JUN 2 7 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345044	A. BUILDING ______ B. WING ______	C 05/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH OF THE PINES HEALTH	103 GOSSMAN DRIVE SOUTHERN PINES, NC 28387

(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 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 record review, staff and resident interviews, the facility failed to honor a resident's request for toileting in a timely manner resulting in the resident soiling herself for 1 of 3 sampled residents interviewed. (Resident # 216). The findings included: Resident #216 was admitted to the facility on 4/9/13 with multiple diagnoses including right proximal humerus fracture and status post right total shoulder arhroplasty (shoulder joint replacement procedure). The admission Minimum Data Set (MDS) assessment dated 4/16/13 indicated that Resident #216's cognition was intact and she needed extensive assistance with toileting and transfer. The nurse's notes dated 5/8/13 at 11:32 PM and 5/14/13 at 1:03 AM indicated that Resident #216 was continent of bowel and bladder and needed assistance to the bathroom. On 5/11/13 at 4:15 PM, the notes indicated that the resident needed assistance with activities of daily living (ADLs) due to being unable to fully use her right arm. On 5/14/13 at 11:30 AM, Resident #216 was interviewed. She stated that she soiled herself most of the time waiting for the staff to answer	F 241	Resident #216 was interviewed by Sharon Wilson, Registered Nurse and Dianne Gadd, Assistant Director of Nursing regarding call bell response and whether it had improved. She responded that it had improved and was very grateful. Dianne Gadd, Assistant Director of Nursing addressed and in-serviced the nurse aide as well. All other alert and oriented residents have been randomly interviewed by Jennifer Belton, Licensed Practical Nurse and Sue Morrison Registered nurse as well as Valeria Clark, Director of Nursing on each shift, including weekends to determine call bell response. Most residents have responded that call bell response has been quick within 1 to 10 minutes. For those that responded that call bell response was slow, the clinical staff, (nurse aide, licensed practical nurses, registered nurses) was educated and the residents were re-interviewed. Follow up interviews done by Valeria Clark, Director of nursing, Jenifer Belton, Licensed practical nursing, Sue Morrison, Registered Nurse, Sharon Wilson, Registered Nurse, indicated that call bell response had improved greatly. All Nurse Aide's and Licensed Practical Nurses, in both long term care and rehab, have been re-in serviced by Dianne Gadd, RN, Assistant Director Of Nursing and Melissa Cohen, RN, shift supervisor. The in-services were held on 5/20, 21 & 25.	7/1/13

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

TITLE Administrator

(X6) DATE 6/24/13

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.

PRINTED: 05/22/2013
FORM APPROVED
OMB NO. 0938-0391

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F 241	Continued From page 1 the call light to take her to the bathroom. She further stated that this morning (5/14/13) she had " dirty " (meaning soiled) herself waiting for the staff. She indicated that she had told NA #2 (assigned to her) that she needed to go to the bathroom after breakfast. NA#2 had told her to turn her light on when she was finished with breakfast and she would be back. NA #2 never came back. She added " it is so embarrassing. " On 5/15/13 at 9:30 AM, NA #2 was interviewed. She denied that the resident had told her that she needed to go to the bathroom. She stated that she was busy picking up the trays and she did not see the call light. On 5/15/13 at 4:45 PM, administrative staff #5 was interviewed. She stated that she had interviewed Resident #216, NA#2 and NA #3. During administrative staff #5's interview with Resident #216, she indicated that she had told NA #2 that she needed to go to the bathroom after breakfast. NA #2 had told her to turn her light on and she (NA #2) would be back. The resident had turned her light on after breakfast and it took a while before NA #3 came to the room. The resident asked NA#3 to take her to the bathroom and NA #3 did but the resident had already soiled herself. Resident #216 also told administrative staff #5 that NA #2 never came back to her room. Administrative staff #5 also revealed that the information provided by the resident during her interview had matched those provided during the interview with NA#3. NA #3 stated that she was with another resident when she saw Resident #216's light was on. When she (NA#3) was finished, she went to answer the light. Resident #216 had asked to take her to the	F 241	They will be held again by Director of Nursing on 7/1, 3 and completion on 7/5, explaining the importance of dignity and keeping up with the call bell so that everyone, all clinical staff, will understand the huge importance it plays in a resident's well-being. Also clinical staff will be working on customer service through Sharon Wilson, RN. Corrective action will be implemented to enforce the importance, on an individual basis, up to suspension/termination or re-education/training. St. Joseph of the Pines is implementing a new position, companion aide, to help out at the meal times from 7a-7p to cover each meal. This will allow the nurse aide to answer call bells in a more timely fashion and will free up the nurse aides so that they can be out on the floors attending to residents' needs. the nurse aide was located when the call bell was going off. The call bell will also ring at the nursing station so that the charge nurse or nurse aide will respond if it has not been answered after 5-10 minutes. This will be monitored by the Registered Nurse each shift, every shift, including weekends.	

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F 241	Continued From page 2 bathroom and she (NA#3) did. NA #3 added that Resident #216 was soiled and she had to clean her up. The resident also told NA #3 that she was so embarrassed for soiling herself. Administrative staff #5 stated that when she interviewed NA #2, she denied that Resident #216 had told her that she needed to go to the bathroom after breakfast. On 5/16/13 at 8:50 AM, NA #3 was interviewed. She stated that she was working on the rehab (rehabilitation) hall where Resident #216 resided. She indicated that she was working with the other resident when she saw the light was on in Resident #216's room. She told NA #2 that the light was on but didn't know if NA #2 heard it or not. She continued working with the other resident and when she was finished the light was still on. She did not remember how long the light was on but it was for a while. She added that this was always the problem during meal time. NAs were busy delivering and collecting trays and nobody to answer the lights. She went to the room to answer the light and Resident #216 had told her that her call light was on for a while and she had been waiting for NA #2 to take her to the bathroom. The resident also stated to NA #3 that NA #2 had told her that she would be back but never came back. NA #3 indicated that she took Resident #216 to the bathroom and she had to clean her up because she had soiled herself. NA #3 stated that the resident had stated that " this was embarrassing." On 5/16/13 at 11:05 AM, administrative staff #1 was interviewed. She stated that she was aware of the issue during meal time on the rehab hall. She added that she already had started hiring	F 241	Each shift nurse, Licensed Practical Nurse, will note, using the audit tool, when a call bell goes off and what the response time is on every shift, every day. The audit tool will be turned in to the Registered Nurse shift supervisor to be discussed in stand up M-F x4/wks. Then audits will be continued 3x a week with each shift nurse, Licensed Practical Nurse (one call bell response time, the Licensed Practical Nurse will monitor a call bell going off and note how long it takes to respond to the bell and document on the form and provide teaching if needed) and brought to stand up M-F. Clinical staff, Licensed Practical Nurses, Registered Nurses will continue using audit sheet to document once a shift, monitoring response time to call bell and then turn the audit sheet in to the RN shift supervisor who bring it to stand-up 1x a week. This will then be turned in to the Director of Nursing every Monday and then brought in to risk management on Mondays for review for eight weeks. Stop Date 8-5-13. The audits will also be brought to the quarterly QA meetings for ongoing monitoring x1 year.	

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F 241	Continued From page 3 staff (not certified) just to help deliver and collect trays on that hall to free up the NAs.	F 241		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to follow doctor's order for Clonidine (antihypertensive medication) consistently for 1 (Resident #134) of 10 sampled residents. The finding included: Resident #134 was admitted to the facility on 9/7/11 with multiple diagnoses including Hypertension. The quarterly Minimum Data Set (MDS) assessment dated 4/10/13 indicated that Resident #134's cognition was moderately impaired. Review of the current physician's orders revealed that Resident #134 was on Ramipril (antihypertensive medication) 5 mgs (milligram) daily since 11/11/11. On 11/19/12, there was an order for Clonidine 0.1 mg. every 6 hours PRN (as needed) for blood pressure more than 180/80. The Medication Administration Record (MAR) and Treatment Administration Record (TAR) for March and April, 2013 were reviewed. Clonidine 0.1 mg. every 6 hours PRN for blood pressure more than 180/80 was transcribed on the MAR but there were no specific time written for every 6 hours.	F 281	The Electronic Medication Administration Record for resident #134 was corrected by putting the parameters in place. All charts were reviewed by the Director of Nursing to ensure that the orders were input correctly. All orders that were incorrect were fixed by 5-14-13. All staff are being in-serviced by the Director of Nursing, Assistant Director of Nursing or Registered Nurse supervisor. This started on 5-14-13 and is still ongoing until all staff are in-serviced. This will be completed by 6-28-13. Another mandatory in-service will begin in 6/24, to show the nurses how to properly input these orders so that they show up on the Electronic Medication Administration Record.	7/1/13.

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F 281	Continued From page 4 There were no blood pressure readings documented. The blood pressure readings documented on the vital signs flow sheets for March and April, 2013 were reviewed. The flow sheets did not have the initials of the staff that had checked or documented the vital signs. The following dates/times when the blood pressure readings were more than 180/80: 3/5/13 at 3:32 AM - 182/99 4/1/13 at 10:35 PM - 190/78 4/2/13 at 9:34 AM - 182/87 4/10/13 at 11:17 PM - 188/86 4/24/13 at 10:03 PM - 183/87 There was no indication on the MAR or nurse's notes that the Clonidine was administered on the above dates and times when the blood pressure was more than 180/80. On 5/15/13 at 12:14 PM, Nurse #2 was interviewed. She indicated that the nurse's aides were checking the vital signs and recorded them on the vital signs sheets. She stated that she did not know why the blood pressure readings were not on the MAR or TAR for March and April, 2013. On 5/1/13, the doctor's progress notes indicated that the blood pressure of Resident #134 have been running high. An order to increase Ramipril to 10 mgs daily was written. On 5/3/13, a doctor's order to check the blood pressure every 12 hours and to use the PRN medication (Clonidine) if systolic blood pressure was more than 180 was written. The blood pressure readings for May, 2013 were recorded on the TAR. The blood pressure on	F 281	This will force the nurse to input any parameter orders that, per the medical doctor, stated to give an "as needed med". This will avoid missed medications and only allows the nurse to input and react upon the order. It will not be incumbent on the certified nurse aide to communicate to the nurse. The facility will have parameter order audit form in order to also check weekly, every Wednesday for 3 months. Admissions nurses will continue to monitor and verify parameter order audits weekly. The Director of Nursing and her designee, Dianne Gadd, Assistant Director of Nursing and the admission nurses, Jenifer Belton and or Sue Morrison will meet every Wednesday to discuss and communicate. This eliminates errors and failures to follow the doctors' orders. The pharmacy consultant will also review these orders per request as part of a double check monthly and monthly monitoring. The Director of Nursing will also monitor by performing an audit daily of any new orders and reviewing that these parameter orders were put in correctly. If it has not education/ retraining/ or corrective action will be the next level.	

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F 281	Continued From page 5 5/7/13 at 7:58 AM was 206/87 and on 5/13/13 at 8:00 PM was 189/87. There was no indication on the MAR or the nurse's notes that Clonidine was administered on those dates/times. On 5/15/13 at 12:00 PM, Nurse Aide #1 (NA) was interviewed. She stated that the nurse's aides were assigned to check the vital signs and to record the blood pressure on the TAR for Resident #134. She further stated that she always informed the nurse when the blood pressure was more than 150. On 5/15/13 at 11:54 AM, administrative staff#1 was interviewed. The administrative staff reviewed the records and stated that the system needed to be changed. She indicated that if the medication ordered had some parameters, the blood pressure or pulse has to be recorded on the MAR and not on the TAR or vital signs flow sheets. She further stated that the nurses have to record the blood pressure on the MAR and not the NAs so they should not miss to administer the PRN medication.	F 281	The Director of Nursing will receive all new orders daily to review for these types of orders to make sure they have been inputted properly. Another in-service will be provided by 6/30/13 for another review of how these orders should show up in the electronic medication administration record. This will include all orders such as pulse, Blood pressure, Oxygen saturation that the medical doctor has prescribed = parameters. The Director of Nursing and the consultant pharmacists will review all audits of parameter audits in each quarterly QA meeting x 1 year to ensure ongoing & systemic compliance.	
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).	F 356	This form has been revised to accurately reflect current shifts as required by CMS regulations. The form now includes the name of the facility, the current date, and the total number of licensed staff, total number and the actual hours worked for registered nurses, licensed practical nurses and certified nursing assistants. The form also includes the resident census. The Scheduler Coordinator was In- Serviced on the new form on 5-14-13 by Valeria Clark, Director of Nursing.	7/1/13

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F 356	Continued From page 6 - 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. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure accuracy of the total number of staff listed on the "Daily Nurse Staffing Form", failed to include the total number of hours worked, and failed to include the facility name. The findings included: During the initial tour of the facility on 5/13/13 at 3PM, the staff posting information dated 5/13/13 was observed prominently displayed at the front desk. The name of the facility was not on the form. The form included a breakdown of shifts by Day Shift (6 AM - 6 PM) and Night Shift (6 PM - 6 AM) and a breakdown of staff by Registered Nurses, Licensed Practical Nurses and Certified	F 356	The staffing form will be monitored once a month for accuracy by the Director of Nursing or her designee, Dianne Gadd, Assistant Director of nursing and results will be reported to the QA committee quarterly x 1 year to ensure continued compliance.	

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F 356	Continued From page 7 Nurse Aides. Each category of staff was followed by a number to indicate how many full time staff for that category were on duty on that particular shift. The numbers recorded on the form for the 6 AM - 6 PM shift were: Registered Nurses - 3; Licensed Practical Nurses - 10.07; Certified Nurse Aides: 25.47. The form lacked any designation of the total number of hours worked by each category of staff. Observation on 5/16/13 at 11:15 AM revealed the staff posting information again lacking the name of the facility and total number of hours worked by each category of staff. For the day shift, the number of full time staff listed by category was: Registered Nurses - 3; Licenses Practical Nurses - 10.57; Certified Nurse Aides - 27.97. During an interview on 5/16/13 at 11:20 AM with Administrative Staff #1 and #2, Administrative Staff #2 stated she was responsible for the staff posting forms and was trained to calculate the number of staff per category by totaling the hours and dividing by 8. Administrative Staff #2 said that the process for calculating the total hours was started when the facility had 3 shifts per 24 hour period for nursing staff and was not changed when the facility went to 12 hour shifts. Administrative Staff #1 added that the current form does not allow a space for the total number of hours.	F 356		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431	All medication rooms and carts were checked for expired medications and proper dating of medications by the Director of Nursing by 5/16/13.	7/1/13

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F 431	Continued From page 8 accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on facility policy, observation and staff interviews, the facility failed to discard expired medications in one of 8 medication carts (800 hall) and one of five medication rooms (800 hall) and failed to date multidose vial and Advair in two of 8 medication carts (800 hall, and 100 odd hall).	F 431	All in-services included dating vials, inhalers, insulin's, eye drops, nebulizer meds, all over the counter liquids and highlighting the over the counter medications as well. The in-services also included discarding expired medications. This was started 5-14-13, and completed 5-24-13. This will also be re-iterated in the in-service book provided by the Director of Nursing on June 24th and completed June 28th. In-services also include all weekend staff and "as needed" PRN (as needed) staff. All med carts, treatment carts, medication refrigerators, fridge temps, and items in the fridges were in-serviced and are now audited daily at each shift by the nurse. The registered nurse then performs a daily audit of the above and turns it in to the Director of Nursing each Monday for review. The Director of Nursing picks one sample and audits behind the Registered Nurses from each shift each day: Melissa Cohen, Sharon Wilson, Caren Cassillas, Dianne Gadd, and Marjorie Wall for consistency. In-service took place on 5-14-13 through 5-24-13 on all staff (Licensed Practical Nurses).	

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F 431	Continued From page 9 The findings included: A facility policy titled Medication Storage in the Healthcare Centers revised 4/99, 7/12 stated, in part, "11. Multi-dose containers of injectables, ophthalmic and otic preparations and inhalers are to be dated and initialed when opened. Except where manufacturer recommendations require shorter expiration date, the above items shall be discarded after 90 days." 1. During a medication cart check on 5/15/13 at 2:30 PM., a bottle of Enteric coated aspirin 325 milligrams was noted in the 800 hall (Pine Hollow) medication cart with an expiration date of 4/13. On 5/16/13 at 10:00 AM., Administrative staff #1 stated she expected the nursing staff to check their medication carts and medication rooms. The expired medications should have been discarded. 2. During a medication cart check on 5/15/13 at 2:30 PM., a multi-dose vial of Vitamin B12 1000 micrograms (mcg)/ milliliter (ml) was noted in the 800 hall (Pine Hollow) medication cart. The vial was opened and undated. On 5/16/13 at 10:00 AM., Administrative staff #1 stated she expected the nursing staff to check their medication carts and medication rooms. She expected the nursing staff to date the multi-dose vials when they were opened. 3. On 5/15/13 at 2:15 PM., a medication room check was conducted on 800 hall (Pine Meadows). A multi-dose vial of Lidocaine 1% was opened and dated 1/18/13.	F 431	All medication rooms and carts will be monitored weekly x 3 months by the RN shift supervisor to ensure that there are no expired medications and that all medications are properly dated. The results of the audits will be reported to the QA committee x 2 quarters by the Director of Nursing to ensure ongoing compliance. These in-services were completed by Registered Nurses: Melissa Cohen, Sharon Wilson, Caren Cassillas, Dianne Gadd, and Marjorie Wall. Another in-service will be done by the Director of Nursing, Valeria Clark starting on June 24th and completed by June 28th.	

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
	345044	A. BUILDING ______ B. WING ______	C 05/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH OF THE PINES HEALTH	103 GOSSMAN DRIVE SOUTHERN PINES, NC 28387

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F 431	Continued From page 10 On 5/16/13 at 10:00AM., Administrative staff #1 stated the Lidocaine should have been discarded after 90 days from 1/18/13. 4. On 5/16/13 at 10:05 AM, the 100 odd-room medication cart check revealed one opened, undated Advair Diskus. Nurse #1 was interviewed on 5/16/13 at 10:05 AM and stated Advair Diskus should be dated when opened. During an interview on 5/16/13 at 11AM, Administrative Staff #1 said she expected nurses to date the Advair Diskus when opened.	F 431		

PRINTED: 06/14/2013
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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CONSTRUCTION SECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345044	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOSEPH OF THE PINES HEALTH	103 GOSSMAN DRIVE SOUTHERN PINES, NC 28387

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K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This facility is Type V protected construction utilizing North Carolina Special locking arrangements, and is equipped with a complete automatic sprinkler system. CFR#: 42 CFR 483.70 (a)	K 000		
K 012 SS=D	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, 19.3.5.1 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 6/11/2013 the following Life Safety item was observed as noncompliant, specific findings include: The soiled linen room on the 400 hallway had unsealed penetrations above the door where the flex conduit and low voltage wire penetrate the wall. CFR#: 42 CFR 483.70 (a)	K 012	The unsealed penetration has been sealed with fireproof caulk. Any other unsealed penetration will be identified and monitored during rounds with the Director of Plant Operations or his designee. Any unsealed areas will be fixed immediately so that other residents will not be affected. All maintenance staff and contractors will be re-educated regarding the importance of the integrity of fireproof barriers. Rounding reports will be brought to the safety committee to ensure ongoing compliance.	7-5-13
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only	K 018		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	ADMINISTRATOR	6/28/13

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.

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K 018	Continued From page 1 required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 6/11/2013 the following Life Safety item was observed as noncompliant, specific findings include: The door to room 459 had an obstruction to the door closing as the door was swinging in to the door frame. CFR#: 42 CFR 483.70 (a)	K 018	The door closers have been removed so that the doors will no longer need to be propped open. Door closers that are present on any door that is not required to be shut at all times will be removed so that no other residents are affected. All staff will be re-inserviced so that doors with closers are not to be propped open at any time. Ongoing monitoring will occur during regular rounds by Director of Plant Operations or his designee. Rounding reports will be brought to the safety committee to ensure ongoing compliance.	7-5-13
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on the observations and staff interviews	K 038	The special locking door was fixed by a qualified contractor. All special locking mechanisms have been tested to assure that they are working properly and will continue to be tested during all regularly scheduled fire drills.	

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	345044	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 038	Continued From page 2 on 6/11/2013 the following Life Safety item was observed as noncompliant, specific findings include: The North Carolina special locking door for the end of the 600 hallway did not release with activation of the door release mechanism at the 600 hall nurses station. CFR#: 42 CFR 483.70 (a)	K 038	Ongoing monitoring will occur during regular rounds of the Director of Plant Operations or his designee to ensure that the special locking mechanisms are in proper working order. Results of rounding will be reported to the safety committee to ensure ongoing compliance.	7-5-13

MC