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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345070	A. BUILDING _____ B. WING _____	C 03/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DURHAM NURSING & REHABILITATION CENTER	411 S LASALLE STREET DURHAM, NC 27705

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F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with resident and staff, the facility failed to provide mouth care to maintain dignity for 1 of 3 sampled residents (Resident #26) reviewed in Stage 2 for dignity. Findings include: Resident #26 was readmitted to the facility on 4/15/11. Resident #26 had diagnoses including chronic obstructive pulmonary disease, chronic pain, and osteoarthritis. The care plan, most recently updated on 11/21/11, indicated the resident required assistance with and/or provision for activities of daily living (ADLs) which include mouth care. Goals included that the resident would experience cleanliness and comfort each day and receive assistance, as needed, for ADLs each day. Interventions included that staff would set up supplies and cue the resident to perform oral hygiene twice a day. Resident #26's annual Minimum Data Set (MDS), dated 11/19/12, indicated the resident was cognitively intact, participated in the assessment, and did not exhibit behaviors of rejecting care.	F 241	This Plan of Correction is submitted as required under State and Federal Law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statement made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding. F241 The facility does and will continue to promote care for residents in a manner that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 1. Resident #26 was provided mouth care on 03/07/13 and will continue per ADL Care Guide. 2.A list of residents having the potential to be affected was compiled on 03/08/13 by the Minimum Data Set Coordinator utilizing the assessment criteria: (setup and/or supervision through total care – personal hygiene) from the Minimum Data Set 3.0.	3/31/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Freda Wright — TITLE: Administrator — (X6) DATE: 4/1/2013

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 241	Continued From page 1 The resident's functional status indicated that for personal hygiene, self-performance, he needed extensive assistance. The Nursing Summary assessment dated 2/28/13 stated the resident was "cognitively intact. He is able to make decisions regarding his clothing and daily activities independently." It indicated he did not reject care, and was easily understood. It stated the resident, "continues to require extensive to total assist with his ADLs secondary to his [diagnoses] of [right] hip disarticulation, osteoarthritis, multi joint contractures and chronic pain." At 11:43am on 3/4/13, Resident #26 stated, "They don't help me brush my teeth. I have asked them to help me, but they don't. They said they would do it 'when they get around to it'." Resident #26's teeth were observed to be covered with a thick, white/yellow coating covering the surface of and in between all visible teeth. At 1:50pm on 3/5/13, Resident #26 stated, "No one has brushed my teeth today or yesterday. I asked them. It was either on the third shift or first shift." Resident #26's teeth were covered with a thick, white/yellow coating covering the surface of and in between all visible teeth. The nursing assistant (NA) assignment sheet dated 3/5/13 for the third shift (11pm-7am) indicated that NA#1 worked and was assigned to Resident #26. A review of ADL care on 3/5/13 for the third shift (11pm-7am) indicated that NA #1 had not documented any ADL care for Resident #26.	F 241	Mouth care was provided by Certified Nursing Assistants to the residents identified on 03/08/13 and will continue per ADL Care Guide. Also beginning 3/08/13 highlighted in Orientation process. 3. An in-service was conducted by DON and Supervisors 3/08/13-3/31/13 for Licensed Nurses and Certified Nursing Assistants regarding mouth care/oral hygiene and the requirements that the facility staff is responsible for performing and documenting. 4. Observation audits of 10 residents will be performed by the Unit coordinator or Supervisor during rounds five times for one week, then three times a week for three weeks, then once a week times two months or until compliance is achieved. The results of this audit will be noted and reviewed in the monthly Quality Assurance Performance Improvement meeting. The results will be brought to the monthly Quality Assurance Performance Improvement Meeting by the Director of Nursing. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to	

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F 241	Continued From page 2 At 1:45pm on 3/6/13, Resident #26's teeth were covered with a thick, white/yellow coating covering the surface of and in between all visible teeth. At 2:47pm on 3/6/13, Resident #26 stated, "I asked [NA #1] this morning if she would brush my teeth. She just ignored me. It makes me feel neglected when I ask them and they won't help me." His teeth were covered with a thick, white/yellow coating covering the surface of and in between all visible teeth. The NA assignment sheet dated 3/6/13 for the third shift (11pm-7am) indicated that NA#2 worked and was assigned to Resident #26. At 10:25am on 3/7/13, Resident #26 stated, "I used to brush my teeth myself, but not anymore. My arms can't take it." NA#2 was unavailable for telephone interview at 12:00pm and 3:18pm on 3/7/13. At 10:55am on 3/7/13, the DON was interviewed regarding ADL care. She stated, "That is from washing a person's face, brushing teeth, and shaving. It is what I call AM care. That is care that is usually done on the first shift. AM care should be done on a daily basis." At 11:31am on 3/7/13, NA#1 was interviewed. She stated, "I work 11pm to 7am. We provide ADL care that includes brushing teeth, shaving, bed baths, showers. Shaving is done when needed and brushing their teeth is done when we get them up or when their mouth looks terrible." When asked about the last time that she was	F 241	ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services.	

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F 241	Continued From page 3 assigned to Resident #26 and the mouth care he required she stated, "I think it was [3/3/2013] when I took care of [Resident #26]. Sometimes I get him up in his chair and he brushes his teeth. He uses the toothbrush and I stand there with him. He uses his hands good, kinda, sort of." NA #1 also said, "Brushing teeth should be done every day."	F 241	F 280 1. Resident #18 care plan and ADL Care guide has been updated on 3/08/13 to reflect the current splint/device goals, interventions and instructions.	3/11/13
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to update a care plan for contracture management. The care plan lacked instructions	F 280	2. An audit was completed by the MDS Coordinator and Supervisors on 03/11/13 for residents with splints/devices having the potential to be affected to ensure care plan goals, interventions/instructions were updated on resident care plan and ADL Care Guide. 3. Clinical/Rehabilitation Manager(s) and Minimum Data Set Coordinator were in-serviced on 03/11/13 by Director of Nursing on F280 requirements to include developing, revising and updating the resident's plan of care periodically and as needs change. 4. The DON, Unit Organizer and Supervisors will audit five care plans with splints/devices 5 days week for four weeks, then five care plans once a month for 2 months and/or until compliance is achieved to ensure care plan goals, interventions are updated. The results of this audit will be noted and reviewed in the monthly Quality	

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F 280	Continued From page 4 for nursing to apply a device in the right hand when the splint was not used by therapy for one of three sampled residents with contractures. Resident #18. The findings included: Resident # 18 was admitted to the facility on 10/7/10 with diagnoses including hemiplegia, dementia, and diabetes. Review of a quarterly Minimum Data Set (MDS) dated 11/28/12 recorded Resident # 18 had long and short term memory problems and could not be interviewed. Resident #18 required extensive to total assistance by staff for all activities of daily living. The quarterly MDS assessed Resident #18 with limitations in movement of both upper and lower extremities. Review of a care plan dated 6/14/12 revealed problems of falls and decreased activity of daily living. These problems were related to impaired physical mobility due to hemiplegia and multi-joint contracture. There were no goals or approaches related to actual contracture management. The use of the carrots by nursing staff was not listed as an approach under another problem on the care plan. The physician ' s orders dated 2/26/13 were for occupational therapy to treat the right hand, apply a splint for four hours, then upgrade to six hours. Resident #18 was to wear carrots (positioning device shaped like a carrot which would prevent the fingers from closing into the palm) when splints were not worn. The staff was to monitor the carrots to ensure placement in her hand.	F 280	Assurance Performance Improvement meeting. The results will be brought to the monthly Quality Assurance Performance Improvement Meeting by the Director of Nursing. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services.	

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F 280	Continued From page 5 Interview with nurse #1 on 3/6/13 at 4:00 PM revealed she was not aware Resident #18 was supposed to have the carrot in place after the splint was removed from the right hand. Interview with aide #1 on 3/6/13 at 4:10 PM revealed she was not aware a carrot was to be used in Resident # 18 ' s right hand. Interview with nurse #2 on 3/6/13 at 4:13 PM revealed she was not aware Resident # 18 should have a carrot in place in her right hand. Further interview revealed therapy was working with Resident #18 and they were responsible for the splint and use of the carrot. Interview on 3/6/13 at 2:10 PM with administrative nurse #2 revealed updates to the care plans used to be done for changes. Staffing hours had been decreased and interim changes were not made for areas on the care plan. She further explained she would make sure problems of a long term nature would be updated, but other problems may or may not make it to the care plan. The process of communicating updates occurred during the administrative morning meetings.	F 280	F 312 1.Resident #26 was provided mouth care on 03/07/13 and thereafter per ADL Care Guide. 3/31/13 2. A list of residents having the potential to be affected was compiled on 3/08/13 by the Minimum Data Set Coordinator utilizing the assessment criteria: (setup and/or supervision through total care – personal hygiene) from the Minimum Data Set 3.0. Mouth care was provided by Certified Nursing Assistants to the residents identified on 03/08/13 and thereafter per ADL Care guide. 3. An in-service was conducted by DON and Nursing Supervisors 3/08/13-3/31/13 for Licensed Nurses and Certified Nursing Assistants regarding mouth care/oral hygiene and the requirements that the facility staff is responsible for performing and documenting. 4. Observation audits of 10 residents will be performed by the Unit coordinator or Supervisor during rounds five times for one week, then three times a week for 3 weeks, then once a week times two months	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced			

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F 312	Continued From page 6 by: Based on observation, record review, and interviews with resident and staff, the facility failed to provide assistance for brushing a resident's teeth for 1 of 2 sampled residents (Resident #26) reviewed in Stage 2 for activities of daily living (ADLs). Findings include: Resident #26 was readmitted to the facility on 4/15/11. Resident #26 had diagnoses including chronic obstructive pulmonary disease, chronic pain, and osteoarthritis. The care plan, most recently updated on 11/21/11, indicated the resident required assistance with and/or provision for ADLs which include mouth care. Goals included that the resident would experience cleanliness and comfort each day and receive assistance, as needed, for ADLs each day. Interventions included that staff would set up supplies and cue the resident to perform oral hygiene twice a day. Resident #26's annual Minimum Data Set (MDS), dated 11/19/12, indicated the resident was cognitively intact, participated in the assessment, and did not exhibit behaviors of rejecting care. The resident's functional status indicated that for personal hygiene, self-performance, he needed extensive assistance. The Nursing Summary assessment dated 2/28/13 stated the resident was "cognitively intact. He is able to make decisions regarding his clothing and daily activities independently." It indicated he did not reject care, and was easily understood. It	F 312	and/or until compliance achieved. The results of this audit will be noted and reviewed in the monthly Quality Assurance Performance Improvement meeting. The results will be brought to the monthly Quality Assurance Performance Improvement Meeting by the Director of Nursing. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services.	

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F 312	Continued From page 7 stated the resident, "continues to require extensive to total assist with his ADLs secondary to his [diagnoses] of [right] hip disarticulation, osteoarthritis, multi joint contractures and chronic pain." At 11:43am on 3/4/13, Resident #26 stated, "They don't help me brush my teeth. I have asked them to help me, but they don't. They said they would do it 'when they get around to it'." Resident #26's teeth were observed to be covered with a thick, white/yellow coating covering the surface of and in between all visible teeth. At 1:50pm on 3/5/13, Resident #26 stated, "No one has brushed my teeth today or yesterday. I asked them. It was either on the third shift or first shift." Resident #26's teeth were covered with a thick, white/yellow coating covering the surface of and in between all visible teeth. The NA assignment sheet dated 3/5/13 for the third shift (11pm-7am) indicated that NA#1 worked and was assigned to Resident #26. A review of ADL care on 3/5/13 for the third shift (11pm-7am) indicated that NA #1 had not documented any ADL care for Resident #26. At 1:45pm on 3/6/13, Resident #26's teeth were covered with a thick, white/yellow coating covering the surface of and in between all visible teeth. At 2:47pm on 3/6/13, Resident #26 stated, " I asked [NA #1] this morning if she would brush my teeth. She just ignored me. It makes me feel	F 312		

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F 312	Continued From page 8 neglected when I ask them and they won't help me." His teeth were covered with a thick, white/yellow coating covering the surface of and in between all visible teeth. The NA assignment sheet dated 3/6/13 for the third shift (11pm-7am) indicated that NA#2 worked and was assigned to Resident #26. At 10:25am on 3/7/13, Resident #26 stated, "I used to brush my teeth myself, but not anymore. My arms can't take it." NA#2 was unavailable for telephone interview at 12:00pm and 3:18pm on 3/7/13. At 10:55am on 3/7/13, the DON was interviewed regarding ADL care. She stated, "That is from washing a person's face, brushing teeth, and shaving. It is what I call AM care. That is care that is usually done on the first shift. AM care should be done on a daily basis." At 11:31am on 3/7/13, NA#1 was interviewed. She stated, "I work 11pm to 7am. We provide ADL care that includes brushing teeth, shaving, bed baths, showers. Shaving is done when needed and brushing their teeth is done when we get them up or when their mouth looks terrible." When asked about the last time that she was assigned to Resident #26 and the mouth care he required she stated, "I think it was [3/3/2013] when I took care of [Resident #26]. Sometimes I get him up in his chair and he brushes his teeth. He uses the toothbrush and I stand there with him. He uses his hands good, kinda, sort of." NA #1 also said, "Brushing teeth should be done every day."	F 312		
F 318	483.25(e)(2) INCREASE/PREVENT DECREASE	F 318		

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F 318 SS=D	Continued From page 9 IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and medical record reviews, facility staff failed to apply splinting devices as instructed by Occupational Therapy for one of three sampled residents with contractures (Resident #18) The findings included: Resident # 18 was admitted to the facility on 10/7/10 with diagnoses including hemiplegia, dementia, and diabetes. Review of a quarterly Minimum Data Set (MDS) dated 11/28/12 recorded Resident # 18 had long and short term memory problems and could not be interviewed. Resident #18 required extensive to total assistance by staff for all activities of daily living. The quarterly MDS assessed Resident #18 with limitations in movement of both upper and lower extremities. Review of a care plan dated 6/14/12 revealed problems of falls and decreased activity of daily living related to impaired physical mobility due to hemiplegia and multi-joint contracture. There were no approaches related to actual contracture	F 318	F318 1. Resident # 18 splint/device is applied as instructed by occupational therapy on beginning on 3/7/13. 2. Residents with splints/devices that have the potential to be affected have been reviewed by Director of Nursing, Supervisors and Unit Organizers as of 3/11/13 for application of splint/device per orders and/or Occupational Therapy instruction. ADL Care Guides updated to reflect current resident needs. Beginning 3/11/13 will be highlighted in Orientation Process. 3. An in-service beginning 3/11/13 to 3/31/13 conducted by Director of Nursing, Nursing Supervisors and Unit Organizer for Licensed Nurses and Certified Nursing Assistants regarding application of splints/devices according to orders/Occupational Therapist instructions. The in-service included the care plan needs of the resident is communicated to the care staff on the ADL Care Guide (Kiosk). 4. The DON, Nursing Supervisors, Unit Organizer will audit five care plans with splints/devices five times a week for four	3/31/13

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F 318	Continued From page 10 management. Review of the occupational therapy notes dated 2/26/13 revealed an evaluation was completed. Resident #18 was referred to therapy due to a decline in range of motion in the right hand. After therapy evaluation, an order was written by the therapist dated 2/26/13 for the splinting management. Occupational therapy would treat the right hand, apply a splint for four hours, then upgrade to six hours. Resident #18 was to wear carrots (positioning device shaped like a carrot which would prevent the fingers from closing into the palm) when splints were not worn. The nursing staff was to monitor the carrots to ensure placement in her hand. Review of the therapy note dated 2/27/13 revealed education was provided to a nursing staff on placing the carrot in the resident ' s right hand after the splint was removed by therapy. Nursing staff were instructed to monitor the resident to ensure the carrot was kept in her hand. Observations on 3/4/13 at 2:47 PM revealed Resident #18 did not have the carrot in her hand. It was lying on the bed covers. Observations on 3/5/13 at 11:00 AM revealed Resident #18 did not have the splint on the right hand, and the carrot was not in the right hand. Observations on 3/6/13 at 4:00 PM revealed Resident #18 did not have the carrot in her hand. Interview with nurse #1 on 3/6/13 at 4:00 PM	F 318	weeks then five care plans once a month for 2 months or until compliance is achieved to ensure care plan goals, interventions are updated. The results of this audit will be noted and reviewed in the monthly Quality Assurance Performance Improvement meeting. The results will be brought to the monthly Quality Assurance Performance Improvement Meeting by the Director of Nursing. Any issues or trends identified will be addressed by the Quality Assurance Performance Improvement Committee as they arise and the plan will be revised to ensure continued compliance. The Quality Assurance Performance Improvement Committee consists of the Administrator, the Director of Nursing, MDS Coordinator, Admission Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	345070	A. BUILDING _____ B. WING _____	C 03/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 318	Continued From page 11 revealed she was not aware Resident #18 was supposed to have the carrot in place after the splint was removed from the right hand. During the interview, Nurse #1 entered Resident #18 ' s room, looked in the bedside drawers and on the floor, but did not find the carrot. Interview with Aide #1 on 3/6/13 at 4:10 PM revealed she was the aide for Resident #18 and was not aware a carrot was to be used in her right hand. Interview with Nurse #2 on 3/6/13 at 4:13 PM revealed she was the nurse for Resident #18, but was not aware the resident should have a carrot in place in her right hand. Further interview revealed therapy was working with Resident #18 and they were responsible for the splint and use of the carrot. Interview with occupational therapy staff member on 3/7/13 at 10:14 AM revealed she placed a splint on the right hand for four hours. After the splint was removed, the carrot was placed in the right hand. Continued interview revealed the nursing staff were to place the carrot in the right hand. If the carrot was soiled, the staff could put a towel in her hand. A therapy note for education was provided to an aide, a nurse and charge nurse. When asked if the carrot was missing on 3/6/13, she reported it was behind the dresser in the room. When asked how important was it for nursing staff to ensure the carrot was in Resident #18 right hand, she responded " very important. " It was further explained the resident did have slight movement in her fingers and the carrot could come out of her hand.	F 318		

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F 318	Continued From page 12 Interview on 3/7/13 at 3:00 PM with administrative nursing staff member revealed the aides know the updates on resident care by reviewing the Kiosk (computer for documentation by the aides). Nursing staff would monitor the resident by making frequent observations of the resident.	F 318		

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	345070	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ APR 25 2013	04/10/2013

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, one story, with a complete automatic sprinkler system. The facility has a license for 126 beds, current census was 81. The deficiencies determined during the survey are as follows:	K 000	This Plan of Correction is submitted as required under State and Federal Law. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute a deficiency, or that the scope and severity determination is correct. Because the facility makes no such admissions, the statement made in the Plan of Correction cannot be used against the facility in any subsequent administrative or civil proceeding.	4/14/13
K 032 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) Based on observation on 4/10/2013 at approximately noon the following exit egress was non-compliant, specific findings include; exit doors #2 and #10 did not release with fire alarm activation. The doors did release with delayed egress.	K 032	K Tag 032 1. The Center's Maintenance Director checked all exit doors for releasing with fire alarm activation. 2. Simplex Grinnell installed 2 relays in the fire alarm system to deactivate the maglocks on all doors when fire alarm is activated. 3. The Maintenance Director will run a weekly check for doors to release during fire alarm activation for 4 weeks then check door release following our fire drill schedule and place results on the fire drill record. 4. Results of these weekly and monthly checks will be submitted to the Monthly Safety Committee	
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8	K 045		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Freda Wright — TITLE: Administrator — (X6) DATE: 4/25/13

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

DRW

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	345070	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/10/2013

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K 045	Continued From page 1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 4/10/13 at approximately noon the following egress illumination was observed as non-compliant, specific findings include; the prayer room would leave the patient in darkness.	K 045	for review. The Safety Committee minutes will be reviewed in the Monthly Quality Assurance Performance Improvement meeting. The QAPI committee consists of the Administrator, the Director of Nursing, MDS Coordinator, Admissions Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager and Activity Manger.	
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	K Tag 045 1. The Center's Maintenance Director inspected all current egress illumination for compliance. 2. Lighting was installed on 4/18/13 in the Prayer room. The light is wired into emergency circuit EM-A1-8. 3. System was checked on emergency power. This check will be done weekly time four weeks, then monthly with fire drill schedule. Results will be recorded on the fire drill form. 4. Results of these weekly and monthly checks will be submitted to the Monthly Safety Committee	4/19/13
K 062 SS=D	This STANDARD is not met as evidenced by: 42 CFR 483.70(a) Based on record review and staff interview, the facility fire alarm system was not being tested in accordance with NFPA 70 and 72, specific findings include; the smoke detector sensitivity testing had not been conducted within the past two years. NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are	K 062		

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K 062	Continued From page 2 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: 42 CFR 483.70(a) Based on record review and staff interview, the facility sprinkler system was not being tested in accordance with NFPA 25 - Standard for the Inspection, Testing and Maintenance of Water-Based Fire Protection Systems (1999 edition), documentation indicated failure to demonstrate inspection, testing and maintenance in accordance with NFPA 25 1-4.2. specific findings include; A Documentation indicated the quarterly inspections had not been completed over the past year. Records indicate a quarterly inspection 5/8/12 and an annual inspection 10/4/12. B. Documentation indicated the five year calibration for all gauges had been last conducted on 2/1/08.	K 062	for review. The Safety Committee minutes will be reviewed in the Monthly Quality Assurance Performance Improvement meeting. The QAPI committee consists of the Administrator, the Director of Nursing, MDS Coordinator, Admissions Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager and Activity Manger. K Tag 052 We are in compliance with this tag. Sensitivity testing was done on 3/4/12. Copy scanned with the POC. K Tag 062 1. Testing of the center's sprinkler system was completed on 4/11/13 by Simplex Grinnell. 2. For compliance all quarterly fire sprinkler inspections will be schedule one year in advance. (See schedule with Simplex Grinnell sent with POC)	4/19/13
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 067		4/19/13

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K 067	Continued From page 3 This STANDARD is not met as evidenced by: At the time of survey, the facility was using the corridor as a return air plenum. Note: If a waiver is requested, the provider must certify that the following conditions are met: (1) Air handling units must be equipped with smoke detectors. (2) There must be a complete corridor smoke detection system. (3) Smoke detectors must be wired to the fire alarm system. (4) Fire alarm system must shut down all air handling units when activated.	K 067	K Tag 067 1. Waiver requested as center uses the corridor as a return air plenum. 2. Air handling units are equipped with smoke detectors 3. Smoke detectors are wired to the fire alarm system 4. Fire alarm system shuts down all air handling units when activated.	4/19/13