STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345403	A. BUILDING _____ B. WING _____	C 05/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARY HEALTH AND REHABILITATION	6590 TRYON ROAD CARY, NC 27518

(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 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to provide range of motion and splint application as ordered for 2 of 3 sampled residents (#96, #14) receiving restorative rehabilitation. The findings include: 1. Resident #96 was admitted to the facility on 05/14/08 with a diagnosis of Hemiplegia. The quarterly Minimum Data Set dated 4/8/11 revealed Resident #96 was to receive Range of motion (ROM) active for 4 days a week, no splint or brace. According to the MDS, the resident upper and lower extremities had functional limitations. The physician order dated 1/10/11 revealed Resident #96 was to receive restorative program for the lower extremities. The care plan dated 4/7/11 revealed there were no interventions for restorative. The physician's order dated 5/9/11 revealed	F 318	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. 1. Residents #96 and #14 received range of motion and splint application immediately as-ordered for restorative rehabilitation. 2. Current facility residents were reviewed to ensure that residents with orders for range of motion and splint application are receiving restorative rehabilitation services as ordered by the physician. 3. Nursing staff was re-educated that residents with orders for restorative rehabilitation for range of motion and splint application are to receive services per the physician's orders. Documentation of restorative rehabilitation for range of motion and splint application is to be completed daily by nursing staff. DON/Designee will conduct Quality Improvement (QI) monitoring of this standard 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months.	6/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	6/6/11

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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CARY HEALTH AND REHABILITATION	6590 TRYON ROAD CARY, NC 27518

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F 318	Continued From page 1 Resident #96 was to begin the restorative program for splint schedule and management. On 5/25/11 at 4:15 pm, Nurse Assistant (NA) #4 revealed Resident #96 received ROM from Restorative aide. NA#4 revealed she only rubbed the resident's feet and kept her feet floated and turned from side to side. On 5/26/11 at 9:30 am, Nurse #2 was unaware that Resident#96 received ROM. She stated the restorative aid does it for the residents. Resident #96's restorative care sheet for the month of May revealed 5 out of 26 days the resident received passive (staff assist resident with weight bearing) for 15 minutes (mins) and splint for 5 mins, April revealed the resident received ROM active (resident completes independently/without assistance) for 15 out of 30 for 15 mins, March revealed the resident received ROM 7 out of 31 days for passive for 15 mins, February revealed the resident received 6 out of 28 days passive for 15 mins, and January revealed the resident received ROM 6 out of 31 days passive for 15 mins. On 5/25/11 at 4:11pm, the resident was observed sleeping in her bed. Her right hand was contracted. The resident did not have a splint on her hand and had a cushion under her feet. On 5/26/11 at 9:36 am, Resident #96 was observed in her room with sleeves on both of her arms. There was no splint in place. On 5/26/11 at 12:55pm, the Restorative aide revealed Resident #96 received ROM and a	F 318	4. DON/Designee will report results of QI monitoring to the Risk Management/Quality Improvement (RM/QI) Committee monthly x 12 months for continued compliance and/or revision. 5. Date of Completion 6-23-11.	

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	345403	A. BUILDING _____ B. WING _____	C 05/26/2011

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F 318	Continued From page 2 splint. The restorative aide revealed there was no resident who received restorative daily. Restorative aid revealed she does not see the orders, but she thought the resident received restorative daily. Restorative aide revealed the resident was supposed to wear the hand splint daily for at least 4-6 hrs a day. The restorative aide stated she informed the Director of Nursing (DON) about her concerns about being short of staff for restorative. Restorative aide revealed the DON was looking for someone. Restorative aide stated she told the DON about being behind when DON started working at the facility. Aide revealed the other restorative nurse was out on maternity leave. She stated "even before that we were short staff because they pulled me on the floor." She revealed now she does not go on the floor. Aide revealed the months of November through December there were additional aides, but since this year came in there had been insufficient staff. On 5/26/11 at 1:13 pm, Restorative aide revealed it was difficult to be in two places at one time. She revealed the previous restorative order was for Resident #96 legs. She revealed the order dated 5/9/11 was for the resident's splint. The aide revealed the resident received restorative for their legs and hands. She stated she had not used splint on Resident #96 today because she did not have time. On 5/26/11 at 3:10 pm, Director of Nursing (DON) revealed the other restorative aid went on maternity leave last week, therefore, there was only one restorative aide working. She revealed she had heard something about the restorative aide leaving before she left. She revealed the documentation for restorative should be	F 318		

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F 318	Continued From page 3 consistent and complete. The DON stated the restorative aide informed her of being behind. She stated the restorative aide also was going on the floor, but no longer does that. The DON revealed she was in the process of hiring someone. 2. A review of Resident #14's record revealed she was originally admitted to the facility on 11/08/04 and readmitted on 12/23/10 with diagnosis to include Osteoporosis, Joint Contracture, Dementia, and a Femur Fracture. A review of the Minimum Data Set dated 1/08/11 indicated range of motion (ROM) limitation in the upper extremity with impairment on both sides. A review of Resident #14 medical record revealed a physician order dated 5/06/11 which stated "Restorative nursing to begin as of 5/09/11 for ROM and bilateral upper extremity (BUE) splint/positioning. Right soft hand splint (protector) for 1-3 hours. Left palm protector for 1-3 hours." A review of the Restorative Care Flow Record May 2011 revealed Resident #14 was provided ROM and splint application on 5/11/11, 5/18/11, and 5/20/11. A review of the restorative notes revealed Resident #14 did not receive ROM or splint application for twelve of the fifteen days with no documentation to indicate resident refusal. Observations of Resident #14 on 5/23/14 at 4:14PM, 5/24/11 at 1:19PM, 5/25/11 at 9:25AM, 10:25AM, 12:05PM, and 2:28PM revealed no splint on the right hand or palm protector on the left hand. An interview on 5/25/11 at 10:26AM with nursing	F 318		

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F 318	Continued From page 4 assistant (NA) #1, assigned to Resident #14, revealed she was unaware of Resident #14's use of splint or palm protector. NA#1 further stated the aide assigned daily care did not provide any range of motion to upper extremities. An interview on 5/25/11 at 2:45PM with the Rehabilitation Director revealed a quarterly check was completed on residents with contracture's and treatment for Resident #14 was implemented as a preventative measure. She reviewed the notes for Resident #14 and stated staff was trained on 5/04/11 for ROM and splint application. A review of the Therapy to Restorative Nursing Recommendations included ROM to fingers on right and left hand, right hand green cylinder roll, left hand, left palm protector, application of splint 1-3 hours and remove at meal times. The Occupational Therapist trained the Restorative Aide and the Director of Nursing signed the form on 5/04/11 indicating completion of the training. On 5/25/11 at 3:55PM an interview with NA#2, assigned to Resident #14, revealed she was unaware of a splint or palm protector utilized for Resident #14. An interview on 5/26/11 at 9:00AM with the Restorative Aide revealed Resident #14 was a participant in the Restorative Program and required ROM and splint application daily. During the interview the Restorative Aide reviewed the Restorative Care Flow Record and confirmed in May 2011 Resident #14 was provided with ROM and splint application on 5/11/11, 5/18/11, and 5/20/11. The Restorative Aide also attempted application on 5/25/11 and indicated the resident refused. The Restorative	F 318		

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F 318	Continued From page 5 Aide stated Resident #14 was not receiving ROM and splints every day due to the inability to manage care for all of the residents receiving restorative. An interview with the Unit Manager on 5/26/11 at 9:11AM revealed Resident #14 should be receiving ROM and soft hand splint to the right hand and left palm protector for 1-3 hours daily.	F 318		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 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.	F 329	1. Resident #96's behavior signs and symptoms were monitored immediately. 2. Current facility residents were reviewed to ensure that those being administered anti-psychotic medication are receiving monitoring of behavior signs and symptoms. 3. Licensed nursing staff were re-educated on the monitoring of behavior signs and symptoms for those residents receiving anti-psychotic medication. Documentation of behavior signs and symptoms for those residents receiving anti-psychotic medication is to occur daily on each shift by licensed nursing staff. DON/Designee will conduct QI monitoring of this standard 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months.	

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F 329	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to monitor behavior signs and symptoms for 1 of 3 sampled residents (#96) being administrated anti-psychotic medication. The findings include: Resident #96 was admitted to the facility on 05/14/08 with a diagnosis of Bipolar disorder. The quarterly Minimum Data Set (MDS) dated 4/8/11 revealed Resident #96 had short and long term memory impairment, as well as, her decision-making skills. The MDS revealed there was no concern about Resident #96's mood and/or behaviors. The Medication Administration Record (MAR) for the month of May revealed the behavior sheet was blank. The month of April had one entry on 4/6/11. There were no other entries for the two months (April and May.) Care Plan dated 4/7/11 revealed staff interventions for Resident # 96's mood were "observe for changes in mood status," and "record /monitor me for patterns of target behaviors." According to the physician's order dated 3/21/11 there was a dose reduction for the seroquel, Resident #96 was ordered Seroquel 25 milligrams (mg) two tablets in the morning and at night for Bipolar disorder. According to Drug information online version, Seroquel is an atypical anti-psychotic medication, which is used to treat Bipolar disorder.	F 329	4. DON/Designee will report results of QI monitoring to the RM/QI Committee monthly x 12 months for continued compliance and/or revision. 5. Date of Completion 6-23-11.	

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F 329	Continued From page 7 The Nurses note for the Month of May revealed there were no concerns about Resident #96 behaviors. The 24 hour report for the month of May did report any behaviors. The E-tracker (electronic device to document notes for staff) revealed for the months of April and May the Nurse Assistant (NA) on 5/25/11, 4/16/11 and 5/8/11 behaviors were documented for the Resident #96. On 5/26/11 at 10:24 am Nurse #2 revealed behavior sheet should only be filled out for as needed anti-psychotic medications. On 5/26/11 at 10:30 am Nurse #1 stated the behavior sheet should be filled out for every time anti-psychotic medication was administrated. On 5/26/11 at 1:46 pm Nurse #1 revealed that staff probably got use to the behaviors and thought it was normal behavior and did not document it. Nurse #1 revealed the resident would yell out a couple times a week. The nurse stated there should have been documentation for Resident #96 on the behavior sheet. The nurse stated the last time Resident # 96 yelled out was yesterday all during the day. On 5/26/11 at 2:02, Nurse #2 revealed scheduled anti-psychotic medication would not be documented unless it was as needed medication, which would be documented on the back of MAR. Nurse #2 stated she would document if it was effective for as needed anti-psychotic	F 329		

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F 329	Continued From page 8 medications only. Nurse #2 revealed Resident #96 yelled out all day yesterday. The nurse stated she gave resident as needed medication (Ativan). The Drug information handbook 14th edition revealed Ativan was to manage anxiety disorders or short-term relief of the symptoms of anxiety. The nurse stated she documented medication administration on the MAR for 5/25/11 and documented medication was effective. There was nothing documented on the behavior sheet. On 5/26/11 at 3:15 pm, the Director of Nursing (DON) revealed the expectations for the behavior sheets were to be filled out completely regardless if the psychotic medication was as needed or scheduled.	F 329		

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	345403	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/23/2011

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K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following, 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/23/11 at approximately noon the following building construction was observed as non-compliant, specific findings include boiler vent escutcheon plate had fallen down and there was not any fire caulking around the area. Outside mechanical room near the generator.	K 012	Tag K 012 1. The vent escutcheon plate in the outside mechanical room has been reset using fire caulking to secure it. 2. This will be monitored weekly x 4 by the Maintenance Director to ensure it does not loosen, then 1 time monthly X 11 months. 3. This will be reviewed by the RM/QI team x 1 monthly for 11 months for trends, patterns, and recommendations. This will be completed by 8/7/2011.	
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.	K 018	Tag K 018 The kitchen door next to Central Storage was repaired with a new non roller latch, knobs, and a strike plate by the maintenance director and now close tightly.. An audit of fire doors was completed in the building to ensure doors latch. Maintenance director will QI monitor the fire doors monthly x 12 months for compliance. This will be reviewed monthly by RM?QI to track trends/patterns or recommendations. This will be completed by August 7, 2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Judy A Carter — TITLE: NHA — (X6) DATE: 7-9-11

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GRJ

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 018	Continued From page 1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/23/11 at approximately noon the following doors protecting corridor openings were observed as non-compliant, specific findings include; kitchen door hardware providing positive latching was broken. The kitchen door next to central storage.	K 018		
K 021 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2	K 021	Tag K 021 The fire door near room 407 was repaired and now latches tightly in its frame. The maintenance director was inserviced on fire door regulations by the administrator. The doors will be audited by the maintenance director 1 time weekly x 4 then 1 time monthly x 11. The results will be presented to the RM/QI committee monthly for trends/patterns, and recommendations. This will be completed 8/72011	
	This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/23/11 at approximately noon the following fire door was observed as			

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K 021	Continued From page 2 non-compliant, specific findings include; fire door near room 407 did not close and latch tightly in it's frame.	K 021		
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/23/11 at approximately noon the following exit discharge illumination was observed as non-compliant: specific findings include no exit discharge lighting in the two curves in the outside exit path from the smoking area around to the main entrance. 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 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 045	Tag K 045 Bidden Electric Company will install lighting along the curved area of the outside exit path from the smoking area to the main entrance providing at least 1 foot-candle of light measured at the floor. The light swill be tied into the emergency power system. It will have a turn-off, turn-on switch that automatically changes at dusk and dawn. This is an isolated need that will be monitored 1 time by the administrator for completion and reviewed by the RM/QI x 1 for compliance. This will be completed by: August 7, 2011 Tag K 050 Fire drills here are completed on all three shifts. They are provided once each shift quarterly by the maintenance director per regulations. Documentation will be completed and inserving tracked and signed by employes. The maintenance director was reeducated to ensure he understands the fire drills are to be provided each shift quarterly. The administrator will monitor 1 time monthly x 12 months. This shall be monitored by RM/QI team monthly x 12 for compliance. This will be completed by August 7, 2011	
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are	K 050		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	345403	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARY HEALTH AND REHABILITATION	6590 TRYON ROAD CARY, NC 27518

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K 050	Continued From page 3 qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) On 6/23/11 at approximately noon the following fire drills were non-compliant: specific findings include, documentation indicated less than the required number of drills were held on third shift of 4th quarter 2010, third shift of 1st & 2nd quarter 2011, and second shift of 1st quarter 2011.	K 050		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/23/11 at approximately noon	K 056	Tag K 056 All 5 fans will be removed as to not obstruct the flow of water from the fire sprinkler system. The building was audited for additional fans obstructing the flow of water from the sprinkler system and none were noted. This is a 1 time observation to be reviewed by the administrator for completion. The RM/QI team will monitor x 1 for compliance or further recommendation. This will be completed by August 7, 2011	

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K 056	Continued From page 4 the following NFPA 13 obstructions were observed as non-compliant, specific findings include; ceiling fans in the main visitors entrance (two), residents smoking porch (one) and main dining (two) have ceiling fans that are within 18" of the sprinkler head and could obstruct the flow of the system.	K 056		
K 061 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/23/11 at approximately noon the following automatic sprinkler system was observed as non-compliant, specific findings include the accelerator line to the dry side of the sprinkler riser has a valve that when closed will affect the operation of the system is not equipped with an electronically supervised tamper alarm.	K 061	Tag K 061 A tamper alarm was installed. This was wired into the electronically supervised system so an alarm will sound when the valves are closed. This will be monitored weekly x 4, then monthly x 11 by the maintenance director. This will be presented to the RM/QI committee for trends, patterns, and recommendations monthly. This will be completed by 8/7/11	
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 26, 9.7.5 This STANDARD is not met as evidenced by:	K 062	Tag K 062 System 1, the side chamber has been overhauled.. System 2 ,we replaced the accelerator and added a new check valve then added a 1 ¼ inch pipe going to the filler cup. This will be monitored by the maintenance director x 1 x 4 weeks weeks to ensure it is working properly then audited monthly X 11 to monitor any trends, patterns, or recommendations for RM?QI team. This will be completed 8/7/11/11	

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K 062	Continued From page 5 42 CFR 483.70(a) By documentation on 6/23/11 at approximately noon the following automatic sprinkler system was observed as non-compliant, specific findings include annual report notes deficiencies in the system that are in need of repair. The following items had not been correct at the time of the survey; A. "System #1-Accelerator not working & side chamber on valve needs to be replaced or overhauled" B. "System #2-Accelerator missing from system and needs a check valve on 1-1/4" pipe going to filler cup"	K 062		
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/23/11 at approximately noon the following Heating Ventilation and Air Conditioning (HVAC) Units were observed as non-compliant, specific findings include air conditioning in the laundry room was not functioning and doors wedged open. The surveyor was told that the unit was under repair.	K 067	Tag K 067 The air conditioning in the laundry will be repaired. Air conditioning in all other areas are functioning properly. Door wedges have been removed from all areas in the building. Staff was reinserviced not to use any props in the facility to wedge doors open.. They were inserviced to report any non functioning air conditioning in the facility to the administrator or maintenance director for repair. This will be monitored by the maintenance director weekly times 4, then monthly times 11 and reviewed monthly by the RM/QI team for trends/patterns or recommendations. This will be completed by August 7, 2011	
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	K 072	Tag K 072 Door closers have been installed on 14 doors to prevent any door swinging in a means of	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARY HEALTH AND REHABILITATION	8590 TRYON ROAD CARY, NC 27518

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K 072	Continued From page 6 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: 42 CFR 483.70(a) By observation on 6/23/11 at approximately noon the following obstructions were observed as non-compliant, specific findings include; corridor doors to housekeeping and janitor's closet on 400 hall and housekeeping and storage closet on the 300 hall swing into the corridor without a listed closure and the door does not swing 180 degrees but leaves a projection of approximately 18" into the corridor. NFPA 7.2.1.4.4 states during its swing, any door in a means of egress shall leave not less than one-half of the required width of an aisle, corridor, or landing unobstructed and shall not project more than 7 in. (17.8 cm) into the required width of an aisle, corridor, passageway, or landing, when fully open.	K 072	egress, and shall leave not less than ½ of the required width of aisle, or corridor unobstructed. All fire doors were audited for compliance by the maintenance director and documentation maintained. The Maintenance Director was inserviced by the Administrator for regulatory compliance and he will monitored this weekly x 4 for compliance, then monthly x 11 for review by the RM/QA for trends, patterns, and r4ecommendations. This will be completed by 8/7/2011.	
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	K 076	K Tag 076 Full and empty oxygen cylinders were immediately separated. Full and empty cylinders are stored in separate rooms in appropriate cylinder racks. Correct signage marks each room. Staff has been reeducated where cylinders are located and must be in appropriate storage racks. This will be monitored by the maintenance director weekly x 4, then monthly x 11. The results will be given to RM/QA monthly x 11 to monitor for trends, patterns or recommendations. This will be completed August 7, 2011	

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K 076	Continued From page 7 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/23/11 at approximately noon the oxygen storage was non-compliant, specific findings include; A. Full and empty oxygen cylinders were stored together. If stored within the same enclosure, empty cylinders shall be segregated and designated (with signage) from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. [NFPA 99 4-3.5.2.2b(2) B. Oxygen cylinders were not properly chained or supported in a proper cylinder stand or cart. [NFPA 99 4-3.5.2.1b(27)] (both A & B were in the 200 hall oxygen storage next to room 209)	K 076		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99, 3.4.4.1. This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 6/23/11 at approximately noon	K 144		

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K 144	Continued From page 8 the following operational inspection and testing was non-compliant. Specific findings include: documentation for monthly load test was conducted without recording percent rated load or temperature rise. A load bank test had not been completed within the past year. Staff stated that testing had been started but had to shut down due to replacement parts needed, NFPA 99 3-4.4.2 Record keeping. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained and available for inspection by the authority having jurisdiction. NFPA 110 6-4.2 (1999 edition) generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. NFPA 110 6-4.2.2 (1999 edition) Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPPS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. (load bank testing)	K 144	K Tag 144 Load bank testing will be completed yearly x 2 hours by a general service electrician and accurate documentation completed by the maintenance director. Record keeping shall include record of inspection, performance and repairs. Level 1 and 2 service shall be exercised monthly for 30 minutes. Accurate documentation will be provided. The maintenance director shall run the tests and provide the documentation. The administrator will monitor the documentation for completeness and timeliness monthly x 11. This information will be given to the RM/QA team to review for trends, patterns or recommendations. This will be completed by August 7, 2011.	