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

PRINTED: 06/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345088	A. BUILDING ______ B. WING ______	04/28/2011

JUN 17 2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME - WINSTON SALEM	5350 OLD WALKERTOWN ROAD WINSTON-SALEM, NC 27105

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The scope and severity was amended on 5/17/11. The F314 was changed from a G to a D. 6/10/11 F 280 and F 314 deleted per team after IDR request and written information submitted.	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely because it is required by the provision of federal and state law.	
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to provide activities for 1 of 2 sampled residents (Resident # 115) whose participation in activities was reviewed. Findings include: Resident # 115 was admitted on 12/28/09 with cumulative diagnoses of diabetes, osteoporosis, dementia with behavioral disturbance, and hypertension. The Activities Progress Note, dated 06/07/10, indicated the Resident # 115 was awake morning, noon and evenings. The resident was noted to roll herself around constantly in her wheelchair, staying short periods of time in music programs. The Activity Director (AD) documented the resident showed little interest in anything else. Church members and family were noted to visit the resident.	F 248	F 248=D Activities Meet Interests/ Needs of Each Res Lutheran Home Winston Salem will continue to provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. • Resident #115 was reviewed by the Activity Director. The Care plan was reviewed. A radio was placed in the resident's room.	5-20-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cissy McCoy
TITLE: Administrator
(X6) DATE: Revised 6/14/11

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 248	Continued From page 1 The Activities Progress Note, dated 08/24/10, indicated the resident wandered in her merry walker. Resident # 115 was listed as receiving 1:1 visits from church members and family and listening to piano music. On 01/19/11, the AD documented in the progress notes that Resident # 115 was out of her room daily. The note indicated the resident enjoyed walking the halls, visiting with the chaplain and her family and listening to music. The Quarterly Minimum Daily Set (MDS), dated 01/19/11, indicated Resident # 115 had unclear speech, was sometimes understood and usually was able to understand. Vision was coded as adequate. The MDS indicated Resident # 115 had impairment of short and long term memory and was severely impaired with cognitive skills for daily decision making. The resident was coded as requiring limited assistance with locomotion on and off the unit. The resident's care plan, last reviewed on 04/26/11, indicated Resident # 115's participation in activities was limited due to the fact she would only stay for a short amount of time and then would leave. The goal was she would attend 2 out of room activities per week. Interventions to obtain that goal was to listen to what the resident wanted to do, encourage attendance to group activities and provide time to walk around with the resident. An observation was made at 4:20 PM on 04/26/11. An activity was being held in the Commons Room that included a radio with music. Resident # 115 was not in attendance. The	F 248	• Care Plans were reviewed for each resident. Activity Goals were placed on the participation records. Nursing Assistants were in-serviced on the importance of assisting residents to activities. Activity Department was in-serviced regarding care plan goals, attendance, plan of correction, and documentation. • Participation Records will be reviewed by the Activity Director twice per week to ensure that participation meets stated goals. • Activity Director will report progress on participation meeting goals to Administrator monthly and quarterly will present to QA&A committee for one year.	5-23-11 5-26-11 5-13-11

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F 248	Continued From page 2 resident was observed lying in bed with her eyes closed. There was no music or television heard or seen in the resident's room. An observation was made on 04/28/11 at 8:30 AM. The resident was in the hall in a Merry Walker. Staff or other resident's were not seen in the hall. An interview was held with the AD, on 04/28/11 at 9:35 AM. He stated activities are designed for cognitively impaired residents by using a computer program. The computer could be taken to the room. The AD stated the computer had a touch screen that could be used by the resident and/or staff could assist as needed. Music could be provided through the computer and games for people with cognitive impairments. The AD stated most in- room activities occurred after 2:30 PM and included in room singing/musical instruments and visits. The activity choice was based on the resident's history of what worked and on the resident's preference. Activities for the resident included invitations to group activities. The AD stated that sometimes Resident # 115 would stay for a short time in activities. He added one on one activities was attempted including talking or evening music. Review was made of the participation records for Resident # 115. The January 2011 Participation Record indicated the resident went to church, had chaplain visits and had attended several group activities, but usually left before the activity had been completed. Participation Records for February, March and April 2011 were reviewed which indicated the resident attended 2 to 3 activities for the months of February and March and no activities in April. The AD acknowledged	F 248		

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F 248	Continued From page 3 the resident had to be assisted to activities. He stated the care plan was not being followed since the resident was to attend activities weekly. On 04/28/11 at 10:30 an activity was being held in the Commons Room. Resident # 115 was not in attendance. Resident # 115 was sitting in the hall in her Merry Walker with her head laid on the merry walker. There were no staff seen interacting with the resident. An interview was held with Nursing Assistant (NA) # 1 on 04/28/11 at 11:02 AM. She stated she had not seen the resident in an activity or anyone providing activities in her room in a very long time.	F 248		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure that heating and air units in the resident's rooms were clean and in good repair for 2 of 2 halls (Rooms 206,208, 209, 212,, 216, 217,218, 221, 224,226, 301, 303, 305, 307, 309, 311, 312, 317) bedrooms. During initial tour on 4/25/11 at 10:35AM to 11:00AM, the following resident rooms, 208, 209, 212, 216, 217, 218, 301, 303, 305, 307, 309, 311, 312, 317 were observed with broken grill slats,	F 253	F253=E Housekeeping & Maintenance Services Lutheran Home Winston Salem will continue to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.	

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F 253	Continued From page 4 dirty grey build up, food particles inside and outside and heating system covers were coming apart from the system and walls. There were sharp edges exposed and several residents operating the system. During a follow-up observation on 4/26/11 at 10:54 AM to 11:45AM, additional rooms 206, 221, 224,226 were observed in the same condition. Additional observations on 4/26/11 at 3:00PM to 4:30PM, the identified resident rooms were re-checked and they remained in the same condition During and interview on 4/27/11 at 10:58AM, housekeeper(HK) #1 indicated that HK was expected to clean the entire room which includes, bathrooms, light fixtures, dust heating systems, dust under beds, wash down beds when necessary, clean night stand/dressers. HK #1 added that when things were broken it should be written on the maintenance work order and reported to maintenance. She further stated that the heating systems should be at least wiped down daily to remove any dust or spills. During an interview on 4/27/11 at 11:14AM, HK#2 indicated that HK was responsible for cleaning the entire resident rooms, which included dusting, mopping, empty trash, cleaning privacy curtains. HK#2 indicated that the heating systems should be wiped down daily and the maintenance was responsible for cleaning the inside and changing the filters. HK#2 further stated that any time housekeeping found things broken in resident rooms it should be reported to nursing and /or maintenance and a work order sheet would be	F 253	• Air conditioning Units in rooms 206, 208, 209, 212, 216, 217, 218, 221, 224, 226, 301, 303, 305, 307, 309, 311, 312, 317 were taken apart and cleaned and covers were bolted down. • Each Resident Room air conditioner unit was checked for a loose cover. The following rooms had removable covers that were bolted down: 202, 204, 206, 208, 210, 212, 213, 214, 215, 216, 217, 218, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 303, 305, 307, 309, 311, 312, 314, 315, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328.	4-27-11 5-19-11

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F 253	Continued From page 5 filled out. HK#2 further stated that several of the heating systems in resident rooms have been broken or missing pieces for a long time. During observations on 4/27/11 at 11:24AM to 11:35AM, housekeeping staff was observed cleaning resident rooms in the area of 206, 208, 209, 212, 216, 217, 218, 224, however the heating systems remained unclean as identified the previous days with the heating covers still coming off system. During an interview on 4/27/11 at 1:25PM, HK#3 indicated that HK was responsible for cleaning the resident's entire room and report anything that needed repair to maintenance supervisor. HK#3 indicated that housekeeping was responsible for wiping down the tops and fronts of the heating system. HK#3 added that many of the heating systems had been broken for a while. Maintenance was responsible for repairs and keeping the inside cleaned. During an interview on 4/27/11 at 2:00PM, the maintenance director reviewed the monthly cleaning schedule and he indicated that the heating systems were done monthly and the expectation was that housekeeping clean the basic areas of the systems and that there has been a problem with keeping the heating covers in place. He added that staff hit the units and the covers come off. He indicated that the only system in place to check the heating system was for his maintenance tech to check all the rooms in the morning to make sure things are in good repair. He added that maintenance was responsible for cleaning out the inside of the heating systems. Resident rooms were toured	F 253	Maintenance Director followed up by checking each unit to ensure all modifications were done correctly. Surveyor was taken and shown how units were repaired during the survey. Preventative Maintenance program regarding Resident A/C units was modified to add checking for loose A/C covers. Surveyor was shown new PM form and given copy during survey. Each resident room air conditioner unit was checked for debris and cleaned internally thoroughly.	

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F 253	Continued From page 6 and he indicated that the maintenance tech were responsible for checking the heating systems daily and replace covers on the systems. He added that staff was expected to report any things in resident rooms that needed repairs. They should complete a work order and place in maintenance box. The maintenance tech should check the box daily. During a follow-up interview on 4/27/11 at 3:17PM, the maintenance director indicated that he and housekeeping staff would clean all the heaters and apply 2 screws into the system to secure the covers. During an interview on 4/28/11 at 9:04AM, the housekeeping supervisor indicated that housekeeping staff was expected to wipe down the front of the heating systems daily when they see a build up of dust and particles. The housekeeping staff was expected to write down the information on the maintenance worksheet to let maintenance know they need to clean the vent. During an interview on 4/28/11 at 9:13AM, DON indicated that it is all staff was responsible for checking and reporting to maintenance when heating systems were dirty or need repair. The staff was also expected to compete the maintenance work order and put it the box located at the nurse station During an interview on 4/28/11 at 9:22AM, HK#4 indicated that there was no routine schedule for cleaning the heating systems. HK#4 added that the expectation was when things were broken and need repair a work order should be	F 253	• Housekeeping and maintenance have a schedule of rooms to check the air conditioning units. Daily Inspection and cleaning sheets will be turned in to Department Supervisors and collected weekly. In-services were held with all staff to remind them of maintenance repair request forms and how to report needed repairs. In-service was held with Maintenance/Housekeeping staff regarding new plan for A/C units. Maintenance and Housekeeping Supervisor will do rounds and document weekly for 90 days, and monthly for the remainder of the year. • Housekeeping and Maintenance Supervisors will	5-26-11 5-13-11

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F 253	Continued From page 7 completed. Maintenance was responsible for cleaning the inside of the vents and housekeeping should wipe down the outside.	F 253	report quarterly on air conditioning units to QA&A for one year.	
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 observations, interviews and record review the facility failed to follow physician's orders for 1 of 13 sampled residents (Resident # 91) whose orders were reviewed. Findings include: Resident # 91 was admitted on 10/03/07 with cumulative diagnoses of Alzheimer's dementia, peripheral vascular disease, diabetes, generalized muscle weakness and hypertension. On 03/03/11, the Physician's Assistant (PA) documented Resident # 91 had a Stage IV sacral pressure ulcer that measured 1.5 centimeters (cm) x 0.3 cm x 0.3 cm with 100% granulation, no odor and minimal drainage. April 2011 physician's orders for Resident # 91 included orders for an air mattress, Skil-care boots (specialized boots used to relieve pressure on a person's feet), turning side to side when in bed with wedge to aid in positioning and keeping a pillow between buttocks and heels to prevent pressure. The Quarterly Minimum Data Set (MDS), dated	F 281	F281 Services Provided Meet Professional Standards Lutheran Home Winston Salem services provided or arranged for by the facility will continue to meet professional standards of quality.	

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F 281	Continued From page 8 03/07/11, indicated Resident # 91 was significantly cognitively impaired. The resident was not coded as rejecting care. The MDS indicated Resident # 91 required extensive assistance with bed mobility and eating. Total care was provided by staff for transfer, toilet use and personal hygiene. The MDS also coded the resident has having 2, Stage IV pressure ulcers with the worst tissue type being necrotic tissue. Skin ulcer treatments included pressure reducing device for the resident's bed, a turning and positioning program, and application of dressings. An observation was made on 04/26/11 at 4:30 PM. Resident # 91 was lying in bed on her left side. Her head was touching the side rail. There was no wedge pillow seen. A pillow was between the resident's legs, but there was no pillow between the resident's buttocks and her heels. The resident's right heel was approximately 2 to 3 inches away from her buttocks. Resident # 91 was not wearing Skil Boots. Her left leg was laying directly on the bed. An observation was made on 4/27/11 at 9:36 AM with the Treatment Nurse (TN). The wedge pillow was seen behind Resident # 91's back. She was lying on right side. A pillow was seen between her legs, but no pillow had been placed between her heels and buttocks to prevent pressure. The Skil-Care boots were not on the residents feet. An interview was held with the TN on 04/27/11 at 3:19 PM. She stated Resident # 91 had been ordered to wear the Skil-Care boots at all times. The TN added the resident was supposed to have a pillow placed between her buttocks and her heels and a wedge cushion behind her back	F 281	• Physician orders for resident #91 were reviewed. Staff were in-serviced on these orders. Care Plan Action form was developed to reflect the positioning devices for resident #91. Updated Care Plan Action Sheet was placed in the communication book for C.N.A.s and was discussed in Neighborhood meetings to remind the staff of resident needs. • Each resident has had a review of physician orders with a comparison to the care plan to develop a Care Plan Action Sheet to reflect positioning	5-26-11 5-26-11

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F 281	Continued From page 9 to maintain positioning. An observation was made on 04/28/11 at 10:30 AM. The resident was lying in bed with her right knee against the bed rail. The SKIL CARE Boots were on. There was no wedge behind the resident and there was no pillow observed between her heels and buttocks. The pillow had been placed in a chair that was about 3 feet from the end of the bed. An interview was held with Nursing Assistant (NA) #2 on 04/28/11 at 10:30 AM. She stated while she did work with Resident # 91 at times, she was not assigned to the resident on that day. NA # 2 stated the resident was supposed to have a pillow between her legs and a wedge to help her position. The NA stated the resident's knee laying against the rail was neither comfortable and could possibly cause skin breakdown. An interview was held with NA # 1 on 04/28/11 at 10:50 AM. Information about special equipment used by residents was shared verbally. The NA stated Resident # 91 was turned every 2 hours, the wedge cushion was used for positioning and she wore boots at all times to protect her feet. The NA added a pillow was supposed to be between her legs, but the resident at times would pull the pillow out. The NA stated it was time for the resident to be on her back for her meal and therefore the wedge pillow could not be used. The NA stated the pillow should have been between Resident # 91's buttocks and heels. An interview was held with the Director of Nursing (DON) on 04/28/11 at 11:14 PM. Information about residents are included in an NA	F 281	devices needed. These Care Plan Action Sheets were placed in the C.N.A. communication book and discussed in the neighborhood meetings to remind staff of resident needs. • Care Plans Action Sheets will be updated by the MDS Coordinator/designee as physician orders are updated. Medical Records Director will inform IDCPT of new orders in morning meetings. ADON/First shift supervisor will make rounds and check for compliance with Care Plans Action Sheets	5-20-11

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F 281	Continued From page 10 Communication Book or inside the wardrobe door. Since these interventions, for Resident # 91, have been in place for a while the information would be communicated verbally, through an information sheet located inside the closet door and in the communication book found at the nurse's station. After a meal, the resident should be placed back on one side or the other when the meal is complete. Meals are served around 9:00 AM on the resident's hall. The DON stated the resident should not have been on her back at 10:30 AM.	F 281	• MDS Coordinator/designee will report on Care Plans Action Sheets for C.N.A.s quarterly in QA&A for one year.	5-13-11
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to follow the individualized care plan for 3 of 13 sampled residents (Resident # 115, Resident # 91 and Resident # 108) whose care plans were reviewed. Findings include: 1. Resident # 115 was admitted on 12/28/09 with cumulative diagnoses of osteoporosis, dementia with behavioral disturbance, and hypertension. The Activities Progress Note, dated 06/07/10, indicated Resident # 115 was awake morning, noon and evenings. The resident was noted to roll herself around constantly in her wheelchair, staying short periods of time in music programs.	F 282	F282=D Services By Qualified Persons/Per Care Plan Lutheran Home Winston Salem will continue to	

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F 282	Continued From page 11 The Activity Director (AD) documented the resident showed little interest in anything else. Church members and family were noted to visit the resident. The Activities Progress Note, dated 08/24/10, indicated the resident wandered in her merry walker. Resident # 115 was listed as receiving 1:1 visits from church members and family and listening to piano music. On 01/19/11, the AD documented in the progress notes that Resident # 115 was out of her room daily. The note indicated the resident enjoyed walking the halls, visiting with the chaplain and her family and listening to music. The Quarterly Minimum Data Set (MDS), dated 01/19/11, indicated Resident # 115 had impairment of short and long term memory and was severely impaired with cognitive skills for daily decision making. The resident was coded as requiring limited assistance with locomotion on and off the unit. The resident's care plan, last reviewed on 04/26/11, indicated the resident's participation in activities was limited due to the fact she would only stay for a short amount of time and then would leave. The goal was she would attend 2 out of room activities per week. Interventions to obtain that goal was to listen to what the resident wanted to do, encourage attendance to group activities and provide time to walk around with the resident. An observation was made at 4:20 PM on 04/26/11. An activity was being held in the	F 282	provide or arrange services by qualified persons in accordance with each resident's plan of care. • Resident #115, #91, and #108 care plans were reviewed. Staff were in-serviced on the care plans. Resident #115 had a care plan review and update and radio placed in room. Resident #91 had Care Plan Action Sheets developed. The Care Plan Action Sheet is placed on the C.N.A. communication book and discussed in the neighborhood meetings to remind staff of resident needs. Resident #108 has had AVF checks placed on the MAR for the nurses.	5-26-11

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	345088	A. BUILDING ______ B. WING ______	04/28/2011

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F 282	Continued From page 12 Commons Room that included a radio with music. Resident # 115 was not in attendance. The resident was observed lying in bed with her eyes closed. There was no music or TV in the resident's room. An observation was made on 04/28/11 at 8:30 AM. The resident was in the hall in a merry walker. An interview was held with the AD on 04/28/11 at 9:35 AM. Review was made of the participation records for Resident # 115. The January 2011 Participation Record indicated the resident went to church, had chaplain visits and had attended several group activities, but usually left before the activity had been completed. Review of the February and March 2011 Participation Records indicated the resident had attended 2 to 3 activities for the entire month. The April 2011 Activity Participation Record indicated Resident # 115 had not attended any activities. The AD reviewed the care plan and acknowledged the resident could not get to activities independently and had to be assisted to activities. He stated the care plan was not being followed. An interview was held with Nursing Assistant # 1 on 04/28/11 at 11:02 AM. She stated she had not seen the resident in an activity or anyone providing activities in her room in a very long time. 2. Resident # 91 was admitted on 10/03/07 with cumulative diagnoses of Alzheimer's dementia, peripheral vascular disease, diabetes, generalized muscle weakness, hypertension and gait disturbance.	F 282	• Physician Orders and Care Plans were reviewed for each resident. Activity Care plans were placed on the participation record. Nursing Assistants were in serviced on the importance of assisting residents to activities. Activity department was in serviced regarding care plan goals, attendance, plan of correction, and documentation. attendance. Each resident had physician orders compared with care plan and a Care Plan Action Sheet was developed to reflect positioning devices needed. These Care Plan	5-26-11

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F 282	Continued From page 13 Resident # 91's individualized care plan with an original date of 11/30/10, indicated the resident had an alteration in skin integrity as evidenced by a Stage IV sacral ulcer and a Stage IV left hip ulcer. Interventions to promote healing and prevent further breakdown included an air loss mattress, turn and position every 2 hours using a wedge behind the resident, notify wound management as needed, nutritional interventions, Foley catheter placement, SkilCare boots (specialized boots to relieve pressure on a resident's feet) at all times, documented weekly skin assessments and incontinent care as needed. The Quarterly Minimum Daily Set (MDS), dated 03/07/11, indicated the resident was significantly cognitively impaired. The resident was not coded as rejecting care. The MDS indicated Resident # 91 required extensive assistance with bed mobility and eating. Total care was provided by staff for transfer, toilet use and personal hygiene. The MDS also coded the resident has having 2, Stage IV pressure ulcers with the worst tissue type being necrotic tissue. Skin ulcer treatments included pressure reducing device for the resident's bed, a turning and positioning program, and application of dressings. An observation was made on 04/26/11 at 4:30 PM. The resident was lying in bed on her left side. Her head was touching the side rail. There was no wedge pillow seen as directed by the care plan. A pillow was between the resident's legs, but there was no pillow between the resident's buttocks and her heels as directed in the care plan. The resident's right heel was approximately	F 282	Action Sheets were placed in the C.N.A. communication book and discussed in the neighborhood meetings to remind staff of resident needs. Nurse #3 was educated regarding AVF checks for dialysis residents. Nurses were in-serviced on AVF checks for dialysis residents. Each Resident on dialysis has been care planned for AVF checks and it has also been placed on the MAR. • Participation records will be reviewed by the activity director twice per week to ensure that participation meets stated goals. Care Plan Action Sheets will be updated by the MDS Coordinator/designee	5-26-11

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F 282	Continued From page 14 2 to 3 inches away from her buttocks. Resident # 91 was not wearing Skil Boots as directed in the care plan. Her left leg was laying directly on the bed. An observation was made on 4/27/11 at 9:36 AM. The wedge pillow was observed behind Resident # 91's back. A pillow was observed between the resident's legs at the knee level, but no pillow was observed between the resident's heel and her buttocks as directed by the care plan. An interview was held with the treatment nurse on 04/27/11 at 3:19 PM. Interventions to prevent skin breakdown and to help heal the existing wounds included a low air loss mattress, Skil Care boots to be worn at all times, an indwelling urinary catheter for incontinence, turned and positioned every 2 hours and as needed, nutritional interventions, a pillow between her heel and buttocks and a wedge cushion to keep her from falling on her back. The treatment nurse acknowledged the resident did not have her boots on or a pillow between her heels and buttocks on 04/27/11 at 9:36 AM. An observation was made on 04/28/11 at 10:30 AM. The resident was lying in bed with her right knee against the bed rail. The SKIL CARE Boots were on. There was no wedge behind the resident and there was no pillow observed between her heels and buttocks as directed by the care plan. The pillow was laying in the chair that was about 3 feet from the end of the bed. An interview was held with Nursing Assistant (NA) # 2 on 04/28/11 at 10:30 AM. She stated while she did work with the resident, she was not	F 282	as physician orders are updated. Medical Records Director will inform IDCPT of new orders in morning meetings. ADON/First shift supervisor will make rounds and check for compliance with Care Plan Action Sheets. AVF checks will be reviewed weekly by the ADON/Supervisor weekly and turned in to the DON monthly. • Activity Director will report progress on participation meeting goald to Administrator monthly and quarterly will present to QA&A committee for one year. MDS Coordinator/designee will report on Care Plan Action Sheets for C.N.A.s quarterly in QA&A for one year. DON will report	5-13-11

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F 282	Continued From page 15 assigned to the resident that day. She stated the resident was supposed to have a pillow between her legs and a wedge to help her position. The NA stated the resident's knee laying against the rail was neither comfortable and could possibly cause skin breakdown. An interview was held with NA # 1 on 04/28/11 at 10:50 AM. Information for residents is found in the care plan book at the front desk. Information about special equipment is shared verbally. The resident is turned every 2 hours, use the wedge cushion for positioning and her boots on. The pillow is supposed to be between her legs, but the resident pulls the pillow out. The NA stated it was time for the resident to be on her back for her meal and therefore the pillow could not be used. The NA stated the pillow should have been between her legs. An interview was held with the Director of Nursing (DON) on 04/28/11 at 11:14 PM. Information about residents are included in an NA Communication Book or inside the wardrobe door. Since these interventions have been in place, for Resident # 91, for a while the information would be through verbal communication, an information sheet inside the closet door and in the communication book. After a meal, the resident should be placed back on one side or the other when the meal is complete. The DON added meals were usually served around 9:00 AM on that hall, so there was no reason for Resident # 91 to be on her back at 10:30 AM. 3. Resident # 108 was admitted to the facility on	F 282	on Dialysis AVF checks quarterly for one year in QA&A.	

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F 282	Continued From page 16 12/21/10 with cumulative diagnoses that included end-stage renal disease Stage 5, hypertensive kidney disease, congestive heart failure, dementia and symbolic dysfunction. The resident received dialysis on Monday, Wednesday and Friday. Review of nursing notes for Resident #108 showed he had a left AVF (arteriovenous fistula) for his dialysis access site. National Kidney Foundation guidelines for care of dialysis patients include monitoring of AVF's by palpating the site to feel a strong pulse or buzzing sensation called a "thrill". If the thrill is felt that means blood is flowing through the blood vessel and the fistula is working. Further review of nursing notes and communication forms to the dialysis provider showed the facility checked the left AVF and thrill on 12/22/10, 12/23/10, 12/24/10, 12/28/10, 12/29/10, 12/30/10, 12/31/10, 1/1/11, 1/2/11, 1/3/11, 1/4/11, 1/5/11, 1/6/11, 1/11/11, 1/13/11, 1/26/11, 1/28/11, 1/13/11, 2/10/11, 2/11/11, 2/20/11, 2/23/11, 2/26/11 then on 4/1/11 and 4/15/11. The section labeled "dialysis access" on the communication forms to the dialysis provider for 12/30/10, 1/1/11, 1/6/11, 1/8/11, 1/11/11, 1/13/11, 1/18/11, 1/22/11, 1/24/11, 2/2/11, 2/4/11, 2/14/11, 2/16/11, 2/21/11 and 4/18/11 were blank. The facility care planned Resident #108's dialysis on 1/3/11 with update on 4/5/11 indicating a goal of the resident having no negative effects from dialysis. Approaches to accomplishing this goal were listed as: Assess resident prior to going to dialysis Complete dialysis communication sheets prior to	F 282		

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F 282	Continued From page 17 resident going to dialysis, noting any problems that dialysis team should be aware of. Check AVF for thrill/bruit (unusual sound that blood makes when it rushes past an obstruction in an artery-heard by stethoscope) before and after dialysis Notice if AVF is actively bleeding; apply pressure and/or dressing if needed. Notify MD of any problems with AVF In an interview on 4/28/11 at 8:41AM Nurse # 2 stated that the nurses check the arms, access site and vital signs of their residents receiving dialysis. She further stated that nurses would fill out the communication form to the dialysis provider with vital signs and any information needed to communicate to dialysis and send it with the resident. Nurse # 2 stated she was not on the shift when the residents returned from dialysis but that nurses would check the access to make sure it's okay and there was no bleeding. In an interview on 4/28/11 at 2:11PM Nurse # 3, the nurse on Resident #108's hall, stated that she was a fill-in nurse and that she was not aware of any procedures related to care of residents receiving dialysis. Nurse # 3 also stated that if that day had been a dialysis day for Resident #108, she would have asked the nursing assistants what to do with the resident before he left for dialysis. In an interview on 4/28/11 at 2:23 PM NA # 3, the nursing assistant taking care of Resident #108, stated that nurses check the resident's blood sugar and vital signs before he leaves for dialysis. In an interview on 4/28/11 at 8:50AM the DON	F 282		

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F 282	Continued From page 18 (Director of Nursing) stated there was no facility policy concerning dialysis and that nurses went by individual physician orders and care plans. The DON further stated that she expected nurse to check bruit on residents receiving dialysis to make sure there was blood flow through the AV fistula. The DON also stated that a report is sent with the resident to dialysis and when the resident returns, the facility checks for thrill/bruit. The DON stated that she had some staff changes that affected Resident #108's hall but that it was her expectation that nurses check for thrill/bruit as care planned for the resident.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to provide dialysis related services in 1 of 1 residents receiving dialysis (Resident # 108) and failed to provide treatment in a timely fashion to a scrotal wound for 1 of 1 residents with a scrotal wound (Resident # 75). Findings include: 1. Resident # 108 was admitted to the facility on 12/21/10 with cumulative diagnoses that included end-stage renal disease Stage 5, hypertensive	F 309	F309=D Provide Care/Services for Highest Well Being	

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F 309	Continued From page 19 kidney disease, congestive heart failure, dementia and symbolic dysfunction. The resident received dialysis on Monday, Wednesday and Friday. On 4/26/11 at 1:49 pm Resident # 108 was observed in his room but did not want to talk. Resident was at dialysis on 4/27/11 and on 4/28/11 at 12:17 PM the resident was not in his room. Review of nursing notes for Resident #108 showed he had a left AVF (arteriovenous fistula) for his dialysis access site. National Kidney Foundation guidelines for care of dialysis patients include monitoring of AVF's by palpating the site to feel a strong pulse or buzzing sensation called a "thrill" . If the thrill is felt that means blood is flowing through the blood vessel and the fistula is working. Further review of nursing notes and communication forms to the dialysis provider showed the facility checked the left AVF and thrill on 12/22/10, 12/23/10, 12/24/10, 12/28/10, 12/29/10, 12/30/10, 12/31/10, 1/1/11, 1/2/11, 1/3/11, 1/4/11, 1/5/11, 1/6/11, 1/11/11, 1/13/11, 1/26/11, 1/28/11, 1/13/11, 2/10/11, 2/11/11, 2/20/11, 2/23/11, 2/26/11 then on 4/1/11 and 4/15/11. The section labeled "dialysis access" on the communication forms to the dialysis provider for 12/30/10, 1/1/11, 1/6/11, 1/8/11, 1/11/11, 1/13/11, 1/18/11, 1/22/11, 1/24/11, 2/2/11, 2/4/11, 2/14/11, 2/16/11, 2/21/11 and 4/18/11 were blank. The facility care planned Resident 108's dialysis on 1/3/11 with update on 4/5/11 indicating a goal of the resident having no negative effects from	F 309	Lutheran Home Winston Salem will continue to ensure each resident receives and facility provides the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. • Resident #108 has had AVF checks placed on the MAR for the nurses. Resident #75 was discharged on 1-6-11. • Nurses were in-serviced on AVF checks for dialysis residents. Nurse #3 was educated on checking AVF site for dialysis residents. Each Resident on dialysis has been care planned for AVF checks and it has also been placed on the MAR. Nurse #1 was	4-28-11 5-26-11

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F 309	Continued From page 20 dialysis. Approaches to accomplishing this goal were listed as: Assess resident prior to going to dialysis Complete dialysis communication sheets prior to resident going to dialysis, noting any problems that dialysis team should be aware of. Check AVF for thrill/bruit (unusual sound that blood makes when it rushes past an obstruction in an artery-heard by stethoscope) before and after dialysis Notice if AVF is actively bleeding; apply pressure and/or dressing if needed. Notify MD of any problems with AVF In an interview on 4/28/11 at 8:41AM Nurse # 2 stated that the nurses check the arms, access site and vital signs of their residents receiving dialysis. She further stated that nurses would fill out the communication form to the dialysis provider with vital signs and any information needed to communicate to dialysis and send it with the resident. Nurse # 2 stated she was not on the shift when the residents returned from dialysis but that nurses would check the access to make sure it's okay and there was no bleeding. In an interview on 4/28/11 at 2:11PM Nurse # 3, the nurse on Resident #108's hall, stated that she was a fill-in nurse and that she was not aware of any procedures related to care of residents receiving dialysis. Nurse # 3 also stated that if that day had been a dialysis day for Resident #108, she would have asked the nursing assistants what to do with the resident before he left for dialysis. In an interview on 4/28/11 at 2:23 PM NA # 3, the nursing assistant taking care of Resident #108,	F 309	educated on follow through when skin issues are observed. Nursing staff were educated on follow through when any new wound is observed. Each resident will have weekly skin checks by the attending nurse. Skin checks will be reviewed weekly by ADON/ Supervisor to ensure appropriate treatments were ordered. Treatment nurse will turn in QA tool on all pressure sores with updates weekly to DON/NHA. WCPA will round with Tx nurse to check wounds and will change tx if necessary. In-service was held with treatment nurse, WCPA, MDS, DON and NHA to discuss communication plan	

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F 309	Continued From page 21 stated that nurses check the resident's blood sugar and vital signs before he leaves for dialysis. In an interview on 4/28/11 at 8:50AM the DON (Director of Nursing) stated there was no facility policy concerning dialysis and that nurses went by individual physician orders and care plans. The DON further stated that she expected nurse to check bruit on residents receiving dialysis to make sure there was blood flow through the AV fistula. The DON also stated that a report is sent with the resident to dialysis and when the resident returns, the facility checks for thrill/bruit. The DON stated that she had some staff changes that affected Resident # 108's hall but that it was her expectation that nurses check for thrill/bruit as care planned for the resident. 2. Resident # 75 was admitted on 02/15/10 with cumulative diagnoses of diabetes, peripheral neuropathy, cardiomyopathy, dementia, and glaucoma. . On 09/20/10 at 3:20 PM, the nurse documented she had been called to Resident # 75's room to observe an open area on the resident's scrotum. The nurse documented she applied Secura (a protective ointment) and notified the treatment nurse. There was no description of the wound nor measurements. Review of the treatment sheet indicated treatment for the scrotal ulcer had not been added. The nurse's note for 09/24/10 at 6:50 AM indicated special attention was paid to the scrotal/sacral area and they were improving. No	F 309	for updating wound care plans. • AVF checks will be reviewed weekly by the supervisor and turned in to the DON monthly. Any changes to wounds/ tx will be brought before the IDCPT weekly and care plans will be updated. • DON will report on Dialysis AVF checks quarterly for one year in QA&A. DON/designee will report on wounds/tx quarterly for one year in QA&A.	5-20-11 5-13-11

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F 309	Continued From page 22 treatment was listed on the treatment sheet for the scrotal ulcer. Review of the completed September 2010 treatment sheet did not indicate any treatment for the scrotal ulcer. Resident # 75's plan of care, with an original date of 10/26/10, indicated the resident's scrotal ulcer or individulized interventions had not been placed for the treatment of the ulcer. There was no indication, after review of the treatment sheets that the scrotal ulcer received treatments during October 2010.. The Wound Care Physician's Assistant (WCPA) assessed Resident # 75 on 11/24/10 and identified a Stage II scrotal wound. The PA stated the resident would not adhere to relieving pressure on his buttocks and would sit most of the day. On 11/25/10 at 2:15 PM, the treatment nurse documented the resident continued to receive treatments to the Stage III on his left ischium. There was no mention of the Stage II scrotal ulcer that began treatment on 11/25/10. The November 2010 Treatment Record indicated Resident # 75 had a Stage II on his scrotum that was identified on 11/25/10. Resident # 75 refused treatments on 16 out of 30 days. The care plan for Resident # 75, revised on 12/02/10, did not include the scrotal pressure ulcer.	F 309		

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LUTHERAN HOME - WINSTON SALEM	5350 OLD WALKERTOWN ROAD WINSTON-SALEM, NC 27105

(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 309	Continued From page 23 On 12/29/10, a Significant Change in Status Minimum Data Set (MDS) was completed for Resident # 75. He was coded as being understood and having the ability to understand others. The resident was scored as having a severe cognitive impairment. The MDS indicated Resident # 75 exhibited both physical and verbal behaviors 1 to 3 days during the assessment period. Rejection of care occurred 4 to 6 days out of the assessment period. The MDS coded the resident as requiring extensive assistance for bed mobility, transfer, dressing, eating and toilet use with personal hygiene coded as total dependence on staff. The resident had impairment of functional range of motion in both lower extremities. Resident # 75 was incontinent of bowel and bladder. Weight was recorded as 212 pounds. The PRESSURE ULCER RISK ASSESSMENT, dated 12/30/10, indicated the resident scored an 11 (a total score of 8 or above represented HIGH RISK). The assessment indicated if a resident scored at high risk a prevention protocol should be initiated immediately. An interview was held with the Treatment Nurse (TN) on 04/27/11 at 2:22 PM. On admission the admitting nurse is responsible for skin assessments and the Braden scale for Pressure Ulcer Risk determination. If a resident was assessed as high risk they are placed on a pressure reduction mattress. If the person scored really high, they would be placed on a low air loss mattress. Skin checks are done weekly by nurses on the hall. On existing wounds, the treatment nurse was responsible for weekly skin checks. Documentation was made in the nurse's	F 309		

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	345088	A. BUILDING ______ B. WING ______	04/28/2011

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F 309	Continued From page 24 notes. If a wound was discovered, the floor nurse would write a standing order, the Responsible Party and physician was notified, the information was put in the physician's book. The TN stated telephone orders were written for standing orders/wound protocols. The expectation was for the nurse that wrote the treatment order to transcribe the order to the treatment book. The treatment nurse reviewed Resident # 75's record. The TN offered no response why the wounds discovered on 09/20/10 did not receive immediate treatment. An interview was held with the Director of Nursing (DON) on 04/27/11 at 4:00 PM. The DON stated skin checks were done weekly. If there was an established skin breakdown, then the treatment nurse was responsible for the weekly charting, transferred that information to a Quality Assurance tool that was given to the DON and documented the information in the nurse's notes. If there was not an established wound then the nurse on the hall was responsible for the weekly skin checks. If a problem developed, such as skin breakdown, the wound nurse was expected to be notified. If a wound was discovered by a staff nurse, then the wound protocol was expected to be followed, the wound was treated as if a significant change and the nurse notified the physician and the Responsible Party. The DON stated the hall nurse was expected to write the treatment on the treatment sheet. This is to be completed during the course of the shift. The DON stated she would have to review the nurse's notes to see if the scrotal wound stayed open for the time period between 09/20/10 and 11/25/10. An interview was held with Nurse # 1 on 04/28/11	F 309		

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F 309	Continued From page 25 at 8:56 PM. Nurse # 1 documented the discovery of scrotal ulcer on 09/20/10. When an ulcer was found the expectation was for an assessment of the wound to be completed and the findings recorded in the doctor's book. The treatment nurse was also notified. The ulcer was treated immediately using standing orders/wound protocol. A telephone order was written and the order was transcribed to the treatment book. When a pressure ulcer was found, documentation should include size, presence of drainage or odor, color of the wound. The nurse reviewed the 09/20/10 note and stated she could not remember the scrotal wound. She stated she was sure she had notified the treatment nurse and concluded she had done her part. The nurse stated she could not answer whether the resident's scrotum received treatment or not since there was no entry on the treatment sheet for a scrotal treatment.	F 309		
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 observations, staff interviews and record review, the facility failed to ensure: 1) 13	F 371	F371=E Food Procure, Store/Prepare/Serve – Sanitary	

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F 371	Continued From page 26 dented cans of food items were not stored with ready to use food items, and 2) the facility failed to clean and air dry 19 resident ' s trays. Findings included: 1. During the initial tour of the kitchen's dry storage area on 4/26/11 at 3: 00 PM, the following canned foods were damaged with significant dents at their rim/seal. They were observed stacked among and intermingled with undamaged canned products ready for resident's use. Two cans of green beans had significant dents. During the second tour of the kitchen's dry storage room on 4/27/11 at 11:45 AM, the following canned foods were damaged with significant dents at their rim/seal. They were observed stacked among and intermingled with undamaged canned products ready for resident use. The products were three dented cans of cut beans, 2 dented cans of slices peaches, 2 dented cans of spaghetti sauce, 2 dented cans of tuna, and 2 dented cans of fruit cocktail. During an interview on 4/27/11 at 11:45 AM., the Dietary Manager (DM) indicated that leaving the dented cans with the ready-to-use cans was an oversight. He indicated that the food service staff normally checks the cans before they are used. If they are dented, they would not use them. He further stated that, the can food products were checked after every delivery for damages such as dents or leakage. If dented cans were found, they would be taken out and stored in the area designated for dented cans.	F 371	Lutheran Home Winston Salem will continue to: 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. • Dented cans were immediately place in dented can area in surveyor's presence. Wet/particulate food trays were cleaned in surveyor's presence. • Staff were in-serviced on the importance of moving dented cans to the dented can area. All cans were checked for dents and dented cans were moved to the dented can area. A form was developed to check off dented cans by truck delivery person as well as dietary staff as the cans are	4-28-11 4-29-11

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F 371	Continued From page 27 2. During the tray line observation on 4/27/11 at 11:40 AM, 19 residents ' insulated trays were observed stacked wet on top of one another. The trays were wet and they had silver ware, napkins, and condiments on them ready for service. Seven of the wet trays had dried up food particles inside the trays. The dietary manager acknowledged the condition of the insulated trays as wet and soiled, and he carried them to the dish room. During an interview with the dietary aide on 4/27/11 at 11:42 AM, he stated that " we would normally air dry them (referring to the residents insulated trays), but the last 2 racks of trays were wet when we put them on top of the prep(preparation) trays(trays with silverware condiment and meal tickets). In an interview with the DM on 4/27/11 at 11: 45 a.m., he stated " I believe the substance inside of the insulated trays was dried up eggs. My staff did not soak the trays before they ran them through the dish machine. " He further stated that, " we will soak and wash all the trays again." The DM further stated that the trays were wet because someone was in a hurry, but he will assign someone to thoroughly clean the dirty trays.	F 371	delivered. Staff were in-serviced on the importance of air-drying and checking trays for particulates and rewashing if needed. A form was developed for use after washing trays to check for particulates and to record air-drying. • Form regarding dented cans will be turned in to CDM after each delivery. CDM/designee will inspect cans after delivery has been stored to see if any dented cans were missed and place them in the dented can area. Form regarding air-drying and checking trays for particulates will be filed out by dietary staff each shift and CDM will check it throughout the week and collect it monthly.	4-29-11

• CDM will report on dented cans and air-drying/checking trays quarterly in QA&A.	5-13-11

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

PRINTED: 06/02/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345088	A. BUILDING 02 - BUILDING 02 B. WING ____	06/01/2011

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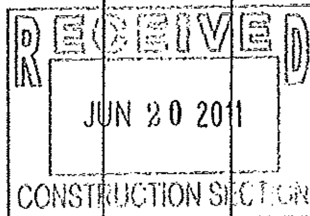
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only 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: A. Based on observation on 06/01/2011the following doors failed to latch when closed (204,212,214,219,223,309,319 and 322) 42 CFR 483.70 (a)	K 018	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely because it is required by the provision of federal and state law. K018 • Repairs have been made to doors for rooms 204, 212, 214, 219, 223, 309, 319, and 322. • All other resident room doors were checked to ensure they would latch when closed. • Maintenance Director/designee will complete a Preventative Maintenance check on all resident room doors on a weekly basis for 60 days and then monthly for one year. • Results of Door Check PM will be discussed at quarterly QA&A meeting for one year.	6-6-11 6-2-11 6-13-11 6-13-11
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	K 038		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cissy! Cynthia D. McCoy
TITLE: Administrator
(X6) DATE: 6/18/11

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.

CD

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

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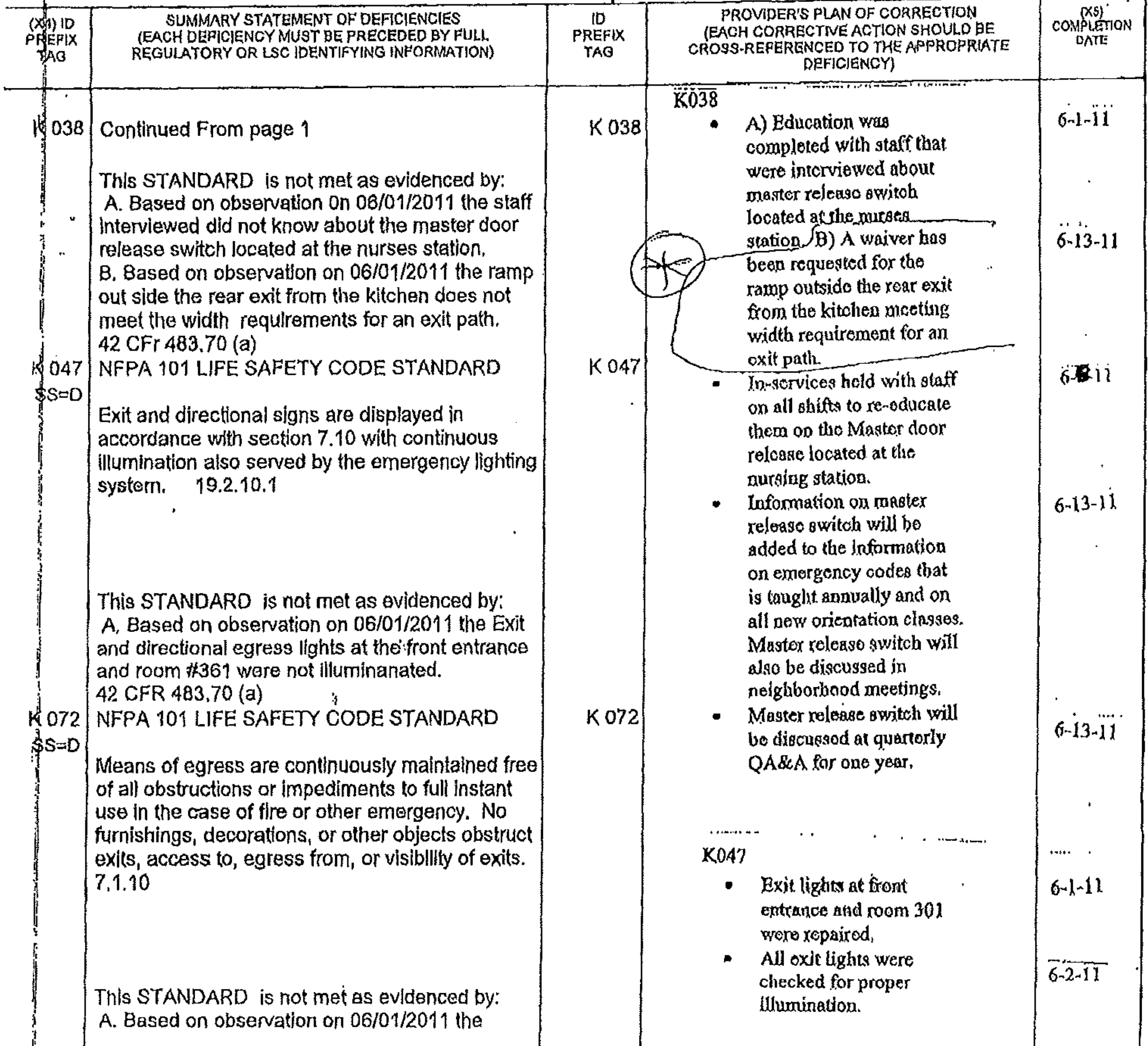
FORM APPROVED
OMB NO. 0938-0391



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K 038	Continued From page 1 This STANDARD is not met as evidenced by: A. Based on observation On 06/01/2011 the staff interviewed did not know about the master door release switch located at the nurses station. B. Based on observation on 06/01/2011 the ramp out side the rear exit from the kitchen does not meet the width requirements for an exit path. 42 CFr 483.70 (a)	K 038	K038 • A) Education was completed with staff that were interviewed about master release switch located at the nurses station. B) A waiver has been requested for the ramp outside the rear exit from the kitchen meeting width requirement for an exit path. • In-services held with staff on all shifts to re-educate them on the Master door release located at the nursing station. • Information on master release switch will be added to the information on emergency codes that is taught annually and on all new orientation classes. Master release switch will also be discussed in neighborhood meetings. • Master release switch will be discussed at quarterly QA&A for one year.	6-1-11 6-13-11 6-[illegible]-11 6-13-11 6-13-11
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: A. Based on observation on 06/01/2011 the Exit and directional egress lights at the front entrance and room #361 were not illuminanated. 42 CFR 483.70 (a)	K 047	K047 • Exit lights at front entrance and room 301 were repaired. • All exit lights were checked for proper illumination.	6-1-11 6-2-11
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: A. Based on observation on 06/01/2011 the	K 072		

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K 072	Continued From page 2 doors to rooms 001 and 012 opened into the egress corridors. These doors do not open 180 degrees nor do they have closers on them . (when open they reduce the corridor width) 42 CFR 483.70 (a)	K 072	• Exit lights will be checked 5 days per week for 30 days; then weekly for 90 days; then monthly for one year.	6-13-11
			• Exit sign illumination will be discussed quarterly in QA&A for one year.	6-13-11
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: A. Based on onservation on 06/01/2011 there were full and empty 02 cylinders mixed in the 02 storage room off the court yard. 42 CFR 483.70 (a)	K 076	K072 • Doors to bathrooms 001 and 012 have been repaired.	6-14-11
			• All bathroom doors that open into the egress corridors have been checked to ensure that they open 180 degrees or have closures on them.	6-2-11
			• All doors that open to the egress corridor will be checked weekly for 60 days and then monthly for one year as a separate preventative maintenance program.	6-13-11
			• Doors that open into the egress corridor will be discussed quarterly in QA&A for one year.	6-13-11

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			• An in-service has been held with the nursing staff to remind them that full and empty oxygen cylinders must be stored separately. Empty area and full area have been clearly labeled with signage.	6-13-11
			• Oxygen storage area will be checked daily for 60 days; then weekly for one year.	6-13-11
			• Oxygen storage will be discussed quarterly in QA&A for one year.	6-13-11