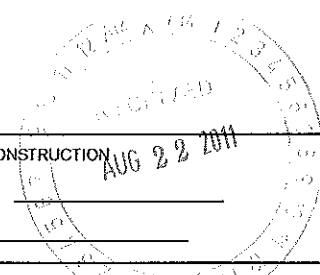


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/02/2011  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345407	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  07/28/2011
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NAME OF PROVIDER OR SUPPLIER  CROSS CREEK HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1719 SWAN QUARTER ROAD SWANQUARTER, NC 27885
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F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and review of medical records, the facility failed to provide the care ordered by the physician for 1 of 3 sampled residents (Resident # 70), that had an order for indwelling urinary catheter removal. Findings include:</p> <p>Resident # 70 was readmitted to the facility on 06/14/11. Diagnoses included cerebrovascular accident and urinary retention.</p> <p>A Hospital Discharge Summary, dated 06/14/11, indicated Resident # 70 had been transferred due to confusion, hallucinations and increased left sided weakness. The summary added the resident had recent history of multiple strokes. The HOSPITAL COURSE indicated the resident had a urinary tract infection and urinary retention. The physician documented a history of urinary retention. Urology was consulted and recommended placement of an indwelling urinary catheter to allow 2 weeks of bladder rest. During hospitalization a voiding trial failed.</p>	F 309	<p>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.</p> <p>To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.</p> <p><b>F 309 SS=D</b></p> <p><b>Corrective Action for Resident Affected</b> Resident # 70 was re-scheduled for catheter removal on 7/14/11. The catheter was removed in advance of the appointment as ordered and the resident was transported to the physician office via ambulance at no cost to the resident.</p> <p><b>Corrective Action for Resident Potentially Affected</b> All residents who have Physician orders received in the current month that are to be implemented in the following month have the potential to be affected by this alleged deficient practice.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sheldin W. ...</i>	TITLE Administrator	(X6) DATE 8/18/11
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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 309	<p>Continued From page 1</p> <p>The resident's care plan, dated 06/16/11, indicated Resident # 70 had an indwelling urinary catheter due to urinary retention.</p> <p>An admission Minimum Data Set (MDS), dated 06/21/11, indicated Resident # 70 was cognitively intact. The resident was assessed as having a urinary tract infection within the previous 30 days. The assessment indicated Resident # 70 had an indwelling urinary catheter.</p> <p>A physician's order was received on 06/29/11 to discontinue the indwelling urinary catheter on 07/07/11 at 6:00 AM. Macroclantin (An antibiotic) 50 milligrams (mg) was ordered for Resident # 70 to be given daily for 10 days. Resident # 70 was scheduled to follow up with the urologist on 07/07/11 at 2:45 PM.</p> <p>Review of the June 2011 Medication Administration Record (MAR) for Resident # 70, indicated the orders from 06/29/11, to remove the indwelling catheter on 07/07/11, were transcribed correctly.</p> <p>Review of the July 2011 MAR indicated the order to remove the catheter on 07/07/11 had been omitted.</p> <p>The nurse's note, dated 07/07/11, indicated the physician's office called to question why the indwelling urinary catheter had not been removed as ordered. The nurse documented she looked in the chart, found the order and apologized to the physician's office. The nurse documented the order had not been placed on the July 2011 order. An appointment for Resident # 70 was rescheduled.</p>	F 309	<p>All resident medication and treatment records were reviewed by the Acting Director of Nursing by 07/31/11 to ensure that any new physician orders received during the month of July were carried over to August and were correctly transcribed to the new medication and treatment records. (See attachment #1)</p> <p><b>Systemic Changes</b> An in-service was conducted on 08/15/11 by the Acting Director of Nursing. (See attachment #2) RNs and LPNs, FT, PT, and PRN employed by this facility completed the in-service. Hospice providers were not included because they do not transcribe orders on facility documents. The in-service topics included:</p> <ol style="list-style-type: none"> <li>1) Proper transcription of Physician orders to the medication and treatment records.</li> <li>2) Proper month-end reconciliation of Physician Orders, Medication Administration Records and Treatment Administration Records.</li> <li>3) This information has been integrated into the standard orientation training for all licensed staff and will be reviewed by the Quality</li> </ol>		

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F 309	<p>Continued From page 2</p> <p>On 07/07/11, physician's orders were received to remove Resident # 70 's indwelling urinary catheter on 07/14/11 at 6:00 AM for a follow up appointment at 2:45 PM.</p> <p>Nurse's notes, dated 07/14/11 at 12:30 PM, indicated Resident # 70 stated he had voided a bit after the indwelling catheter removal.</p> <p>The urological consult form, dated 07/14/11, indicated Resident # 70 had failed the voiding trial with 775 milliliters (ml) of urine as a post void residual collected.</p> <p>On 07/15/11 at 2:35 PM, the nurse documented the resident told her he was unable to urinate at the physician's visit yesterday and his catheter was replaced.</p> <p>An interview was held with the Acting Director of Nursing (ADON) on 07/27/11 at 2:55 PM. She stated Resident # 70 came into the facility with the catheter for urinary retention. Voiding trials failed. The ADON stated when orders were received the nurse that received the order transcribed the order to the MAR or the Treatment Record. At the end of the month, the orders are put into the MAR by the Medical Record clerk. The nurses on the hall are responsible for checking and double checking orders to make sure all new orders have been added and all orders are correct. After review of the 07/07/11 physician ' s order for Resident # 70 and comparison of the June MAR to the July MAR, the ADON stated the order had not been carried forward. She added nurses had not caught the error on double check. The ADON</p>	F 309	<p>Assurance process to verify the change has been sustained.</p> <p><b>Quality Assurance</b> The Director of Nursing or MDS Coordinator will monitor this issue using the "Survey QA Tool for Monthly MAR and TAR Review. (See attachment # 3) The monitoring will include verifying that all new orders received during the current month are transcribed to the next month during month-end review. All resident records will be reviewed. See attached monitoring tool. This will be done during the first full week of each month for three months or until resolved by QOL/QA committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate.</p>	8/18/11

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F 309	<p>Continued From page 3</p> <p>stated the harm caused was Resident # 70 endured an hour trip to and from the physician's office for no reason. Because the staff had not removed the catheter as ordered, the physician was unable to provide the intended treatment.</p> <p>An interview was held with Nurse # 3 on 07/27/11 at 3:15 PM. She stated the end of the month the new physician's orders were compared with the new MARS. The old MAR is then compared with the new MAR to make sure nothing had been missed. Nurse # 3 stated this was done by the nurses on the hall. The nurse reviewed the July 2011 orders and stated she signed as completing the first check but she would not know who did the second check since that nurse was not required to sign. The nurse stated she just missed transcribing the 07/07/11 physician ' s order for Resident # 70 to the MAR for July.</p> <p>An interview was held with Resident # 70 on 07/28/11 at 8:57 AM. He stated he remembered the day he went for his appointment and the physician could not provide treatment because the indwelling urinary catheter had not been removed as ordered. The resident stated both his Responsible Party and another family member had taken off work to go with him. Resident # 70 stated he and his family had been very aggravated by the situation. He stated the physician had been upset the catheter had not been removed. The resident stated he had been transported by a private ambulance service and he thought he and his family would be responsible for payment.</p> <p>An interview was held with the ADON on 07/28/11 at 9:00 AM. She stated the resident was</p>	F 309			

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F 309	Continued From page 4 transported via ambulance. The facility was responsible for the cost of transportation.  On 07/28/11 at 10:05 AM, a telephone interview was conducted with Resident # 70 's Responsible Party. She stated on 07/07/11, she had taken a day off from work to accompany Resident # 70 to his urology appointment. On arrival, the physician could not provide the planned treatment because the facility had forgotten to remove the indwelling urinary catheter. The Responsible Party stated the physician, the resident and she had been agitated by this delay in treatment. She added she had lost a day ' s work because of this. The Responsible Party stated the resident had been transported by an ambulance to the appointment and she was not sure who was responsible for payment.	F 309	<b>F 441 SS=D</b>  <b>Corrective Action for Resident Affected</b> Resident # 44- room was thoroughly cleaned and all food items removed or placed in closed containers. Appropriate pest control spray was applied per the facility pest control vendor on 8/5/11. (See attachment #4)  <b>Corrective Action for Resident Potentially Affected</b> All residents residing in the facility with open wounds have potential to be effected during dressing changes. The facility pest control vendor was contacted and provided appropriate pest control spray to all areas of the facility both inside and out on 8/5/11.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	<b>Systemic Changes</b> Five WS-B5 Flying Insect Control units (lights) supplied by the facility pest control vendor, were installed strategically near exit doors and at the nursing station on 8/18/11. (See attachment #5) These devices are designed to capture flying insects at point of entry and in high traffic areas. The pest control vendor will continue to provide monthly and as needed pest control services. All food items will be removed promptly from resident areas after meals and as needed.	

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F 441	<p>Continued From page 5</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, the facility failed to prevent pests from landing on wound beds in 1(Resident #44) of 3 sampled residents whose wound care was observed. Findings include:  Resident #44 was admitted to the facility on 02/21/11 with diagnoses of paraplegia, bilateral above knee amputations, hypertension, and stage 4 pressure wounds.  Resident #44's most recent Minimum Data Set (MDS) assessment, a quarterly dated 05/20/11, documented his cognition as intact. Resident #44 required extensive assistance of two staff</p>	F 441	<p>Staff has fly swatters available at the nursing station for immediate intervention and is to report incidence of flying insect pests and location to the Environmental Services Director for further intervention during regular office hours.</p> <p><b>Quality Assurance</b> The monitoring will include verifying that all newly installed insect control units are functioning as designed and are emptied on a monthly basis and ensuring that all food items are removed from resident rooms at the completion of meals and as needed. This will be done daily for four weeks and then weekly for three months or until resolved by QOL/QA committee. Reports will be given during the daily stand-up meetings and to the weekly Quality of Life- QA committee and corrective action initiated as appropriate</p>	8/13/11

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F 441	<p>Continued From page 6</p> <p>members for bed mobility and transfers and was non-ambulatory. The assessment indicated Resident #44 had impaired functional limitations for range of motion on both sides of upper and lower extremities.</p> <p>A wound care observation was done on 07/21/11 at 2:15 PM on Resident #44. Nurse #1 and Nurse #2 did the wound care. Nurse #1 cleansed the wound on Resident #44 's sacral area. The sacral wound measured approximately 6.5 cm (centimeters) in length by 3 cm width and 2.5 cm in depth. As Nurse #1 turned to reach dressings off the bedside table several flies were observed landing on wounds located on Resident #44's left ischium area. Resident #44 's wound on the left ischium area measured 8.2 cm length by 8 cm width and 1 cm depth with several smaller stage 2 wounds around the larger wound. Nurse #2 waved the flies off of Resident #44. Nurse #2 cleansed the wound on Resident #44's left ischium area, and Nurse #1 placed a dressing over the area with one hand while waving the flies away with her other hand. Two flies were observed landing on Resident #44's right upper posterior thigh and moving into the wound bed on the right ischium area. The wound on Resident #44's right ishium measured 3 cm length by 8 cm width and 2 cm depth with a smaller stage 2 open wound to the left of the larger wound. Nurse #1 waved the flies away, cleansed the wound and put a dressing in place.</p> <p>An interview, on 04/27/11 at 2:50 PM, was conducted with Nurse #1. Nurse #1 confirmed flies were in the room of Resident # 44 and did land on the wound bed during the dressing change. Nurse #1 said she and Nurse #2 tried to</p>	F 441	<p><b>F 456 SS=E</b></p> <p><b>Corrective Action for Resident Affected</b> No specific resident is identified.</p> <p><b>Corrective Action for Resident Potentially Affected</b> All residents residing in the facility have potential to be effected. The facility Environmental Services Director determined that the existing lint grate in the washing machine drain was no longer functioning properly and a new grate was fabricated and put in place. The odor that remained in the pipes was caused by a build up in the grease trap for the dietary department and that has been cleaned.</p> <p><b>Systemic Changes</b> A new lint grate was fabricated and placed in the washing machine floor drain to ensure lint removal and proper water drainage on 8/18/11. (Attachment # 7) Laundry staff will clean the lint grate (Attachment # 9) at the end of each shift. The grease trap for the dietary department was pumped and cleaned on 8/15/11 (See attachment #6) and will be done on an every six month basis going forward.</p>		

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F 441	Continued From page 7 swat at them to keep them off.  In an interview with Nurse #2 on 07/28/11 at 9:05 AM, she stated she saw flies land on Resident #44's wounds multiple times during the dressing change. Nurse #2 said she observed flies on the wound beds of Resident #44's left ischium and right ischium areas. Nurse #2 said she cleansed the wounds on the left ischium after the flies were on it. Nurse #2 said the flies were a problem in the facility and she had to take a fly swatter in another room one day when she did wound dressings on another resident.  In an interview conducted with Resident #44 on 07/28/11 at 9:30 AM, he said he had a lot of flies in his room and they had been worse over the past few days. Resident #44 said he had no feeling in the lower part of his body but the flies bothered him.  In an interview with the acting Director of Nurses (DON) on 07/28/11 at 10:45 AM, she stated she would not expect flies to land on any open wound bed. The DON said the flies had gotten worse the past week in the facility.  An interview was conducted with the Administrator on 07/28/11 at 11:55 AM. The Administrator said the flies had increased in the building over the past week but her expectation would be not to have flies in a resident 's room during dressing changes and definitely would not expect them to land in a wound bed.	F 441	<b>Quality Assurance</b> The Environmental Services will schedule the grease trap service with the vendor on an ongoing every six month basis and maintain records in the ESD office. The Environmental Services Director will monitor the cleaning of the lint grate in the washing machine drain. This will be done daily for four weeks and then weekly for three months or until resolved by QOL/QA committee.		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION  The facility must maintain all essential	F 456			

*7/28/11*



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F 456	Continued From page 8 mechanical, electrical, and patient care equipment in safe operating condition.  This REQUIREMENT is not met as evidenced by: Failed to maintain a launrdy room w/o standing water and mildew  Observation and iNterview 1105am 7/28/11-  Laundry Room Multiple Flies and lands on pile of clothes on laurndry prep table, Room with foul smell throughout of mildew. Mant Mgr reported smell of mildew coming from pipes of washing machine drains and water sits overnight and mildew smell comes from that. Drain area was opened in laundry room and standing water with a gray matter substance was sitting on top of the standing water found.	F 456	<b>F 469 SS=E</b>  <b>Corrective Action for Resident Affected</b> No specific resident is identified.  <b>Corrective Action for Resident Potentially Affected</b> All residents residing in the facility have potential to be effected. The facility pest control vendor was contacted and provided appropriate pest control treatments to all areas of the facility both inside and out on 8/5/11.	
F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM  The facility must maintain an effective pest control program so that the facility is free of pests and rodents.  This REQUIREMENT is not met as evidenced by: Failed to maintaine pet control throughout the facility  Excess namber of flies noted center of bldg at nurses' station. Interviews with staff indicated not	F 469	<b>Systemic Changes</b> Five WS-B5 Flying Insect Control units (lights) supplied by the facility pest control vendor, were installed strategically near exit doors and at the nursing station on 8/18/11. (See attachment #5) These devices are designed to capture flying insects at point of entry and in high traffic areas. The pest control vendor will continue to provide monthly and as needed pest control services. All food items will be removed promptly from resident areas after meals and as needed.	

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F 469	Continued From page 9 usual--last week had not flies. See KJ notes/tag 441	F 469	<p>Staffs have fly swatters available at the nursing station for immediate intervention and are to report incidence of flying insect pests and location to the Environmental Services Director for further intervention during regular office hours. <i>(Attachment #8)</i></p> <p><b>Quality Assurance</b> The monitoring will include verifying that all newly installed insect control units are functioning as designed and are emptied on a weekly basis and ensuring that all food items are removed from resident rooms at the completion of meals and as needed. This will be done daily for four weeks and then weekly for three months or until resolved by QOL/QA committee. Reports will be given during the daily stand-up meetings and to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.</p>	8/18/11	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345407	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  09/07/2011
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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: A. Based on observation on 09/07/2011 there was a hole around the junction box of the of the light fixture in the ceiling of the bath room at room 110. B. There was an opening around the duct penetrating the rated ceiling of the mech. room at room 301. 42 CFR 483.70 (a)	K 012	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies.  To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.  K 012 SS=D  Corrective Action for Facility The opening around the junction box of the light fixture in the ceiling of the bathroom in room 110 was repaired on 9/8/11. The opening around the duct penetrating the rated ceiling of the mechanical room at room 301 was repaired 9/8/11.	
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 1 1/4 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	Corrective Action for Residents Potentially Affected All bathrooms and mechanical room ceilings were checked and verified that no other openings were present on 9/7/11.  Systemic Changes Environmental rounds will be conducted on a weekly basis by the Environmental Services Director. Any areas noted to need repair will be corrected immediately. See attachment #1  Quality Assurance The Environmental Services Director will monitor this issue using the "Environmental Services Weekly Rounds" Form. See attachment #1. This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate.	9/8/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Sharon K. ...* TITLE: Administrator (X8) DATE: 9/20/11

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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K 018	Continued From page 1	K 018	<b>K 018 SS=D</b>  <b>Corrective Action</b> The door to room 310 was adjusted to close properly. The shoe rack on the door of room 209 was removed and the door closed properly on 9/7/11.  <b>Identification of related safety hazards potentially affecting Residents</b> Environmental rounds were conducted by the Environmental Services Director on 9/7/11. All doors close properly.	
K 038 SS=F	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	<b>Systemic Changes</b> Environmental rounds will be conducted on a weekly basis by the Environmental Services Director. Any areas noted to need repair will be corrected immediately. See attachment #1  <b>Quality Assurance</b> The Environmental Services Director will monitor this issue using the "Environmental Services Weekly Rounds" Form. See attachment #1. This will be done weekly for three months or until resolved by QOL/QA committee. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate.	9/8/11
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or	K 051	<b>Corrective Action</b> The existing fire alarm panel was serviced on 9/8/11. A component location map was placed near the fire alarm panel on 9/8/11. Staff were instructed in the location of the emergency door release switch on 9/8/11.  <b>Identification of related safety hazards potentially affecting Residents</b> The existing fire alarm panel will be replaced in order to prevent the magnetic doors from relocking when the fire panel is silenced on 9/23/11. The component location map and the location of the emergency door release	

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K 051	Continued From page 2 extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051	switches was posted on 9/8/11 and reviewed with existing staff. See attachment #5  <b>Systemic Changes</b> The Fire Control Panel will be replaced with an updated Gamewell/FCI Conventional Fire Alarm Control Panel on 9/23/11. See attachment #3 for specifications. All staff will attend one of the mandatory in-services on the new fire alarm panel and component location map on 9/23/11 and 9/26/11 and will be reviewed during general orientation for all new employees.  <b>Quality Assurance</b> The monitoring is included in the "Weekly Fire Safety Check List". See attachment #4 Reports will be given during the daily stand-up meetings and to the weekly Quality of Life- QA committee and corrective action initiated as appropriate  K 051 SS=D  <b>Corrective Action</b> The existing fire alarm panel was serviced on 9/8/11 to provide a visual signal for A/C power, battery and phone connection.  <b>Identification of related safety hazards potentially affecting Residents</b> The existing fire alarm panel will be replaced in order to provide audible and visual signal for loss of A/C power, battery and phone connection on 9/23/11.	9/26/11
K 061 SS=D	This STANDARD is not met as evidenced by: A. Based on observation on 09/07/2011 the fire alarm panel failed to give an audible or a visual signal on loss of AC power, Battery and phone connection. 42 CFR 483.70 (a) 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	K 061	<b>Systemic Changes</b> The Fire Control Panel will be replaced with an updated Gamewell/FCI Conventional Fire Alarm Control Panel on 9/23/11. See attachment #3 for specifications. All staff will attend one of the mandatory in-services on the new fire alarm panel on 9/23/11 and 9/26/11.	

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K 061	Continued From page 3 This STANDARD is not met as evidenced by: A. Based on observation on 09/07/2011 the valve controlling the high and low pressure switch was not supervised. 42 CFR 483.70 (a)	K 061	<b>Quality Assurance</b> The monitoring is included in the "Weekly Fire Safety Check List". Attachment #4. Reports will be given during the daily stand-up meetings and to the weekly Quality of Life- QA committee and corrective action initiated as appropriate	9/20/11
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	K 076	<b>K 061 SS=D</b>  The existing fire alarm panel was serviced on 9/8/11. The new high low pressure switch could not be integrated into the existing fire panel.  <b>Identification of related safety hazards potentially affecting Residents</b> The existing fire alarm panel will be replaced in order to supervise the valve controlling the high and low pressure switch on 9/23/11.  <b>Systemic Changes</b> The Fire Control Panel will be replaced with an updated Gamewell/FCI Conventional Fire Alarm Control Panel on 9/23/11. See attachment #3 for specifications. All staff will attend one of the mandatory in-services on the new fire alarm panel on 9/23/11 and 9/26/11 and will be reviewed during general orientation for all new employees.	
K 130 SS=F	This STANDARD is not met as evidenced by: A. Based on observation on 09/07/2011 there were full and empty O2 cylinders mixed in the O2 Storage room near room 202. B. There was a wheel chair where the resident was using O2 that did not have a "No Smoking " sign. 42 CFR 483.70 (a)	K 130	<b>K 076 SS=D</b>  <b>Corrective Action</b> Full and empty oxygen tanks were separated 9/7/11. An "oxygen in use" label was placed on the wheelchair of resident # 624 on 9/7/11.  <b>Identification of related safety hazards potentially affecting Residents</b> "Oxygen in use Signs" are present on the floor and for wheelchairs for all residents receiving oxygen as of 9/7/11.	9/20/11
	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786			

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K 130	Continued From page 4 This STANDARD is not met as evidenced by: A. Based on observation on 09/07/2011 the hot water temperture was 130 degrees F. 42 CFR 483.70 (a)	K 130	<p><b>Systemic Changes</b> Environmental rounds will be conducted on a weekly basis by the Environmental Services Director. Any residents receiving oxygen will have the proper signage in place. See attachment #1.</p> <p><b>Quality Assurance</b> The Environmental Services Director will monitor this issue using the "Environmental Services Weekly Rounds" Form. See attachment #1. This will be done weekly. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate</p> <p>K 130 SS=D</p> <p><b>Corrective Action</b> The water temperature was adjusted immediately.</p> <p><b>Identification of related safety hazards potentially affecting Residents</b> All water temperatures throughout the building were checked and were within mandated parameters on 9/7/11.</p> <p><b>Systemic Changes</b> Water temperature checks will continue to be performed weekly by the Environmental Services Director. Locks have been changed on the mechanical room doors where the water heaters are located to prevent access by unauthorized personnel.</p> <p><b>Quality Assurance</b> The Environmental Services Director will monitor this issue using the "Weekly Water Temperature Checks" Form. See attachment #2. This will be done weekly. Reports will be given to the monthly Quality of Life- QA committee and corrective action initiated as appropriate</p>	<p>09/15/11</p> <p>09/13/11</p>
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