STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345518	A. BUILDING _____ B. WING _____	C 07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUAIL HAVEN VILLAGE	155 BLAKE BLVD PINEHURST, NC 28374

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID# W8QB11.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review, resident and staff interviews, the facility failed to provide Resident #28 with the amount of baths/ showers that he wanted each week. The findings included: Resident #28 was admitted to the facility 1/21/13. A Significant Change Minimum Data Set (MDS) dated 4/5/13 indicated that Resident #28 was cognitively intact. He required limited assistance with personal hygiene and bathing. It was noted that Resident #28 stated it was somewhat important to choose between tub bath, shower, bed bath and sponge bath. On 7/8/13 at 1:55 PM., an interview was conducted with Resident #28. He stated he received one shower/ whirlpool bath once a week or less. He said he had received a whirlpool bath today and one a week ago on Friday. Resident #28 stated he would like a whirlpool or shower three times a week. Resident #28 said he did not	F 242	**F 242** **483.15(b)Self Determination-right to make choices:** **For resident affected/residents with potential to be affected:** *July skin check sheets for resident #28 were assessed by Director of Nursing (DON) on 07-10-13. Sheets reviewed proved shower given 07-01-13, offered 07-04-13 but refused, and given 07-08-13. *Certified Nursing assistant (C.N.A.) assigned to resident #28 07-06-13 was educated on 7-12-13 by RN supervisor on facility expectations. In addition employee counseled one on one by DON on 07-29-13 on expectations (including but not limited to: completing a skin check sheet with each shower/whirlpool offered, notify nurse with any refusals, and to complete showers/whirlpools as scheduled and as requested). *An audit of all shower/whirlpools for all active residents from 06-01-13 to 07-09-13 was completed by DON on 07-12-13 to identify any other concerns. *In addition all full time C.N.A.s and LPNs were educated on regulation F 242 (resident right to make choices) on identified concerns from survey and DON audit, and expectation to adhere to shower/whirlpool schedule	080813

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

Executive Director 7/31/13

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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F 242	Continued From page 1 know his shower/ bath schedule. A review of the shower schedule revised 7/1/13 revealed Resident #28 was on the shower schedule for Monday spa and showers on Thursday and Saturday afternoon. A review of Resident #28's skin check report forms for June/ July 2013 (completed each time Resident #28 received a shower/ whirlpool) revealed Resident #28 received a shower/ whirlpool on the following dates: 6/3/13, 6/10/13, 6/13/13, 6/17/13, 6/20/13, 6/27/13, 7/1/13 and 7/8/13. On 7/9/13 at 4:25 PM., Nurse #1 stated Resident #28's daughter asked about two weeks ago if resident could get three showers/ week. Nurse #1 told her that there were two scheduled showers (one in the whirlpool). Resident #28's daughter said that he was a very particular person with his grooming and he had told his daughter to ask for 3 showers/ week. Nurse #1 stated the shower schedule was changed at that time to three showers/ whirlpool weekly (July 1, 2013). She indicated Resident #28 was informed of the change at that time. Nurse #1 stated the skin check report form was filled out by the nursing assistants every time a resident received a shower/ whirlpool. They, in turn, gave it to the charge nurse who signed off on the form and placed it in a box at the nursing station. They were picked up daily and kept for an internal record for review. Nurse #1 stated the expectation was for residents to receive all showers as scheduled.	F 242	beginning on 07-12-13 through 07-24-13 by RN supervisors. Staff notified of consequences of future performance issues as outlined by employee handbook. *Education will also be provided at mandatory annual skills fair as outlined above for all (part time, full time, and as needed staff as well as weekend staff) C.N.A.s on August 5 and August 6, 2013, for all L.P.N.s and Registered Nurses (R.N.s) on August 8 and 9, 2013 by Director of Nursing. *On July 23, 2013 RN supervisor met with resident to review staff compliance to his requests. Resident verbalized he has received showers/whirlpools as requested/assigned. *Evaluation of skin check sheets for resident #28 reveal showers have been offered as assigned since initiation of education (07-12-13). <u>**Measures in place/monitoring solution:**</u> *LPNs have been educated (by RN supervisor and Director of Nursing on dates above) to compare skin checks forms submitted by C.N.A.s against shower/whirlpool schedule that is posted at nurse's station. *LPN staff will sign each skin check sheet for documented proof	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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F 329	Continued From page 2 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff and physician interviews, the facility failed to discontinue Glipizide (antidiabetic medication) as ordered by the physician for one (Resident #38) of ten sampled residents reviewed for unnecessary medication use. The findings included: Resident # 38 was admitted to the facility 12/2/09	F 329	checks were done against shower schedule, prior to the end of each shift to ensure compliance. *If a resident refuses a shower the C.N.A. must document on skin check sheet and submit skin check sheet to nurse. *LPN will sign on Skin Check Sheet after confirming refusal with resident. *LPN staff have been educated by DON to attempt to identify the cause of refusal and indicate on skin check sheet any changes in resident preferences. *The DON will amend shower schedule as resident change in preferences are reported. *RN supervisors will track showers (by documenting completed skin check sheets indicating showers/whirlpools or refusals on QA sheet) effective 07-12-13. *RN supervisors will track showers qd through August, then a minimum of 3xweek in September, then 2xweek October and at least 1xweekly thereafter (unless otherwise recommended by QA committee) to ensure compliance to shower schedule. *Any issues noted will be addressed by RN supervisor with LPN and C.N.A. assigned to resident and will be reported to DON.	

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F 329	Continued From page 3 with most recent readmission noted as 4/24/12. Cumulative diagnoses included: Diabetes. Renewal physician orders for May 2013 revealed an order for Glipizide 10 mg. (milligram) tablet-take 2 tablets (20 mg.) by mouth every morning and Glipizide 5 mg--take one tab by mouth before supper. A review of physician's orders for Resident #38 revealed an order dated 5/17/13 to discontinue Glipizide. A review of the Medication Administration Record (MAR) for May 2013 revealed the order for Glipizide every morning was discontinued on 5/17/2013 and yellowed out on the MAR. Glipizide 5 mg. in the evening was not discontinued on the May MAR or yellowed out. The physician orders and MAR for June 2013 were reviewed and revealed Glipizide 5 mg. every evening had been handwritten in by nursing staff on both physician orders and MAR and continued to be administered for the entire month of June (30 doses). The physician orders and MAR for July was reviewed and revealed the Glipizide 5 mg. every evening had been handwritten in by nursing staff on both physician orders and MAR and was administered July1--July 9th, 2013. On 7/10/13 at 10:37 AM., Nurse #1 stated Glipizide should not have been transcribed to the June and July physician orders and MAR's. On 7/10/13 at 11:27AM., Administrative staff #1	F 329	*DON will address performance issues as indicated per policy and procedure with employees involved. *DON will also conduct a minimum of random 1xweek checks to insure compliance/proper follow through by supervisors through October. *Audits and concerns in performance will be brought by DON to Quality Assurance (QA) meeting and followed as indicated/recommended by QA committee. **F329** **483.25 Drug regimen is free from unnecessary drugs:** **For residents affected/For residents having the potential to be affected:** * Resident #38's physician was consulted on 07-10-13. He reviewed resident blood sugars and gave order to discontinue Glipizide the same day. *The nurse that initially received the order to discontinue the Glipizide 5-17-13 was counseled on facility expectations by DON on 07-12-13. *The LPN involved in checking Medication Administration record (MAR) for June to insure May	080813

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F 329	Continued From page 4 stated the order for the Glipizide should not have been transcribed to the June and July orders/ MAR's. On 7/10/13 AT 3:15 pm., Nurse #1 stated she had spoken to Resident #38's physician. He had reviewed the blood sugars and had discontinued the Glipizide today and ordered Lantus insulin. On 7/10/13 at 3:36 PM., Resident #38's physician stated he was not aware that Resident #38 had continued to receive Glipizide after he had ordered it discontinued in mid-May. He stated he expected them to stop the medication as ordered on 5/17/13.	F 329	orders were transcribed correctly was educated by RN supervisor verbally on 07-16-13. The RN involved in checking MAR for June was counseled by DON via telephone 07-10-13 on facility expectations, proper procedure for thorough MAR checks. *LPN responsible for nightly order checks/transcription checks educated by RN supervisor on 07-31-13. *DON conducted MAR review from May to June and from June to July on all active residents on unit 1 on 07-24-13 and 07-25-13 to ensure accuracy. Issues noted were reported to MD by DON on 07-25-13. *DON, ADON and RN supervisor to complete audit of MAR on station 2 by 08-14-13. Issues noted will be reported to MD on that date by RN noting issue. *In-service (by pharmacy nurse consultant) to be provided on 08-06-13 that will include expected transcription procedures along with thorough MAR review procedures to all nurses (part time, full time and as needed as well as weekend staff) *Review of F329 regulation and proper procedure in order transcription and checking Medication Administration Records	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility did not adhere to their policies, to ensure that all dietary staff wore hair nets when working in the kitchen and failed to require that all cooks checked and established a safe food temperature, prior to serving meals to residents.	F 371		

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F 371	Continued From page 5 The findings included: The facility's policy, titled "Operations Purposes & Quality Assurance Manual for Food & Beverage" , dated 3/21/97 was reviewed. It read, "Hair nets or caps should always be worn in food preparation areas and during food preparation. Hot food temperatures will be taken on the line before service at each meal. Temperatures will be recorded each time in a temperature log book." On 7/10/13 at 4:00 pm, wait staff #1 entered the kitchen without a hair net in place to retrieve ice for the dining room. She had long hair that was gathered back in a pony tail. She was approached about the use of a hair net and explained that she was unaware that she was required to wear a hair net when entering the kitchen. Wait staff #1 was seen exiting the kitchen, carrying a large open container of ice. On 7/10/13 at 4:05 pm, the Kitchen Manager was interviewed. He stated that he always felt that there was a "gray area" between the requirements for the wait staff and his dietary aides. He shared that the wait staff came in and out of the kitchen 100 times and did not wear hair nets and weren't expected to wear them because he did not consider them dietary staff, who prepare the food. On 7/10/13 at 4:25 pm, wait staff #2 was observed in the salad area with a hair net in place. She stated that she never wore a hair net when entering the kitchen before this evening. On 7/10/13 at 4:26 pm, wait staff #3 was	F 371	will be included in annual skills fair training (by Director of Nursing) for all nurses (full time, part time and as needed as well as weekend staff) is scheduled August 8 +9, 2013. *The DON to evaluate in-service signature sheets from mandatory meetings against active roster to identify any staff that did not attend. *Any nurse that was unable to attend the mandatory in-services will be contacted by DON to arrange training session prior to next shift worked. Director of Nursing will provide those training sessions. **Systemic changes/Monitoring solution:** *Night nurses to complete nightly order checks all on orders on all residents to insure accurate transcription and document on night shift check off sheet. *LPN staff to complete thorough MAR checks on all MAR on all residents to include comparing existing MAR to new MAR along with new physician orders for month. *RN supervisors will review Medication Administration Records on the first working day of month an all MARs for all residents for	

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F 371	Continued From page 6 observed to have on a hair net. She shared that she had been employed as a wait staff for five years and that the former kitchen manager required all staff to wear hair nets but her current supervisor did not require them to wear one when entering the kitchen. She stated that she wore a hair net sometimes. On 7/10/13 at 3:50 pm, a tour was conducted of the kitchen. Cook #1 had placed all food pans on the steam table and was preparing to start her tray line at 4:00 pm. Cook #1 was asked to check food temperatures and to show the log where she recorded temperatures. It was noted that the July 2013, "Food Service Temperature Log" only had slots to record the entrée, starch, fruit and vegetable, dessert, beverage and alternate. The log did not have slots to record temperatures of mechanically altered food (chopped and pureed). There were no entries for temperatures of the whole dinner meal for the entire month. Cook #1 was observed grabbing a sheet of paper and began to use a thermometer to record the temperature of each food item to be served with the exception of beverages. All of the food items fell within the recommended temperature ranges. On 7/10/13 at 3:57 pm, the kitchen manager was interviewed. He stated that the cooks were responsible for checking food temperatures and he wasn't sure why the current log didn't reflect that the food was checked for each meal. On 7/11/13 at 11:07 am, Cook #1 was interviewed and asked to explain her process for assuring that food was served at safe temperatures. She	F 371	next three months (through October). The reviews will include checking for accuracy, proper transcription and discontinuation of medications as MD orders indicate. *DON will also complete random monthly audits of new MARs (on minimum of 10% of residents) during first week of month through October for quality assurance. *Any issues identified by RNs will be addressed with employees involved per policy and procedure and be reported to DON. *Audit concerns will be brought to QA committee by DON and followed as indicated. **F371** **483.35 Food Procure, Store/Prepare/Serve:** **For residents affected/having the potential to be affected:** *Dietary manager provided ongoing education to kitchen staff starting on July 12, 2013 on dress code (to include mandatory hair nets for all staff working in kitchen) as well as requirement to check all food temperatures prior to serving meals to residents. * Food temperatures log was amended on 07-31-13 to include	080813

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F 371	Continued From page 7 stated that she checked temperatures daily but often forgot to write them down on the log. She also stated that prior to the request to record the dinner temperatures for 7/10/13; she had not checked the food temperatures. On 7/11/13 at 11:00 am, Cook #2 was interviewed. She stated that she prepared most of the morning meals and always checked the food temperatures before serving, then recorded it on the log. On 7/11/13 at 12:15 pm, the kitchen manager was interviewed. He stated that when he worked in place of the main cooks, he did not check food temperatures, since he did not know that it was a requirement. He shared that he did weekly audits and checked food temperatures then. In addition, he shared that he had not been daily monitoring if the cooks checked the temperatures.	F 371	entry for all food items including pureed, chopped and mechanical soft. *Food temperatures have obtained on all applicable food items and logged prior to each meal since 07-12-13. *Mandatory dietary staff meeting scheduled on August 13th to review F371 regulations and facility expectations to adhere to dress code policy requiring hair nets for staff working in kitchen as well as requirement to document food temperatures on all food prior to serving meals to residents. *Dietary manager will compare in-service signature logs from mandatory training to active roster to identify any staff that did not attend. *Dietary manager will contact any employees that did not attend to schedule in-service training prior to next shift worked. **Systemic changes/Monitoring solution**: *New QA sheet developed for dietary supervisor to complete qd (includes monitoring all staff working in the kitchen wearing hair nets, and checking/documenting food temperatures on all food prior to serving meals to residents) *Any issues noted by dietary supervisor will be addressed with	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of	F 425		

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F 425	Continued From page 8 a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interview, physician interview and pharmacist interview, the facility failed to ensure the correct medication was received for 1 (Resident #94) of 10 residents reviewed for unnecessary medications. The findings included: Resident #94 was admitted to the facility on 6/6/13. Diagnoses included cerebrovascular accident and hypokalemia. Physician orders dated 6/6/13 and the June Medication Administration Record (MAR) included potassium chloride 10 milliequivalents (mEq) orally daily. The orders were hand written. The MAR indicated the potassium chloride was given daily. The printed physician orders and the MAR for July 2013 included potassium citrate 10 mEq daily. The start date read 6/6/13. The MAR indicated potassium citrate had been given daily. There was no entry on the orders or MAR for potassium chloride. On 7/9/13 at 4:50 PM, the medication cart was checked. The only potassium preparation for	F 425	employees involved and reported to dietary manager. *Dietary manager will follow up on performance issues as indicated per policy and procedure. *Concerns will be brought by Dietary manager to QA committee and followed as indicated. *Dietary manager will conduct audits of QA sheets completed by supervisors to insure compliance to expectations and proper follow through. Audits by Manager will be conducted a minimum of 5x week through August, minimum of 3xweek through September, and then continued minimally of 2xweek or as recommended by QA committee. **F425** **483.609a)(b) Pharmaceutical SVC-accurate procedures** **For residents affected:** *Pharmacy contacted about discrepancy 07-09-13. Potassium Chloride ordered from pharmacy that day as ordered by MD and received that evening. *Pharmacy director also contacted 07-09-13 and informed. She reported education will begin immediately in pharmacy. *MD notified 07-09-13. MD ordered renal panel and agreed	080813

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F 425	Continued From page 9 Resident #94 potassium citrate 10 mEq. Some of the tablets had been punched out from the card. During an interview on 7/9/13 at 5:06 PM, Administrative Staff #1 said the discrepancy between potassium chloride and potassium citrate should have been caught by the nurse who checked the July MAR against the June MAR. Administrative Staff #1 also stated she would speak with the pharmacy and notify the physician of the error. On 7/10/13 laboratory results revealed Resident #94's serum potassium was 4.2 millimols per liter (mmol/L) (normal range was 3.6 - 5.1 mmol/L). During an interview on 7/11/13 at 10 AM, the physician indicated that he expected Resident #94 to receive the potassium chloride as ordered and considered potassium citrate an error on the part of the pharmacy. During an interview on 7/11/13 at 12:25 PM, the pharmacist indicated she had been made aware of the error by Administrative Staff #1 on 7/9/13. The pharmacist stated that the pharmacy technician made a data entry error on 6/6/13 by entering potassium "citrate" rather than potassium "chloride", and the error was not detected by the pharmacist responsible for checking the actual orders against the orders transcribed. The pharmacist stated that only potassium citrate had been supplied for the resident until 7/9/13. The pharmacist added that as an additional safety measure potassium citrate was removed from the stock shelf since it is so rarely ordered.	F 425	with continuing Potassium Chloride as originally ordered. *MAR entry clarified to reflect accurate order 07-09-13. * Lab results on 7-10-13 proved potassium level therapeutic at 4.2 mmol/L. *MD reviewed results on 07-12-13 and ordered Potassium Chloride to be discontinued. **For residents with potential to be affected:** *An audit of all active residents with orders for oral potassium conducted by Assistant Director of Nursing on 07-12-13. MD orders were compared to actual product being administered. No other issues noted. *All nurses involved in were educated by Assistant Director of Nursing on 07-09-13 on regulation, medication administration, thorough MAR review on change over and facility expectations. *Nurse responsible for checking MAR for accuracy again counseled one on one by DON on 07-30-13 to review thorough chart review for quality assurance on change over night. *Mandatory meeting for all nurses (full time, part time and as needed and weekend staff) is scheduled on August 6 with pharmacy nurse	
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		

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	345518	A. BUILDING _____ B. WING _____	C 07/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
QUAIL HAVEN VILLAGE	155 BLAKE BLVD PINEHURST, NC 28374

(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 431 SS=D	Continued From page 10 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 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:	F 431	consultant. Training will include proper medication administration, documentation and order transcription. *Regulation and facility expectations to be reviewed at mandatory annual in-service for all nurses (full time, part time and as needed as well as weekend staff) scheduled August 8+9. Training will include review Potassium Citrate + Potassium Chloride (differences and indications) , medication administration techniques, thorough MAR checks. *DON will review in-service attendance log against active roster to identify any nurse that did not attend. * Any nurse that was unable to attend the mandatory in-services was contacted by DON to arrange training session prior to next shift worked. Director of Nursing will provide those training sessions. **Systemic changes/Monitoring solution:** *RN supervisors to complete audits of MARs on first working day of each month x 3 months (through October) to insure quality assurance (proper transcription of	

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F 431	Continued From page 11 Based on observation, staff interview and record review the facility failed to date Aplisol (Tubersol) PPD (Purified Protein Derivative) skin testing solution when opened for 1 of 2 medication room refrigerators (Unit 1). Review of the facility Medication Expiration Check off Sheet revealed PPD (Apilsol) was to be discarded 30 days after opening. On 7/11/13 at 3:09 PM, an opened vial of Apilsol (Tubersol) PPD (skin testing solution for tubercoulsis) was observed; the date opened was not present. Interview with Nurse #1 on 7/11/13 at 3:10 PM revealed the Apilsol (Tubersol) PPD should have been dated when it was opened and that without the date staff would not know when it needed to be discarded. Administrative Staff #2 discarded the Apilsol (Tubersol) PPD.	F 431	months orders) and thereafter per QA committee recommendation. *DON to conduct random audits on a minimum of 10% of MARs during the first week of 1xmonth q month x 3 months for quality assurance. *RN staff to complete audit of all active residents receiving potassium (to insure potassium sent from pharmacy matches MD orders) q month x 3 months (through October) and thereafter per QA committee recommendation. *RN staff to report to DON any concerns noted. *DON to report concerns to QA committee for review and follow as indicated per recommendations. **F 431** **483.60(b)(d)(e) Drug records, labels/store drugs & biological** **For residents affected/residents with potential to be affected:** *PPD (Apilsol) was immediately discarded by RN 07-11-13. *LPN nurses responsible for checking refrigerator counseled by RN (07-12-13; 07-16-13). RN	080813

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F 431		F 431	responsible for the unit was counseled by DON 07-12-13. *RN staff conducted audit of both unit refrigerators and carts 07-11-13 for proper product labeling. No other issues were noted. **Systemic changes/monitoring solution:** *Mandatory Annual Skills fair training for all nurses (full time, part time and as needed as well as weekend staff) scheduled August 8 and 9th. Training will be conducted by DON and will include storage parameters and labeling of vials of PPD (apilsol) when opened. *Pharmacy consultant will be in August 6 to conduct mandatory training session for all nurses (full time, part time and as needed as well as weekend staff) and will include storage parameters and proper labeling of PPD vials when opened. *DON will evaluate in-service attendance log and compare to active nurse roster to identify any staff that did not attend. * Any nurse that was unable to attend the mandatory in-services was contacted by DON to arrange training session prior to next shift worked. *LPN staff to continue checking products in refrigerators for proper	

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F 431		F 431	labeling (including open date) every night. *LPN staff effective August 1, 2013 are to document the checks of refrigerators and carts every night (to ensure products are properly labeling with open date) on amended third shift check off sheet indicating this check. *Issues noted by LPNs are to be reported to RN supervisors. *RN staff are to complete checks of products in all medication refrigerators for proper labeling (open date) 5xweek through July. 3x week through August. 3x week through September. 2 x week through October and thereafter as recommended by QA committee. *Concerns during audits by RNs are to be addressed directly with employees involved and reported to DON. *DON will conduct random minimum of 2xmonth audits through October. *Concerns will be brought by DON to QA committee for recommendations and followed as indicated.	

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	345518	A. BUILDING 01 - BUILDING 01 B. WING	08/06/2013

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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 V construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000		
K 038 SS=D	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: 42 CFR 483.70(a) By observation on 8/6/13 at approximately noon the following exit discharge illumination was observed as non-compliant, specific findings include a single bulb fixture at the Pinetree Terrace exit near station one. Lighting must be arranged to provide light from the exit discharge leading to the public way (parking lot). The walking surfaces within the exit discharge shall be illuminated to values of at least 1 ft-candle measured at the floor. Failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candles in any designated area. NFPA 101 7.8.1.1, 7.8.1.3, and 7.8.1.4.	K 038	K 038 The facility has ordered new outside exit lights for the exit door in question. A two bulb light will replace the old one bulb exit outside light. The facility Maintenance Director audited the lighting for other exit doorways and will replace any other one bulb exit lighting. The Maintenance and housekeeping staff maintains the facility interior and exterior lighting and replaces lighting as needed. The Maintenance Director will report to the campus Executive Director upon the completion of replacing the exit light. The Maintenance Director will also report to the QA Committee the change in the lighting and completion of the replacement of the light at the next QA meeting. Completion date on or before 8/30/13.	8/30/13
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 052		

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

Executive Director 8/23/13

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

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

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K 052	Continued From page 1 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 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 8/6/13 at approximately noon the following fire alarm system was observed as non-compliant, specific findings include documentation for sensitivity testing was not available.	K 052	K 052 The facility requested the fire alarm system service company to complete a system sensitivity test. The test was completed on 8/22/13. The system passed the sensitivity test and was found to be in compliance with NFPA Code. This test checks the whole system and found the whole system in compliance with the code. The Maintenance Director has scheduled with the fire system service company to have the system sensitivity test completed annually with the annual system check. The Code requirement is every 2 years. The Maintenance Director has reported to the Executive Director that the test was completed and the system passed. The Maintenance Director will also report to the QA Committee at the next QA	8/22/13
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 8/6/13 at approximately noon the following automatic sprinkler system was observed as non-compliant, specific findings include the ball valves to the accelerator are not	K 062	meeting the test results and the plan to do the sensitivity test with the annual testing the service company completes each year. Completion date on 8/22/13.	

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K 062	Continued From page 2 electronically supervised. This is typical of two automatic sprinkler riser systems. A distinctive supervisory signal shall be provided to indicate a condition that would impair the satisfactory operation of the sprinkler system. 9.7.2.1	K 062	**K 062** The Ball Valves in question were replaced on the sprinkler system the system was serviced by the sprinkler service company on 8/22/13 and tested to be in compliance and are electronically supervised. The system is annually tested by the service company for compliance. The Maintenance Director has reported the Executive Director of the update to the Ball Valves. The Maintenance Director will report to the QA Committee at the next meeting of the updates to the Ball Valves. Completion date on 8/22/13.	8/22/13