but did not document this. She also indicated that she notified the Social Worker to start working with the families on spending down the funds for the resident.

During an interview with the Social Worker on 7/26/12 at 12:30 PM she indicated that she did work with families to spend down funds within $200.00 of the spending limit on things such as pre burial need but did not have any documentation of this for resident #57.

2a. Review of the document titled " Resident Fund Management Service Authorization and Agreement to Handle Resident Funds " dated 10/7/09 revealed Resident #14 had a Resident Fund Account with the facility.

Review of the Annual Minimum Data Set (MDS) assessment dated 4/13/12 for Resident #14 revealed the resident was cognitively intact.

During interview with Resident #14 on 7/24/12 at

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F 159	Continued From page 5 1:47 PM she stated that she did have a personal funds account with the facility but was not issued a monthly statement. She indicated that she could get a statement or find out the balance if she asked. During interview with the Business Office Manager on 7/26/12 at 11:39 AM she stated that Resident #14 did have a personal fund account but she did not provide a quarterly statement of personal funds to Resident #14. The Business Manager said only provided quarterly statements to the Responsible Party, even for alert and oriented residents. 2b. Review of the document titled " Resident Fund Management Service Authorization and Agreement to Handle Resident Funds " dated 1/30/12 revealed Resident #12 had a Resident Fund Account with the facility. Review of the Quarterly Minimum Data Set (MDS) assessment dated 5/25/12 for Resident #12 revealed the resident was cognitively intact. During interview with the Business Office Manager on 7/26/12 at 11:39 AM she stated that Resident #12 did have a personal fund account but she did not provide a quarterly statement of personal funds to Resident #12. The Business Manager said only provided quarterly statements to the Responsible Party, even for alert and oriented residents. 2c. Review of the document titled " Resident Fund Management Service Authorization and Agreement to Handle Resident Funds " dated 7/1/08 revealed Resident #37 had a Resident	F 159		

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F 159	Continued From page 6 Fund Account with the facility. Review of the Quarterly Minimum Data Set (MDS) assessment dated 4/6/12 for Resident #37 revealed the resident was moderately cognitively impaired. During interview with the Business Office Manager on 7/26/12 at 11:39 AM she stated that Resident #37 did have a personal fund account but she did not provide a quarterly statement of personal funds to Resident #37. The Business Manager said only provided quarterly statements to the Responsible Party, even for alert and oriented residents.	F 159		
F 160 SS=B	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on financial records review and staff interview, the facility failed to convey resident funds money within 30 days of death for 2 of 3 sampled residents who had a Resident/Personal Fund Account with the facility (Resident #51 and #89) and failed to convey resident funds money to the appropriate party for 2 of 3 sampled residents who had a Resident/Personal Fund Account with the facility (Resident #88 and #89).	F 160	F-160 #1 Residents #51 #89, #88 no longer reside at the facility. #2 Current residents are at risk for the deficient practice. #3 Business Office Manager has been re-educated by the Nursing Home Administrator regarding the requirements of conveyance of personal funds upon death to convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. A Quality Improvement tool will be completed weekly x 12 weeks, then monthly x 9 months to identify appropriate conveyance of funds upon death within 30 days of death by the Business Office Manager. The Nursing Home Administrator will audit these results weekly x 12, the monthly x 9 months. #4 The Business Office Manager or Nursing Home Administrator will report the results of the Quality Improvement tool to the Performance Improvement committee monthly x 12 months to identify trends and need for further education and/or monitoring.	8/23/12

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F 160	Continued From page 7 Findings include: 1a. Financial record review revealed Resident #51 expired on 5/18/12. The Resident Fund Account was closed out on 7/10/12, 53 days after the resident had expired, and a check in the amount of $2,182.55 was mailed to the Clerk of Courts. During an interview with the Business Office Manager on 7/26/12 at 11:39 AM, the Business Manager stated that she was aware of the 30 day deadline for conveyance of funds but for Resident #51 she had initially been uncertain where to send the funds as the resident had previously lived in another State. 1b. Financial record review revealed Resident #89 expired on 12/5/11. Resident Fund Account was closed out on 1/10/12, 36 days after the resident had expired, and a check in the amount of $1,033.90 was mailed to the Social Security Administration. During an interview with the Business Office Manager on 7/26/12 at 11:39 AM, the Business Manager stated that she was aware of the 30 day deadline for conveyance of funds. 2a. Financial record review revealed Resident #88 expired on 12/5/11. The Resident Fund Account was closed out on 12/12/11, and a check in the amount of $1,000 was mailed to a funeral home. During interview with the Business Office manager on 7/26/12 at 11:39 AM she stated the resident had a burial fund so the Resident Fund	F 160		

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F 160	Continued From page 8 Account balance was transferred there. The Business Office Manager did not provide documentation authorizing this direct payment to the funeral home in lieu of the Responsible Party or Clerk of Court. 2b. Financial record review revealed Resident #89 expired on 12/5/11. Resident Fund Account was closed out on 1/10/12 and a check in the amount of $1,033.90 was mailed to the Social Security Administration. During interview with the Business Office Manager on 7/26/12 at 11:39 AM she stated that since she had received notification that Resident #89 had an overpayment from Supplemental Security Income (SSI) and owed $1,760 as of 10/5/11 (prior to expiring on 12/5/11) she believed she should convey the funds directly to the Social Security Administration. The Business Office Manager did not provide documentation authorizing this direct payment to the Social Security Administration in lieu of the Responsible Party or Clerk of Court.	F 160		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by:	F 309	F-309 #1 Resident #85 is receiving pain medication as ordered by the physician. Resident #85 is receiving skin care treatment as ordered by the physician. #2 Current residents have been re-assessed for pain management utilizing the "Pain Assessment Tool" which identifies location of pain, type of pain, duration of pain and verbal and/or non-verbal indicators of pain. The attending phyician has been notified of any residents that exhibit verbal or non-verbal indication of inadequate pain management with orders received and carried out as indicated by the physician. The assessments were completed by the Weekend Supervisor and/or Unit Manager and reviewed by the Director of Clinical Services.	8/23/12

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F 309	Continued From page 9 Based on observation, resident and staff interview and record review, the facility failed to put interventions in place for pain and failed to provide skin care treatment as ordered for 1 of 2 residents (Resident #85). The findings included: 1a. Resident #85 was admitted to the facility on 7/5/12. Cumulative diagnoses included pressure ulcer to the heel. The admission Minimum Data Set (MDS) dated 7/12/12 indicated that Resident #85 had moderate cognitive impairment, required extensive assistance of 2 persons for bed mobility, had an unstageable pressure ulcer (right heel) and denied having pain. Physician orders dated 7/17/12 included "betadine swab right heel, wipe away excess, dry dressing daily". Nurse s notes dated 7/19/12 at 3:10 PM indicated the physician was faxed requesting something for pain for Resident #85. Review of Resident #85's physician orders revealed no order for pain medication. During an interview on 7/23/12 at 4:39 AM, Resident #85 said that his feet hurt most of the time but his doctor did not want to write a prescription for a pain reliever. He added that he got some relief with repositioning his feet which he could do independently. On 7/25/12 at 2:35 PM, Nurse #1 was observed providing treatment to Resident # 85's right heel as ordered. At the beginning of the treatment,	F 309	Continued from Pg 9 #3 Current licensed nurses have been re-educated by the Director of Clinical Services, Unit Manager, and/or Weekend Supervisor on pain management policy and procedure, providing skin care treatments as ordered, and residents with new onset of pain will be documented on the 24 hour report until resolved with an order and/or follow up by the physician. This education will be reviewed during the orientation process for newly hired licensed nurses by the Unit Manager or Director of Clinical Services. A Quality Improvement tool will be completed for three (3) residents receiving skin treatments by the Director of Clinical Services, Unit Manager, and/or weekend supervisor by direct observation of treatments being performed as ordered, resident interview, and if verbal or non-verbal indicator of pain present that interventions are in place. This tool will be completed daily x 14 days, then daily x 5 days/week x 2 weeks, then 3/x per week x 2 weeks, then weekly x 2 weeks, then monthly x 10 months. #4 The Director of Clinical Services or Unit Manager will report the results of the Quality Improvement tool to the Performance Improvement committee monthly x 12 months to identify trends and need for further education and/or monitoring.	

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F 309	Continued From page 10 Nurse #1 asked the resident if he had any pain. The resident said that his right foot hurt. Nurse #1 proceeded with the treatment. During the treatment, Nurse #1 again asked if he was having pain. The resident said yes. Nurse #1 stated, "I apologize." Resident #85 replied, "You apologize every day." Immediately upon completion of the treatment Nurse #1 asked the resident about pain. The resident said he had no pain at this time but will have pain again. During a follow-up interview on 7/25/12 at 3:10 PM, Resident #85 said that he had pain in his right foot most of the time. He said sometimes the pain kept him awake at night, or if he did fall asleep, his foot was hurting when he awoke. During an interview on 7/25/12 at 3:15 PM, Nurse #1 stated that Resident #85's level of pain was hard to judge. "He does not pull back or flinch unless I actually touch the heel. He says he has pain in his right heel." Nurse's notes dated 7/25/12 at 3:25 PM indicated the physician was faxed again regarding pain medication. During an interview on 7/26/12 at 9:45 AM, Nurse #1 stated that the faxed request for pain medication on 7/19/12 should have been followed up by the nurse on 7/20/12. Nurse #1 stated that she did not pursue getting an order for pain medication for Resident #85 because he did not act like he was having pain and only complained of pain when asked. Nurse #1 indicated that typically, if a resident had pain during a treatment, she would see that the resident was pre-medicated.	F 309		

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F 309	Continued From page 11 During an interview on 7/25/12 at 10:03 AM, the Director of Nursing (DON) indicated that she expected pain assessments to be done before and during treatment. If the resident expressed pain, she would expect some type of pain relieving measures to be taken. 1b. Resident #85 was admitted to the facility on 7/5/12. Cumulative diagnoses included incontinence associated dermatitis involving buttocks. Physician orders dated 7/5/12 included an order for Calmoseptine (a moisture barrier ointment) to buttocks every shift and as needed. A Progress Note dated 7/17/12 revealed that Resident #85 was evaluated by a Wound Ostomy Clinician (WOC). The treatment plan included Lotrimin cream to buttocks twice a day then cover completely with Calmoseptine. Physician orders dated 7/17/12 included Lotrimin cream to buttocks twice a day and continue Calmoseptine over Lotrimin cream to moisture proof. On 7/25/12 at 2:35 PM, Nurse #1 was observed providing treatment to Resident #85. Nurse #1 applied the Calmoseptine first to two open areas on the buttocks, then applied the Lotrimin over the Calmoseptine. The buttocks were a deep red color. Nurse #1 indicated that they were much improved since starting the Lotrimin cream. During an interview on 7/25/12 at 3:15 PM, Nurse #1 indicated that the WOC came to the facility every other Tuesday and she accompanied the WOC on rounds. Nurse #1 indicated that the	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345442	A. BUILDING _____ B. WING _____	07/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 12 WOC verbally communicated to her that the Calmoseptive was to be applied first, then the Lotrimin. Nurse #1 acknowledged the discrepancy between the written orders, and her understanding of the verbal communication. Nurse #1 indicated that clarification was needed.	F 309		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356	F-356 #1 Daily staffing with accurate information is posted daily. #2 No residents were identified #3 The Director of Clinical Services and Unit Manager were educated to the requirements of posting accurate, complete staffing information to include census on a daily basis by the Nursing Home Administrator. The weekend supervisor and licensed nurses were educated regarding posting of the daily staffing by the Direcotr of Clinical Service and/or Unit Manager. A Quality Improvement tool will be completed by the Nursing Home Administrator or designee daily 5 x week x 2 weeks, then 3 x week x 2 weeks, then weekly x 8 weeks to ensure daily staffing posting is accurate and complete. #4 The Nursing Home Administrator or Director of Clinical Services will report the results of the Quality Improvement tool to the Performance Improvement committee monthly x 3 months to identify trends and need for further education and/or monitoring.	8/23/12

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F 356	Continued From page 13 This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interview, the facility failed to post daily staffing with accurate information for 4 out of 4 days. The findings include: On 7/23/12 at 2:47 pm, during the initial tour of the facility, the daily staff posting was observed on the bulletin board across from the nurse's station. On the board, hung a staff posting from 7/21/12 that lacked resident census. On 7/24/12 at 4:55 pm, the 7/23/12 staffing hung alongside the current staffing, dated 7/24/12, however, it still lacked the resident census. The Assistant Director of Nursing was interviewed on 7/24/12 at 5:45 pm. She explained that she completed the daily staffing and was putting staff, being trained during orientation on all of the forms, for nursing staff. Further, she stated that she completed the weekend staffing on Fridays and left them for the weekend supervisor to post. She stated that she purposely left the resident census off of the form because she does not have that information when she left the papers on Fridays. She stated that her weekend staff has not been trained how to complete the staffing or how to update the form when staffing needed to be adjusted or resident census changed. She indicated that she hoped to train her weekend staff so that they could comply with the	F 356		

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F 356	Continued From page 14 regulations.	F 356		

RECEIVED
SEP 0 4 2012
CONSTRUCTION SECTION

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

PRINTED: 08/24/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III-protected construction, one story, with a complete automatic sprinkler system. Facility is using NCSBC-special locking. The deficiencies determined during the survey are as follows:	K 000	This Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in this Statement of Deficiencies. This Plan of Correction is prepared solely because it is required by State and Federal law.	
K 012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.6.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings include: facility had unsealed penetration in one hour rated of building. To maintain construction rating of building penetrations must be seal. Locations of penetrations: 1. gas furnace room off C-hall. 2. smoke wall in attic off F-hall. 42 CFR 483.70(a)	K 012	**K 012** 1) The penetrations in the gas furnace room on C-Hall and smoke wall in attic on F-Hall shall be sealed with approved fire-stop material. 2) The Administrator and Maintenance Director shall inspect the facility for other unsealed penetrations and repair them with approved fire-stop material. 3) The Maintenance Director shall maintain a log of any installation work that includes penetration of one hour rated fire barriers within the facility. The log shall indicate the date and locations of the penetrations and the material used to seal the penetrations. 4) The Maintenance Director shall attend monthly facility safety committee meetings and review the penetration log to assure compliance.	9-28-12
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD	K 029		

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

Richard M. Bryan, Administrator — 9-4-12

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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K 029	Continued From page 1 One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings include: dry storage room door and Med. records door are not self closing. 42 CFR 483.70(a)	K 029	**K 029** 1) Automatic door closers shall be installed on the dry storage room door in the kitchen and the medical records room door on C-Hall. 2) The Administrator and Maintenance Director shall inspect the facility for any other hazardous areas that have doors without self-closing devices. Automatic door closers shall be installed as needed. 3) The Maintenance Director shall inspect all hazardous area room doors in the facility each month to assure the automatic door closers are in place and operational. This inspection shall be part of the Maintenance Director's monthly preventative maintenance schedule. 4) The Maintenance Director shall attend monthly facility safety committee meetings and review the facility's preventative maintenance schedule to assure compliance.	9-28-12
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the	K 056	**K 056** 1) Cited sprinkler valves connected to the system accelerator shall be electrically connected the facility's fire alarm system with a tamper switch. 2) SimplexGrinnell shall inspect all other sprinkler valves and install tamper switches as needed.	9-28-12

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K 062 SS=E	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 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings include: facility could not provide proper documentation that the 3 year full flow test and 5 year obstruction investigation has been performed on sprinkler system. 42 CFR 483.70(a)	K 062	**K 062** 1) Documentation of the three year full flow test and five year obstruction investigation of the facility's sprinkler system shall be obtained from SimplexGrinnell and be submitted with this Plan of Correction. 2) The Maintenance Director shall maintain a permanent file or binder containing records of all required sprinkler system repairs, tests and equipment installations. 3) The Maintenance Director shall attend monthly facility safety committee meetings and review any sprinkler system work that was done to assure compliance.	9-28-12
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised	K 144		

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K 144	Continued From page 3 under load for 30 minutes per month in accordance with NFPA 99, 3.4.4.1. This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:00 am onward, the following items were noncompliant, specific findings include: at time of survey staff could not get generator to crank under test. 42 CFR 483.70(a)	K 144	**K 144** 1) Kraftpower Company shall be contacted to service the facility's emergency power generator to determine why the generator did not start on test mode and repair accordingly. 2) The Kraftpower service technician shall educate the Maintenance Director on the procedure to start the generator on test mode. 3) The Maintenance Director shall include running the emergency power generator on test mode on the monthly preventative maintenance schedule. 4) The Maintenance Director shall attend monthly facility safety committee meetings and review the monthly preventative maintenance schedule to assure compliance.	9-28-12

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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