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F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interview the facility failed to assess and obtain a physicians order for 1 of 1 sampled resident's to self administer a medication at the bedside (#164). Findings: Review of the facility's Self Administration of Medication dated 1/11, indicated in part, Goal: Resident administering own mediation must be assessed as safe to do so and must be supported by a physicians order. The medication when left at the bedside must be secured to prevent another resident from possible harm. 1. Residents may not maintain medication at the bedside (even OTC medications) without an assessment and a physicians order. 2. If the resident or RP brings in medication and has this at the bedside the nurse must report this to the Don (DON) or Supervisor so that action can be taken. 3. Prior to the resident keeping medication at the bedside or self-administering other medication, the IDT (Interdisciplinary Team) must complete an assessment form. If the resident is	F 176	Resident # 164 now has a Physician's order to self administer Calcium Carbonate. The Interdisciplinary Team assessed resident # 164 and deemed him safe for self-administration, and a care plan has been developed. The medication will be kept in a safe location to prevent access by other residents. An Audit was completed by the RN supervisor on 11/28/11 to identify Residents found to have medications brought in from home who could be affected by the deficient practice. Licensed Staff was in-serviced on 11/4/11 , 11/21/11 and 11/28/11 concerning proper procedures for self administered medications by the staff developer, DON and pharmacy consultant. The Administrator has informed the resident's families by a letter written on 11/28/11 to contact the DON prior to bringing any medications into the facility for resident self administration.	12/1/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE 11/28/11

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 176	Continued From page 1 deemed safe, the physician must be notified, orders received and a care plan developed. Resident # 164 was admitted with the diagnosis of diabetes mellitus, end stage renal disease, asthma and hypertension. The annual Minimum Data Set (MDS) dated 10/24/11, indicated the resident had severely impaired cognitive skills, long and short term memory problems and no documented behaviors. A review of Resident #164's facility standing orders dated 3/16/11, and current physician ' s orders dated 11/3/11, revealed calcium carbonate was not ordered. Review of Resident #164 medical records revealed no self administration of medication assessment was completed or care plan developed. During an observation of a medication pass, 11/3/11 at 9:30 am, a bottle of calcium carbonate was on Resident #164 bedside table. The bottle contained 5 tablets. An interview with nurse #4 while administering the medication indicated she did not know if Resident #164 had an order or was able to self administer his medications at the bedside. During an interview 11/3/11 at 9:32pm, with the Staff Development Coordinator (SDC) indicated Resident #164 was not assessed to administer medications at the bedside. Resident #164 was asked to surrender the calcium carbonate but he refused. Resident #164 indicated he had brought this medication from home and takes it when his stomach was upset, and no one had said anything before. During an interview11/3/11 at 10:28 am, the	F 176	Residents that qualify with orders for self-administration of medications will be assessed on admission, quarterly, annually and with change in condition. The DON, ADON, SDC, or RN supervisor will monitor compliance for self administration of medication weekly x4 then monthly x2. Results of this monitoring will be reported to the Quality Assurance Committee each month for 3 months and then quarterly thereafter for 1 year.	12/1/11

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F 176	Continued From page 2 Director of Nursing (DON) indicated if a resident were to self administer medication, they were assessed and a physician order was obtained. If a resident had medication at the bedside, the expectation would be for the nurse to take it from the resident, call the doctor and to get an order. The resident ' s and families are educated during the admission process by the admissions coordinator and they sign consent to that effect. She concluded by saying the facility cannot control what families bring in to the facility. During an interview 11/3/11 at 11:34 am, the admission coordinator indicated the residents and families were informed the pharmacy provided the medications and a consent form was signed. She concluded by saying there was never a problem with families bringing in medications. During an interview 11/3/11 at 11:34 am, Aide # 1 indicated she saw the calcium carbonate on the bedside table 10/31/11.	F 176		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review the facility failed to have identified medical symptoms for 2 of 3 sampled residents and failed to implement systematic approaches to reduce restraints (Resident #131, and #156). The findings included:	F 221		

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F 221	Continued From page 3 1. Resident #156 was admitted to the facility on 5/23/2011 and readmitted to the facility on 10/04/2011 with a cumulative diagnosis including Diabetes Mellitus, Breast Cancer, Dementia, Anxiety, and Pseudo Seizures. The admission MDS (minimum data set) assessment dated 5/30/2011 indicated that Resident #156 usually understood others and was usually understood. The MDS assessment for long term and short term memory contained the word " BLANK. " The MDS assessment for decision making for daily living contained the word " BLANK " and the resident ' s cognition was severely impaired. The document also revealed the resident required extensive and total assistance of one staff with ADLs (activities of daily living), transfers, mobility and required limited assistance of one staff with transfers. The resident was incontinent of bowels and bladder. The resident needed physical assistance with bathing. The document revealed the resident ' s balance was unsteady and the mobility devices were a walker and a wheelchair. The document indicated psychosis; physical or verbal behaviors were not exhibited. Rejection of care occurred 1-3 days during the assessment period. The presence of wandering was not exhibited during the assessment period. The MDS assessment indicated that Resident #156 did not have a history of falls. The restraint section of the MDS indicated that restraints were not used. The document did not indicate the resident had any repetitive movements or health concerns that persistently required medical attention or concerns with body functions.	F 221	Resident 131 and 156 have been reevaluated for use of restraints by Therapy and the IDT on 11/23/11 . Resident 156 exhibited improvement, and the seat belt was removed. Resident 131 continues to exhibit the need for seatbelt for prevention of falls. The care plan has been updated to reflect their current conditions on 11/23/11. All residents currently using a restraint were reassessed by Therapy on 11/29/11. Residents in need of a restraint, were assessed by therapy and nursing for least restrictive device use on 11/29/11. Care plans were developed for each resident in need of a device. This facility is also enrolled in the CCME restraint reduction initiative. Staff has been in-serviced on 11/4/11 and on 11/21/11 by the DON concerning procedures for restraint use.	12/1/11

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F 221	Continued From page 4 The care plan included a problem onset dated 6/03/2011 for seizure disorder with potential for complications; potential for injury. The interventions included observation for signs and symptoms of seizure activity, protection of the resident during seizure activity, administration of medication as ordered by the physician, monitoring for adverse effects of medication with notification of the physician, monitoring serum levels as ordered, monitoring of vital signs, neurological checks and assistive device as needed for positioning and safety. The care plan updated 8/25/2011 did not include a problem, goals or interventions related to the use of restraints The most recent quarterly MDS assessment dated 10/21/2011 indicated that Resident #156 usually understood others and was usually understood. The MDS assessment for long term and short term memory contained the word " BLANK. " The MDS assessment for decision making for daily living contained the word " BLANK " and the resident ' s cognition was severely impaired. The document also revealed the resident required extensive assistance of one staff with ADLs (activities of daily living), transfers, mobility and required limited assistance of one staff with transfers. The resident was incontinent of bowels and bladder. The document revealed the resident ' s balance was unsteady and the mobility device was a wheelchair. The document indicated that psychosis; physical or verbal behaviors were not exhibited. Rejection of care and the presence of wandering were also not exhibited. The MDS assessment indicated that Resident #156 did not have a fall history since admission or during prior assessments.	F 221	Prior to restraining a resident, non-restraint interventions will be implemented and a pre-restraint assessment will be completed by a licensed nurse. The interdisciplinary team will evaluate the least restrictive device required and consult the Doctor for an order. The responsible party will be informed of the need for the device and a care developed. All restraint orders will be re-assessed for possible reduction quarterly and with a change of condition by the interdisciplinary team. The IDT will review resident's restraints and documentation in the weekly Standards of Care meeting. Findings will be reviewed by the QA committee monthly for 3 months and then quarterly thereafter for a period on 1 year.	12/1/11

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F 221	Continued From page 5 The restraint section of the MDS indicated that restraints were not used. The document did not indicate the resident had any repetitive movements or health concerns that persistently required medical attention or concerns with body functions. Review of the PT (Physical Therapy) notes dated 10/04/2011 through 11/02/2011 documented the resident was seen twice a day 5 times a week for 8 weeks. The resident presented with generalized muscle weakness and de conditioning after a recent hospital stay. The Physical Therapy discharge summary dated 10/26/2011 documentation indicated that the resident was able to safely transition from lying to sitting position and sitting to lying position requiring assistance close enough to reach if assistance was needed. The resident could ambulate 55 feet on level surfaces requiring holding of the resident ' s hand support only. The resident was able to safely transition from sit to standing and standing to sitting with minimal assistance. The resident required 2 staffs for ambulation. The resident continued with the restorative nursing program. There was no mention of the presence or assessments for the use of restraints. Review of a facility form titled, " pre restraining assessment " dated 10/28/2011 indicated that Resident #156 was alert, with a short attention span and disoriented. The balance when sitting section indicated the resident slumped and would slide down. The recovery balance while sitting was marked no for recovery from leaning forward, backward, and sideways positions. The form indicated that the resident misinterpreted words, sounds and did not understand what was being	F 221		

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said. The referral/recommendations section indicated the team evaluation was conducted on 10/28/2011. Recommendations were seat belt to wheelchair secondary to abnormal posture and safety. The form was signed and dated by the DON (Director of Nursing).

Review of the Physician's orders from 10/04/2011 to 11/02/2011 revealed no order for a restraint.

During tour of the facility the resident was sitting alone in a wheelchair in the bedroom with a blue lap belt in place. The seat belt was bolted into the seat of the wheelchair. The resident was sitting quietly in an upright position without any repetitive physical movements, sliding or scooting in the chair. The television was not on and the resident was not involved in any other activities.

During an observation on 11/02/2011 at 8:15am Resident #156 was sitting in the hallway up against the wall with the seat belt in place. The resident did not exhibit any repetitive physical movement, leaning in any direction or attempts to get up unassisted. Resident #156 was asked to release the seat belt and even though the resident was holding the metal buckle the resident could not release the seat belt. Resident #156 did not answer

During an observation on 11/2/2011 at 9:45am Resident #156 was in the activity area during a group activity. The resident did not exhibit any repetitive physical movement, leaning in any direction or attempts to get up unassisted. The seat belt was in place and was not released.

On 11/02/2011 at 12:15pm Resident #156 was

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observed in her wheelchair in her room eating lunch with the assistance of a staff member. Continuous observation from 12:15pm to 12:50pm revealed no attempts by the resident to get up, sliding or scooting in the wheelchair. The seat belt was not removed during the meal.

During an interview on 11/02/2011 at 2pm NA #2 indicated the resident was unable to remove the lap belt. The NA indicated that the seat belt was kept on at all times when the resident was in the wheelchair. The NA said the seat belt was used for safety positioning and to prevent the resident from getting up unassisted and falling. She added the resident was total care and required staff assistance for transfers. The NA indicated she was unaware of the resident falling out of the chair or out of the bed. The NA said she had seen the resident scoot down in the chair but she had not seen her try to get up. The NA said she could not recall if the resident had a restraint before she was hospitalized.

During an interview on 11/02/2011 at 3:30pm Nurse #2 indicated she worked with the resident on a regular basis. Nurse #2 checked the medical record and the MAR (medication administration record) and said that Resident #156 did not experience seizures since her return from the hospital on 10/04/2011. Nurse #2 said the resident had been attempting to get up from the wheelchair unassisted. The Nurse said the resident had released the seat belt and placed herself back to bed unassisted. Resident #156 was in bed with the wheel chair positioned next to the bed. The Nurse said the belts are bolted into the seat of the wheelchairs specifically for residents needing the seat belts. She said the

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decision to place a resident into a restraint was an IDT (interdisciplinary team) decision. The Nurse said the seat belt required a Physician's order.

During an interview on 11/02/2011 at 3:48pm the DON (director of nursing) said she completed the resident's pre restraining assessment on 10/28/11. The DON said the restraint is left on the residents a few days to see how they do with it in place. The DON said she talked to the staff and observed Resident #156 on 11/01/2011. The DON said based on staff input and her observation of the resident leaning to the side she determined the resident needed the seat belt. She said the resident is getting up more and she now needs the seat belt. The DON was asked when and how often the seat belt is released and she said during care if the resident is up, during an activity or during anytime the resident is closely monitored. The DON said the facility was in the early phases of assessing the resident for the seat belt and the nurses document the restraint once it is determined that it is needed. She said usually the IDT would ask PT to evaluate the residents but they had not talked to therapy for this resident. The DON said the resident cannot remove the seat belt on her own and they are just trying her out.

A follow up interview on 11/03/11 at 10am with the DON was conducted. The DON said the resident went out to the hospital and came back with a diagnosis of seizure disorder. She said the seizures may or may not come back. She said she discussed the seat belt with the resident's family regarding positioning and the family said to do anything to keep the resident safe. She said

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the belt keeps the resident's hips back in the chair with seizures. The DON said once the resident's strength returns they will try lesser restrictive devices such as pillows and cushions. The DON said no less restrictive devices were tried before implementing the seat belt. She repeated that they were in the early phases of assessing the resident.

The DON said she would expect to find in the chart a Physician's order now that she knows the resident needs to keep the seat belt. She said she would go write an order. The DON provided a copy of a Physician's order dated 11/02/2011 that read: " seatbelt to w/c (wheelchair) for positioning secondary to abnormal posture and safety. "

2A. Resident # 131 was admitted 8/25/11, with the diagnosis dementia, diabetes mellitus. The admission Minimum Data Set (MDS) dated 9/1/11, indicated the resident was severely impaired with cognitive skill and long and short term memory problems. She required limited assistance with bed mobility, walking on and off the unit, extensive assistance with dressing and total dependence with eating, bathing, and toileting. Resident #131 required a walker or wheelchair for mobility. Residents balance was not steady but was able to stabilize without human assistance with walking, turning, moving on or off the toilet or surface to surface transfer. The MDS further indicated no restraints were used.

Review of physicians order dated 8/26/11, " 1.Seat belt to w/c (wheelchair) for safety 2. Fall mat at bedside. " Physicians orders dated thru 10/31/11, " indicated body alarm to bed and

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F 221	Continued From page 10 when up in chair for safety , Check placement every shift , seat belt to wheelchair for safety. " Review of the Pre-Restraint Assessment dated 8/29/11, indicated Resident #131 " does not understand what is being said and can not comprehend surroundings. The recommendation was seatbelt for abnormal posture and safety while in chair " next evaluate 11/no day/11. The Physical Restraint Elimination Assessment dated, 8/29/11, indicated no start date, and the action plan , seat belt needed secondary to decreased safety and tend to lean forward in chair The restraint Care Area Assessment (CAA) dated, 9/1/11 read in part, " resident frequent attempts to get out of restraints, falls and resident had the use of physical restraint device for prevention of injury to self or to others characterized by high risk for injury/fall, impaired mobility, physical aggression related to decreased safety awareness& unstable health condition. " Review of the resident's care plan dated 9/2/11, identified the problem as, use of physical restraint device for prevention of injury to self or to others characterized by high risk for injury/fall, impaired mobility, physical aggression related to decreased safety awareness. The goals included will not injure self or others through next review (no time frame). Approaches were to evaluate and treat for underlying causes of potential behaviors, falls, injury, i.e., pain, dehydration infections, hyper/hypoglycemia, constipation, environmental barriers, medication effects, sleep problems, incontinence, et,(sic) Psych(psychiatric) consult as needed and /or consultant pharmacist for review of medication,	F 221		

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F 221	Continued From page 11 Remove device during supervised activities and re-apply upon completion. Discuss unacceptable behavior with resident. Review of the resident's care plan dated 9/8/11, identified the problem as risk for falls characterized by multiple risk factors related to cognitive deficit and decreased safety awareness. The goals included will remain free of injury as evidenced by no falls or accidents through next review.(no time frame) Approaches were to, monitor for signs and symptoms of dizziness and encourage resident to report episodes of dizziness to staff. Assist as necessary Assist during transfer and mobility. Evaluate effectiveness and side effects of psychotropic drug(s) for possible decrease in dosage/elimination of drug Monitor and intervene for factors causing falls ,i.e. bowel/bladder needs, mobility, transfers, etc. Monitor medication for potential side effects that may increase risk for falls, i.e., blurred vision, orthostatic hypotension, dizziness, etc. Rehab/therapy referral Provide divisional activities Bed in the lowest position. During an observation on 11/1/13 at 11:13 am, Resident #131, was sitting in a wheelchair in her room with a self release seat belt secured around her waist. During an observation on 11/2/11 at 2:09 pm, Resident #131 was observed wandering in her wheelchair holding 2 baby dolls with a blue seat belt around her waist. During an observation on 11/2/11 at 6:11 pm, an aide was sitting next to Resident #131 cueing her as she sat in her wheelchair and the self release belt was secured around her waist as she ate her meal. During an observation on 11/3/11 at 8:30 am, Resident #131 was eating in the restorative dining room with the blue seat belt in	F 221		

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F 221	Continued From page 12 place eating her meal. Aide # 4 indicated the resident could not release the seat belt on command but fiddled with it and could release it sometimes. During an observation on 11/3/11 at 11:38am, in the restorative dining area, Resident #131 was sitting at the table and had not been served her lunch meal. Aide #4 reached under the table and unlatched the blue seat belt. During an interview on 11/3/11, at 8:58 am, Aide # 3 indicated Resident #131 was not steady when she walks, restorative aides walk with her daily and she cannot release the seat belt but she does mess with it and can unhook it. During an interview on 11/3/11 at 3:21 pm, the director of the physical therapy department indicated the seat belt was used for safety. Resident #131 did not have the cognitive ability to judge that she was leaning to far forward. She kept her arms occupied with her dolls, and didn't use them to balance herself. The facility tried a personal alarm, it constantly rang because she would lean to far forward so it was discontinued. He indicated the lap belt was the most appropriate and least restrictive device at the time she was evaluated. The nursing department reevaluated restraints for future reduction. During an interview on 11/3/11 at 4:40 pm, MDS #1 indicated Resident #131 had no diagnosis for the use of the lap belt or full side rails. During an interview on 11/3/11 at 2:26pm, director of nursing (DON) indicated the medical diagnosis for the seat belt was based on the history and physical dated 8/20/11,when the resident had an history of syncopal episode 2/2010 and ataxia with frequent falling episodes. She indicated a seat belt was not the least	F 221		

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F 221	Continued From page 13	F 221		

restrictive device that could be used for Resident #131 the concern was how far she leans forward in her chair and concluded the facility was looking at all restraints to determine which could be eliminated.

2B. Review of the admission assessment dated 8/25/11, revealed " RP requested low bed, full side rails & personal alarm for safety. All devices in place. "
The restraint section was checked for use of side rails and indicated to complete the side rail safety form and initiate a care plan.
There was no physicians order for bilateral full length side rails.

The Side Rail Rational Screen dated 8/25/11, indicated " Full side rail requested by RP. "

No Physical Restraint Reduction Assessment form was completed for the side rails.

Review of the nursing notes dated for 8/29/11 at 3:40pm, in part, " resident was observed with feet and legs through the side rails attempting to get out of bed. 5:35 pm , ..swinging legs over bed redirected six times, side rails padded. "

Review of the 24 hours report dated 8/29/11, indicated Resident # 131 climbing oob-alarm padded rails, low bed. Review of the 24 hour report dated 8/30/11, indicated Resident #131 padded rail self release belt personal alarm.

Review of the care plan revealed no care plans for bilateral padded full side rails.

During an observation at 11:13 am on 11/1/13 of

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F 221	Continued From page 14 Resident #131, bilateral side padded side rails, one side rail in an up position against the wall the other side rail was in a down position the bed was in a low position and floor pad was off the floor and placed to the side. During an interview on 11/3/11 at 2:45pm, Aide # 3 indicated Resident #131 attempted to get out of bed she used the full padded side rails and a bed alarm. During an interview on 11/3/11 at 4:40pm, MDS #1 indicated there was no physicians order with a medical symptom for use of the full bilateral side rails. During an interview on 11/3/11 at 4:49 pm, the DON indicated Resident #131 was able to get out of her bed on her own and padding were used to prevent her from becoming entangled in the rails. She indicated the half side rail, bed alarm and low bed with pad would be more appropriate.	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse,	F 225		

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F 225	Continued From page 15 including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to prevent the employment of an individual with a substantiated allegation of abuse for 1 of 5 employees whose screening records were reviewed. Findings include: Record review of employment pre-screening documents revealed an inquiry to the North Carolina Nurse Aide, Medication Aide, and Health Care Personnel Registry (HCPR) dated 5/17/11. The search results indicated housekeeping staff #1 "has 1 substantiated finding(s) of Abuse of a Resident, which occurred while the individual was employed in a Nursing Facility. This information	F 225	No Resident was named in this deficiency. The facility will not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law , or have had a finding entered into the state nurse aide registry. Policies and procedures are in place to prevent the hiring of staff that have allegations of abuse or neglect. The procedures involve printing the healthcare personnel registry findings, a criminal background check, and reports from HHS OIG Fraud reporting as well as the Excluded party List system. These reports are reviewed by the Payroll Clerk, The department head doing the hiring and the administrator prior to hiring the applicant. These procedures will be followed closely by all department heads that hire staff and also the human resources person. Each	12/1/11

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F 225	Continued From page 16 was entered on the Registry 02/28/2002." Record review of housekeeping staff #1's employment record revealed she was hired on 5/24/11. Record review of the facility schedule revealed housekeeping staff #1 worked on 7/18/11, 7/19/11, 7/23/11, 7/24/11, 8/29/11, 9/3/11, 9/4/11, 9/12/11, 9/13/11, 9/23/11, 9/25/11, 9/26/11, 9/27/11, 10/1/11, 10/2/11, 10/9/11, 10/11/11, 10/15/11, 10/16/11, 10/21/11. The scheduled revealed she worked on A, B, and D halls. Her schedule prior to 7/18/11 was unavailable. In an interview on 11/3/11 at 5:50PM, the Housekeeping Manager stated the Accounts Payable (AP) Manager conducted background checks for potential employees before orientation began. Results of the reports were given to the respective department heads. If there were any concerns with the results, the department heads reported to the administrator. The Housekeeping Manager stated she didn't see the verification of an allegation of abuse from the HCPR for housekeeping staff #1. She stated "it should have been with the rest of the reports I got. I would never have hired her if I had seen the report." She stated housekeeping staff #1 was hired 5/24/11 as a part-time employee. Housekeeping staff #1 worked in all areas of the facility and had direct contact with the residents. In an interview on 11/3/11 at 6:15PM, the Administrator stated potential employees completed an application first, then screenings were completed. Next background checks and verification with the Nurse Aide, Medication Aide,	F 225	employee will be rescreened with the Health Care Registry to insure that no one has an allegation of abuse or neglect. Inservices have been held with key staff on 11/4/11 concerning the proper screening of employees prior to employment. This will be monitored by the Business Office Manager, The Payroll Clerk and the Administrator. The administrator will report to the Quality Assurance Committee monthly for 3 months and then quarterly thereafter for 1 year. Any problems noted will be brought	

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F 225	Continued From page 17 and HCPR were completed. He stated the AP Manager distributed the results to the department heads. The AP Manager was supposed to flag the results if there were any problems. If the department heads had any questions or concerns, they followed up with the administrator. The administrator stated he was unaware of the substantiated finding of abuse for housekeeping staff #1 until today. He stated "I never would have hired that person." His expectation was for the AP Manager to review the background checks and screenings, flag those with any problems or concerns, and notify the respective department heads. In an interview on 11/3/11 at 6:17PM, the AP Manager stated after potential employees brought in their applications, she ran criminal background checks and searched the North Carolina Registries, which included the HCPR. The AP Manager stated she looked over the reports and let the department heads know if anything looked questionable. She didn't remember any questionable results for housekeeping staff #1. She stated "I would have given the reports to the housekeeping manager, I didn't catch it." Review of the facility's allegations of abuse since 5/24/11 revealed no allegations reported involving housekeeping staff #1. The administrator provided written documentation dated 11/3/11 of housekeeping staff #1's termination.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written	F 226		

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F 226	Continued From page 18 policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record and staff interviews, the facility failed to implement a policy for reporting substantiated findings of abuse for 1 of 5 employees whose screening records were reviewed. Findings include: The facility policy titled Abuse and Neglect Prohibition Policy, undated, page 3, read in part "Procedure - Screening 1. The facility will screen for employees with a history of abusive behavior or who may be at risk for being abusive." Record review of employment pre-screening documents revealed an inquiry to the North Carolina Nurse Aide, Medication Aide, and Health Care Personnel Registry (HCPR) dated 5/17/11. The search results indicated housekeeping staff #1 "has 1 substantiated finding(s) of Abuse of a Resident, which occurred while the individual was employed in a Nursing Facility. This information was entered on the Registry 02/28/2002." Record review of housekeeping staff #1's employment record revealed she was hired on 5/24/11. Record review of the facility schedule revealed housekeeping staff #1 worked on 7/18/11, 7/19/11, 7/23/11, 7/24/11, 8/29/11, 9/3/11, 9/4/11, 9/12/11, 9/13/11, 9/23/11, 9/25/11, 9/26/11, 9/27/11, 10/1/11, 10/2/11, 10/9/11, 10/11/11,	F 226	No Resident was named in this deficiency. The facility will not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law , or have had a finding entered into the state nurse aide registry. Policies and procedures are in place to prevent the hiring of staff that have allegations of abuse or neglect. The procedures involve printing the healthcare personnel registry findings, a criminal background check, and reports from HHS OIG Fraud reporting as well as the Excluded party List system. These reports are reviewed by the Payroll Clerk, The department head doing the hiring and the administrator prior to hiring the applicant. These procedures will be followed closely by all department heads that hire staff and also the human resources person. Each	12/1/11

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F 226	Continued From page 19 10/15/11, 10/16/11, 10/21/11. The scheduled revealed she worked on A, B, and D halls. Her schedule prior to 7/18/11 was unavailable. In an interview on 11/3/11 at 5:50PM, the Housekeeping Manager stated the Accounts Payable (AP) Manager conducted background checks for potential employees before orientation began. Results of the reports were given to the respective department heads. If there were any concerns with the results, the department heads reported to the administrator. The Housekeeping Manager stated she didn't see the verification of an allegation of abuse from the HCPR for housekeeping staff #1. She stated "it should have been with the rest of the reports I got. I would never have hired her if I had seen the report." She stated housekeeping staff #1 was hired 5/24/11 as a part-time employee. Housekeeping staff #1 worked in all areas of the facility and had direct contact with the residents. In an interview on 11/3/11 at 6:15PM, the Administrator stated potential employees completed an application first, then screenings were completed. Next background checks and verification with the Nurse Aide, Medication Aide, and HCPR were completed. He stated the AP Manager distributed the results to the department heads. The AP Manager was supposed to flag the results if there were any problems. If the department heads had any questions or concerns, they followed up with the administrator. The administrator stated he was unaware of the substantiated finding of abuse for housekeeping staff #1 until today. He stated "I never would have hired that person." His expectation was for the AP Manager to review the background checks	F 226	employee will be rescreened with the Health Care Registry to insure that no one has an allegation of abuse or neglect. Inservices have been held with key staff on 11/4/11 concerning the proper screening of employees prior to employment. This will be monitored by the Business Office Manager, The Payroll Clerk and the Administrator. The administrator will report to the Quality Assurance Committee monthly for 3 months and then quarterly thereafter for 1 year. Any problems noted will be brought	

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F 226	Continued From page 20 and screenings, flag those with any problems or concerns, and notify the respective department heads. He stated the facility would be reviewing their policy and procedure for screening new employees and reporting of findings. In an interview on 11/3/11 at 6:17PM, the AP Manager stated after potential employees brought in their applications, she ran criminal background checks and searched the North Carolina Registries, which included the HCPR. The AP Manager stated she looked over the reports and let the department heads know if anything looked questionable. She didn't remember any questionable results for housekeeping staff #1. She stated "I would have given the reports to the housekeeping manager, I didn ' t catch it." Review of the facility's allegations of abuse since 5/24/11 revealed no allegations reported involving housekeeping staff #1. The administrator provided written documentation dated 11/3/11 of housekeeping staff #1's termination.	F 226		
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews,	F 252		

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F 252	Continued From page 21 family interview, and staff interviews, the facility failed to maintain an environment free from lingering odors on 1 of 4 hall (the 300 halls). Findings include: During the initial tour of the facility on 10/31/11 at 11:30 am, a strong urine odor was detected on the 300 hall. On a subsequent follow-up tour of the facility on 10/31/11 at 1:20 pm, a strong urine/ feces odor was detected on the 300 hall. A foul smell was noted on the 300 hall on 10/31/11 at 3:00 pm. Upon entering the 300 hall on 11/1/11 at 9:00 am, a foul smell was noted midway down the 300 hall. On 11/2/11 at 10:34 am, a strong, lingering feces odor was noted on the 300 hall. During an interview on 11/2/11 at 2:35 pm with the social worker, she stated that " Resident # 126 tries to be independent, but he occasionally has accidents in his room; instead of asking for help he will hang the soiled clothes in his closet. " When asked by the surveyor what interventions are in place to have the room odor-free, the social worker said, " None. The resident will not allow housekeeping to come in and clean his room. " During an interview on 11/2/11 at 5:04 pm, the MDS Coordinator indicated that resident # 126 ' s room has an unpleasant odor all the time because the resident refuses to allow housekeeping to clean his room.	F 252	The room of resident # 126 has been deep cleaned on 2 occasions since the survey. Resident # 126 has a history of being resistive to care as well as being combative with workers trying to provide housekeeping and personal services. The MD was notified by the Charge nurse on 11/7/11. Interventions have been put into place in order to assist Resident # 126 with being more comfortable when housekeeping and personal services are provided. Any resident that is resistive to care and services has a potential to be affected by this deficiency. Training has been conducted with housekeeping and nursing staff on how to handle combative residents and the procedures to follow when faced with problems that they can not handle themselves. This training was conducted on 11/4/11 and 11/21/11 by the SDC.	12/1/11

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F 252	Continued From page 22 A family member for an unsampled resident was interviewed on 11/3/11 at 8:59 am. The family member stated the 300 hall had a "terrible smell." The family member stated that " once I hit the 300 hall, it smelled like urine and feces. " She further stated that when you walked down the 300 hall, it smelled like stool and urine. When the family member brings the concern to the attention of the facility staff, they indicate they will "take care of it." The family member further stated that the odor continues. During an interview on 11/3/11 at 2:11 pm with the administrator, he stated that " my expectations are for the all the residents ' rooms and the facility as a whole to be clean and free of odor. " He further added that Resident # 126 has a behavioral problem: " he will not allow housekeeping to clean his room and sometimes he refuses care. " The administrator added that " yesterday [11/2/11], the resident was soaking wet with urine and would not allow staff to change him. I was called to the hall to intervene. " During an interview on 11/3/11 at 3:42 pm with the housekeeping supervisor, she stated, " Resident # 126 ' s room is known to have a strong urine odor in the room. " She added that " the resident normally urinates on the bed cover and that gives the room a strong urine odor. We normally deep-clean all rooms once per week but his room is cleaned whenever there is that odor. Whenever it has this strong odor, we normally strip his bed. " She further added that the resident has behavior problems and will not allow anyone to clean his room or give him care at times. The housekeeper added that she does not	F 252	Monitoring of this resident and any other resident with similar conditions will be conducted by the Ambassador assigned to that room and the administrator. The Administrator will report concerns to the Quality Assurance Committee monthly for 3 months and then quarterly for a period of 1 year.	

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F 252	Continued From page 23 know if his room was deep-cleaned the last scheduled time because she was off and the resident is known to threaten housekeeping staff with his cane. Everyone is afraid to go in and clean the room. She further stated that " earlier this year we had ambassadors assigned to each hall but the ambassador for this hall left and she was not replaced. "	F 252		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews, the facility failed to develop Care Plans for 2 of 3 sampled residents with restraints	F 279		

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F 279	Continued From page 24 (Resident # 70 and Resident #156). Findings included: 1. Resident #70 was admitted to the facility on 6/30/10 with diagnoses that included pancytopenia, Tourette's syndrome, hypertension, seizure disorder, and traumatic brain injury. Review of the annual (7/15/11) and quarterly (9/20/11) MDSs indicated Resident # 70 had short- or long-term memory problems and was dependent for daily decision-making skills. Both MDSs also indicated the resident had a trunk restraint. A physician's order dated 4/11/11 indicated Resident # 70 was to have a seat belt on the wheelchair secondary to involuntary movement due to Tourette's syndrome. The Care Area Assessment (CAA) summary dated 7/15/11 read in part, " the care area triggered due to the fact that the resident uses a seat belt on his wheel chair. He has poor trunk control and involuntary movement secondary to [Tourette's] syndrome. He is at risk for injury related to the use of a physical restraint. Will be referred to therapy for evaluation of continued use of device. Will proceed to care plan. " Review of the resident 's comprehensive care plan found no documentation of a restraint care plan. During an interview on 11/4/10 at 12:26 pm, the MDS nurse indicated that the physical restraint	F 279	Resident # 70 and # 156 now have their MDS and Care Plans updated to reflect the restraint use. The care plans describe the services that are furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well being as required. The facility will use the results of the assessments that it develops to review and revise the resident's comprehensive plan of care. The facility will develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs that are identified in the assessment. The Interdisciplinary team and Licensed Staff were in-serviced on 11/4/11 and on 11/21/11 concerning proper care planning for devices and restraints. The in-service was conducted by the DON.	12/1/11

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F 279	Continued From page 25 triggered on the MDS; therefore, Resident # 70 should have had a physical restraint care plan, which would have included goals and approaches to the use of the trunk restraint. She further indicated that she was unable to locate the restraint care plan. In an interview on 11/4/11 at 1:00 pm, with the DON (Director of Nurses), she stated that her expectations were that the trunk restraint should have been assessed and care planned for Resident # 70. 2. Resident #156 was admitted to the facility on 5/23/2011 and readmitted to the facility on 10/04/2011. Resident #156 cumulative diagnosis included Diabetes Mellitus, Dementia, Anxiety, and Pseudo Seizures. The admission MDS assessment dated 5/30/2011 and the quarterly MDS assessment dated 10/21/2011 indicated that Resident #156 usually understood others and was usually understood. The MDS assessment for long term and short term memory contained the word " BLANK. " The MDS assessment for decision making for daily living contained the word " BLANK " and the resident ' s cognition was severely impaired. Section P of the MDS was not coded for the use of restraints. The care area triggers worksheet dated 6/03/2011 (restraints) notes indicated that Resident #156 did not have a restraint in place in her wheelchair. There was nothing checked under the " care plan decision " section of the page. In addition, under the individual worksheet section for physical restraints plan was marked unchecked.	F 279	Monitoring will be done by the DON, ADON, and MDS nurses in the weekly Standards of Care meeting. Each month the DON will report toe the QA Committee the results of the monitoring for 3 months and then quarterly thereafter for 1 year.	

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F 279	Continued From page 26 Review of the resident ' s care plan revealed no documentation of a restraint in the care plan. During an observation on 11/02/2011 at 8:15am Resident #156 was sitting in the hallway up against the wall with the seat belt in place. Resident #156 was asked to release the seat belt and even though the resident was holding the metal buckle the resident could not release the seat belt. Resident #156 did not answer. During an observation on 11/02/2011 at 9:45am Resident #156 was in the activity area. Several staff members were in the activity room during the activity. The seat belt was in place and was not released. On 11/02/2011 at 12:15pm Resident #156 was observed in her wheelchair in her room eating lunch the seat belt was in place during the meal. During an interview on 11/02/2011 at 2pm NA #2 indicated the resident was unable to remove the lap belt. The NA indicated that the seat belt was kept on at all times when the resident was in the wheelchair. The NA said the seat belt was used for safety positioning and to prevent the resident from getting up unassisted and falling. During an interview on 11/02/2011 at 3:30pm Nurse #2 indicated she worked with the resident on a regular basis. She said the decision to place a resident into a restraint was an IDT (interdisciplinary team) decision. During an interview on 11/02/2011 at 3:48pm the DON (director of nursing) said she completed the	F 279		

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F 279	Continued From page 27 resident ' s pre restraining assessment on 10/28/11. The DON said the restraint is left on the residents a few days to see how they do with it in place. The DON said she talked to the staff and observed Resident #156 on 11/01/2011. The DON said based on staff input and her observation of the resident leaning to the side she determined the resident needed the seat belt. She said the resident is getting up more and she now needs the seat belt. The DON was asked when and how often the seat belt is released and she said the seat belt is released during care if the resident is up, during an activity or during anytime the resident is closely monitored. She said usually the IDT would ask PT (physical therapy) to evaluate the residents but they had not talked to therapy for this resident. The DON said the resident cannot remove the seat belt on her own and they are just trying her out. During an interview on 11/04/2011 at 3:30pm the MDS Coordinator indicated that when she assessed the resident the seat belt was not in place and the resident assessment had been completed by the DON on 10/28/2011. Therefore, the care area triggers were not completed.	F 279		
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 observation, staff interview, record	F 282		

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F 282	Continued From page 28 review, the facility failed to implement the intervention of physical therapy after falls for one (1) of four (4) sampled residents reviewed for accidents. (Resident #50) The findings include: 1. Resident #50 was admitted to the facility on 2/9/11 with diagnoses that included hypertension and a seizure disorder. The quarterly Minimum Data Set (MDS) dated 10/12/11, revealed Resident # 50 had moderately impaired short term and long term memory and judgment. He was independent with transfers ambulation and toileting and required one person to assist with his bathing and hygiene. His balance was steady at all times, and he was highly visually impaired . Resident #4's fall care plan dated 6/4/10, with reviews on and 5/6/11, 7/22/11 and 10/24/11revealed one of the implemented interventions was, added on 5/6/11 *Rehab/ therapy referral. Record review revealed no physical therapy request had been completed 5/6/11, 8/28/11 or 10/24/11. The Nurse's Notes revealed Resident #50 had sustained falls on 8/28/11 and 10/24/11. The falls did not resulted in harm to the resident. During an interview conducted on 11/2/11 at 4:45 pm, MDS Coordinator #2, indicated during the morning meeting resident falls are discussed. The physical therapy director attended the meeting and the assumption was the physical therapy department would evaluate the resident and implement any interventions. During an interview conducted on 11/4/11 at 9:37am, the physical therapy director indicated after a fall, the nursing staff made the determination when to request for an evaluation to the therapy department. He concluded by	F 282	Resident # 50 has been referred to therapy for falls screening and intervention. The care plan has been updated to reflect the therapy screening and intervention in relation to his fall. Each resident that sustains a fall may be affected by the deficient practice and will be referred to therapy by the DON for possible interventions. Any interventions will be considered by the IDT and then care planned appropriately. Licensed Staff have been in-serviced on 11/4/11 and on 11/21/11 by the DON and Staff Developer concerning proper procedures to follow when a resident falls. The standards of Care committee will review resident's falls weekly to assess interventions and documentation.	12/1/11

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F 282	Continued From page 29 revealing Resident #50 had never been referred to therapy. During an interview conducted with the director of nursing 11/5/11 at 2:00pm, the expectation was for everyone to carryout the interventions and she was not aware that Resident #50 had not been evaluated by physical therapy.	F 282	Each month the DON will report to the QA Committee the results of the number of falls and the interventions put in place by therapy. This reporting will occur each month for 3 months then quarterly for a period of 1 year.	
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. This REQUIREMENT is not met as evidenced by:	F 329		

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F 329	Continued From page 30 Based on record review, observation, pharmacist interview, and staff interviews, the facility failed to monitor for involuntary movements for 3 of 6 residents receiving antipsychotic medications (residents #15, #64, #131). Findings include: 1. The facility policy, titled Medication Monitoring, undated, page 94, read in part "Residents who are receiving antipsychotic drug therapy are adequately monitored for significant side effects of such therapy, through the use of the AIMS (abnormal involuntary movement scale) or DISCUS (dyskinesia identification system condensed user scale) and other appropriate tests. AIMS or DISCUS should be completed upon initiation of antipsychotic therapy and once every 6 months." Resident #64 was admitted to the facility on 6/27/11 and readmitted on 10/12/11 with multiple diagnoses including schizo-affective disorder. Review of the resident's clinical record revealed physician orders dated 6/30/11 for Haloperidol 5mg (milligram) twice daily. On 9/8/11, the haloperidol was discontinued and Seroquel 50mg twice daily was started.. Haloperidol and Seroquel are antipsychotics used for the treatment of schizophrenia Lexicomp's Drug Information Handbook, 14th edition, read in part: Haloperidol and Seroquel - Adverse Reactions - involuntary movements. Monitor parameters included - abnormal involuntary movement scale (AIMS). Review of the resident's care plan dated 9/28/11 revealed the use of drugs with the potential for	F 329	Residents 64, 15, and 131 have had their AIMS updated by the Nursing Staff. The Assistant Director of Nurses completed these. Residents that could be affected will have the following procedure completed. Any resident upon initiation of antipsychotic therapy will have the AIMS completed initially and every 6 months by the RN Supervisor. Care plans will be updated as appropriate. Staff have been inserviced on 11/4/11, 11/21/11 and 11/28/11 concerning proper AIMS completion. Monitoring will be completed by the nursing staff, Pharmacist, DON, ADON, SDC and the MDS nurses. Each month the DON will report to the Quality Assurance Committee on the monitoring of the AIMS . This reporting will be done monthly for 3 months and then quarterly thereafter for 1 year.	12/1/1(

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F 329	Continued From page 31 neuromuscular side effects. Approaches included evaluate the side effects of medications. An observation on 11/3/11 at 11:18AM revealed the resident with a continuous slight tongue rolling movement. An observation on 11/3/11 at 2:45PM revealed the resident with a continuous slight tongue rolling movement. Record review revealed no documentation of AIMS or DISCUS monitoring. Record review revealed a side effect monitoring sheet which read in part "Movement Side-Effects - Antipsychotics - involuntary movement of mouth, tongue, face, or jaws." Review of the monitoring sheets for August, September, October, and November 2011 revealed no documentation of any involuntary movements. There were no monitoring sheets for June or July 2011 in the resident's chart. Review of nursing notes revealed no documentation of monitoring for involuntary movements with the resident's antipsychotic medications. In an interview on 11/3/11 at 3:45PM, the Director of Nursing (DON) stated the Staff Development Coordinator (SDC) was responsible for completing the AIMS tests and filing the results in the resident's chart. She stated the resident's medications were reviewed during the morning clinical meetings. The pharmacist also monitored for AIMS or DISCUS tests during her monthly review and sent her recommendations to the	F 329		

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Assistant Director of Nursing (ADON). Her expectation was for AIMS monitoring to be completed on admission, when a new antipsychotic medication was started, and every six months thereafter.

In an interview on 11/3/11 at 5:17PM, the SDC stated for new admissions, she would know if a resident were receiving an antipsychotic when she reviewed the 24 hour assessment. Since all new orders are reviewed in the morning meetings, she would also pick up on the need for AIMS monitoring at that time. The pharmacist also monitored residents for AIMS testing during her monthly review and sent a report to the ADON. The SDC stated she kept a file of when the AIMS tests were due.

In an interview on 11/4/11 at 10:53AM, the SDC stated it had not been reported to her that resident #64's AIMS tests were not done and she had not picked up on it during the morning clinical meetings. The SDC stated she was not aware of the resident's tongue movements until she completed an AIMS test on 11/3/11.

On 11/4/11 at 10:55AM, the SDC provided a copy of an AIMS test for resident #64, dated 11/3/11. The AIMS test indicated mild movements of the tongue.

An observation on 11/4/11 at 2:10PM revealed the resident with a continuous slight tongue rolling movement.

In an interview on 11/4/11 at 2:16PM, resident #64's nurse (nurse #5) stated the resident had exhibited tongue rolling movements since her

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admission. She had not noticed any increase in the resident's symptoms. The nurse stated she had not documented the movements anywhere in the resident's record. She was not aware it was a possible side effect with the resident's antipsychotic medications.

In a telephone interview on 11/4/11 at 2:50PM, the pharmacist stated she reviewed for AIMS tests with antipsychotic medications during her monthly drug regimen review. She had provided the facility with a list of medications that required AIMS monitoring and verbally requested AIMS testing from the nursing staff. Her written reports were sent to the ADON.

The ADON was unavailable for interview.

2. The facility policy, titled Medication Monitoring, undated, page 94, read in part "Residents who are receiving antipsychotic drug therapy are adequately monitored for significant side effects of such therapy, through the use of the AIMS (abnormal involuntary movement scale) or DISCUS (dyskinesia identification system condensed user scale) and other appropriate tests. AIMS or DISCUS should be completed upon initiation of antipsychotic therapy and once every 6 months."

Resident #15 was admitted to the facility on 5/10/11 with multiple diagnoses including dementia with psychosis, hallucinations, and major depression. Review of the resident's clinical record revealed physician orders dated 5/10/11 for Seroquel 100mg at bedtime. On 9/2011, Seroquel was increased to 100mg twice daily. Seroquel is an antipsychotic used for the

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F 329	Continued From page 34 treatment of psychosis. Lexicomp's Drug Information Handbook, 14th edition, read in part: Seroquel - Adverse Reactions - involuntary movements. Monitor parameters included - abnormal involuntary movement scale (AIMS). Record review revealed no documentation of AIMS or DISCUS monitoring. Record review revealed a side effect monitoring sheet which read in part "Movement Side-Effects - Antipsychotics - involuntary movement of mouth, tongue, face, or jaws." Review of the monitoring sheets for May, June, July, August, September, October, and November 2011 revealed no documentation of any involuntary movements. Review of nursing notes revealed no documentation of monitoring for involuntary movements with the resident's antipsychotic medication. In an interview on 11/3/11 at 3:45PM, the Director of Nursing (DON) stated the Staff Development Coordinator (SDC) was responsible for completing the AIMS tests and filing the results in the resident's chart. She stated the resident's medications were reviewed during the morning clinical meetings. The pharmacist also monitored for AIMS or DISCUS tests during her monthly review and sent her recommendations to the Assistant Director of Nursing (ADON). Her expectation was for AIMS monitoring to be completed on admission, when a new antipsychotic medication was started, and every	F 329		

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F 329	Continued From page 35 six months thereafter. In an interview on 11/3/11 at 5:17PM, the SDC stated for new admissions, she would know if a resident were receiving an antipsychotic when she reviewed the 24 hour assessment. Since all new orders are reviewed in the morning meetings, she would also pick up on the need for AIMS monitoring at that time. The pharmacist also monitored residents for AIMS testing during her monthly review and sent a report to the ADON. The SDC stated she kept a file of when the AIMS tests were due. On 11/4/11 at 10:55AM, the SDC provided a copy of an AIMS test for resident #15, dated 11/3/11. The AIMS test indicated no abnormal involuntary movements. In a telephone interview on 11/4/11 at 2:50PM, the pharmacist stated she reviewed for AIMS tests with antipsychotic medications during her monthly drug regimen review. She had provided the facility with a list of medications that required AIMS monitoring and verbally requested AIMS testing from the nursing staff. Her written reports were sent to the ADON. The ADON was unavailable for interview. 3. The facility policy, titled Medication Monitoring, undated, page 94, read in part "Residents who are receiving antipsychotic drug therapy are adequately monitored for significant side effects of such therapy, through the use of the AIMS (abnormal involuntary movement scale) or DISCUS (dyskinesia identification system condensed user scale) and other appropriate	F 329		

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F 329	Continued From page 36 tests. AIMS or DISCUS should be completed upon initiation of antipsychotic therapy and once every 6 months." Resident #131 was admitted to the facility on 8/25/11 with multiple diagnoses including dementia with associated behavioral symptoms and chronic depression. Review of the resident's clinical record revealed physician orders dated 8/25/11 for Seroquel 50mg daily at 6PM. Seroquel is an antipsychotic with a non-approved indication of dementia. Lexicomp's Drug Information Handbook, 14th edition, read in part: Seroquel - Adverse Reactions - involuntary movements. Monitor parameters included - abnormal involuntary movement scale (AIMS). Review of the resident's care plan dated 9/8/11 revealed the use of drugs with the potential for neuromuscular side effects. Approaches included evaluate the side effects of medications. Record review revealed no documentation of AIMS or DISCUS monitoring. Record review revealed a side effect monitoring sheet which read in part "Movement Side-Effects - Antipsychotics - involuntary movement of mouth, tongue, face, or jaws." Review of the monitoring sheets for August, September, October, and November 2011 revealed no documentation of any involuntary movements. Review of nursing notes revealed no documentation of monitoring for involuntary movements with the resident's antipsychotic	F 329		

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(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 329	Continued From page 37 medication. In an interview on 11/3/11 at 3:45PM, the Director of Nursing (DON) stated the Staff Development Coordinator (SDC) was responsible for completing the AIMS tests and filing the results in the resident's chart. She stated the resident's medications were reviewed during the morning clinical meetings. The pharmacist also monitored for AIMS or DISCUS tests during her monthly review and sent her recommendations to the Assistant Director of Nursing (ADON). Her expectation was for AIMS monitoring to be completed on admission, when a new antipsychotic medication was started, and every six months thereafter. In an interview on 11/3/11 at 5:17PM, the SDC stated for new admissions, she would know if a resident were receiving an antipsychotic when she reviewed the 24 hour assessment. Since all new orders are reviewed in the morning meetings, she would also pick up on the need for AIMS monitoring at that time. The pharmacist also monitored residents for AIMS testing during her monthly review and sent a report to the ADON. The SDC stated she kept a file of when the AIMS tests were due. On 11/4/11 at 10:55AM, the SDC provided a copy of an AIMS test for resident #131, dated 11/3/11. The AIMS test indicated no abnormal involuntary movements. In a telephone interview on 11/4/11 at 2:50PM, the pharmacist stated she reviewed for AIMS tests with antipsychotic medications during her monthly drug regimen review. She had provided	F 329		

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	345291	A. BUILDING _____ B. WING _____	C 11/04/2011

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F 329	Continued From page 38 the facility with a list of medications that required AIMS monitoring and verbally requested AIMS testing from the nursing staff. Her written reports were sent to the ADON. The ADON was unavailable for interview.	F 329		
F 356 SS=B	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356		

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UNIVERSAL HEALTH CARE / OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

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F 356	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews the facility failed to post complete nursing staff information 4 of 5 days of the survey. Findings include: On 10/31/2011 at 10am during a tour of the facility, the facility had posted in the entrance foyer on the Administration door the name of the facility, the resident census and the number of Nurses and Nursing Assistants that were working. The posting was in clear view of visitors. The facility did not have posted the actual hours the Nurses and Nursing Assistants were working. On 11/01/2011 at 1pm the facility had posted in the entrance foyer on the Administration door the name of the facility, the resident census and the number of Nurses and Nursing Assistants that were working. The posting was in clear view of visitors. The facility did not have posted the actual hours the Nurses and Nursing Assistants were working. On 11/02/2011 at 10am the facility had posted in entrance foyer on the Administration door the name of the facility, the resident census and the number of Nurses and Nursing Assistants that were working. The posting was in clear view of visitors. The facility did not have posted the actual hours the nurses and nursing assistants were working. An interview on 11/03/2011 at 3:30pm an	F 356	No resident was identified in this deficiency. Residents residing in the facility could be affected by the deficient practice. The DON was in-serviced by the Regional clinical Director on 11/3/11 regarding the correct form to use for daily posting of staff hours. The correct form was posted in a clear and readable format in a prominent place readily accessible to residents and visitors on 11/3/11 by the DON. The data is being posted daily at the beginning of each shift. The daily staffing form contains o Facility name o The current date o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift.	12/1/11

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F 356	Continued From page 40 interview was conducted with the Staff Development Coordinator (SDC). The interview revealed the facility's staffing form had just been updated in the past week and the current posting was the newly updated form. The SDC stated the person responsible for posting the staffing form was the front desk receptionist. On 11/03/2011 at 4:00pm an interview was conducted with the front desk receptionist. The front desk receptionist confirmed that she completes the nursing staff posting form and posts the form daily for visitor review. On 11/3/2011 at 5:05pm an interview was conducted with the DON (Director of Nursing). The DON confirmed the posted form was the current updated form. The DON also confirmed that the front desk receptionist was responsible for completing this form daily. The DON acknowledged the actual hours were not documented on the form posted on 10/31/2011, 11/01/2011, 11/02/2011 and 11/03/2011.	F 356	- Registered Nurses - Licensed Practical Nurses or Licensed vocational nurses (as defined under state law) - Certified Nurse Aides o Resident Census Monitoring is being done by daily review of the staffing form by the Administrator and week-end RN Supervisor. The QA committee will review compliance monthly for 3 months.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet	F 425		

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UNIVERSAL HEALTH CARE / OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

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F 425	Continued From page 41 the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and pharmacist interview, the facility failed to remove expired insulin vials from 2 of 5 medications carts. Findings include: 1. The facility policy, titled Preparation for Medication Administration, undated, page 58, read in part "Vials and ampules of injectable medications are used in accordance with the manufacturer ' s recommendations for storage, use, and disposal." The facility policy, titled Medication Storage in the Facility, undated, page 33, read in part "The following guidelines should be followed for expiration dates for open multi-dose medications: 28 days: Insulins." An inspection of the 300 hall medication cart on 11/4/11 at 3:30PM revealed one 10cc (cubic centimeters) vial of Lantus (insulin), with an opened date of 9/3/11, and one 10cc vial of Humalog (insulin), with an opened date of 9/28/11. The manufacturer's product information for	F 425	No residents were named in this deficiency. Residents with orders for insulin may be affected by the deficient practice. The facility will provide routine pharmaceutical services that include procedures that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biological to meet the needs of each resident. All insulin vials were checked for dates of expiration on 11/4/11 by the Staff Developer and DON and any that had expired were discarded as indicated. The DON and ADON will inspect the drug carts weekly to assure that no medications have expired. Insulin vials will be dated on the day they are opened and discarded after 28 days as recommended by the manufacturer. Staff have been in-serviced on 11/4/11 and on 11/21/11 and 11/28/11 concerning proper medication storage by the DON, and Pharmacist .	12/1/11

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F 425	Continued From page 42 Lantus read in part: "Storage - Open (in-use) vial: vials must be discarded 28 days after being opened." The manufacturer's product information for Humalog read in part: "After starting use (open) vials: keep in the refrigerator or at room temperature below 86 degrees Farenheit (30 degrees Celsius) for up to 28 days. Throw away an opened vial after 28 days of use." In an interview on 11/4/11 at 3:30PM, Nurse #6 acknowledged the two vials of insulin were expired. Nurse #6 stated most insulin had a 28 day expiration date after being opened. She stated every nurse was responsible for checking the medication cart. Each nurse that gave insulin was responsible for checking the expiration date before administering it. She added the pharmacy checked all drug storage areas monthly. In a telephone interview on 11/4/11 at 4:55PM, the pharmacist stated the manufacturer recommended discarding insulin 28 days after opening. She stated a pharmacy technician checked drug storage areas, including the medication carts, monthly for outdated medications. In an interview on 11/4/11 at 5:15PM, the Director of Nursing (DON) stated insulin could be used for 28 days after opening. She stated the third shift staff usually checked the carts for outdated items. The nursing staff also checked the date on insulin before administering. The medication carts had recently been audited by the facility and the pharmacy technician. The DON stated she expected the nursing staff to date and initial	F 425	A monitoring tool has been created and will be completed by the nurses and then turned in to the DON each week. The pharmacist and the pharmacy tech that is provided by our pharmacy will also monitor each month and provide a report of their findings to the DON. The DON will report findings to the Quality Assurance Committee each month for 3 months then quarterly for a period of 1 year.	

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F 425	Continued From page 43 insulin when opened, review the dates daily before giving insulin, and remove any expired items from the medication carts. 2. The facility policy, titled Preparation for Medication Administration, undated, page 58, read in part "Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations for storage, use, and disposal." The facility policy, titled Medication Storage in the Facility, undated, page 33, read in part "The following guidelines should be followed for expiration dates for open multi-dose medications: 28 days: Insulins." An inspection of the 400 hall medication cart on 11/4/11 at 4:05PM revealed one 10cc vial of Lantus (insulin), with an opened date of 10/1/11, and one 10cc vial of Novolog (insulin), with an opened date of 9/28/11. The manufacturer's product information for Lantus read in part: "Storage - Open (in-use) vial: vials must be discarded 28 days after being opened." The manufacturer's product information for Novolog read in part: "Recommended Storage - Novolog, vials: after initial use a vial may be kept at temperatures below 30 degrees Celsius (86 degrees Farenheit) for up to 28 days." In an interview on 11/4/11 at 4:05PM, Nurse #7 stated insulin could be used for 28 days after opening. She stated it was up to each nurse to	F 425		

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F 425	Continued From page 44 check the cart for outdated items. Nurse #7 stated the pharmacy also checked the medication carts monthly. In a telephone interview on 11/4/11 at 4:55PM, the pharmacist stated the manufacturer recommended discarding insulin 28 days after opening. She stated a pharmacy technician checked drug storage areas, including the medication carts, monthly for outdated medications. In an interview on 11/4/11 at 5:15PM, the Director of Nursing (DON) stated insulin could be used for 28 days after opening. She stated the third shift staff usually checked the carts for outdated items. The nursing staff also checked the date on insulin before administering. The medication carts had recently been audited by the facility and the pharmacy technician. The DON stated she expected the nursing staff to date and initial insulin when opened, review the dates daily before giving insulin, and remove any expired items from the medication carts.	F 425		
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;	F 441		

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F 441	Continued From page 45 (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. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to wash their hands and/or sanitize them before and after contact with 1 of 1 resident (Resident #126). 1. An observation was made on 11/4/11 at 4:15 pm of Nursing Assistant (NA) #5 walking down the 300 hall with 2 sandwiches and a bowl of soup in transit to deliver food to a resident. NA #6 asked NA #5 to assist her with Resident # 126's	F 441	Resident # 126 was not affected by the deficient practice. CNA # 5 was in-serviced on 11/4/11 by DON concerning correct infection control practices related to hand washing. Any resident within the facility has the potential to be affected by this practice. Staff has been in-serviced on 11/4/11 and on 11/21/11 by the DON, Staff Developer and infection control nurse concerning proper infection control including hand washing procedures. Monitoring will be done by the DON, ADON, and SDC through observations of resident care twice weekly to ensure that proper infection control is in place. The DON will report to the QA Committee which includes the infection control committee, each month for 3 months and then quarterly thereafter for a period of 1 year.	12/1/11

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F 441	Continued From page 46	F 441		

incontinent care. NA #5 and NA #6 entered the resident's room, leaving the resident ' s room door ajar. NA #5 placed the 2 sandwiches and the bowl of soup on the resident ' s bedside table. She then proceeded to put on a pair of gloves and assisted NA #6 with the resident ' s incontinent care. After assisting with the resident's incontinent care, NA #5 took the pair of gloves off and, without washing her hands, she picked up the sandwiches and soup, exited the resident's room, and proceeded to deliver the sandwiches and soup to another resident.

During an interview with NA # 5 on 11/4/11 at 4:29 pm, she acknowledged that she did not wash her hands before or after contact with the resident. She stated, " I forgot to wash my hands." NA # 5 stated she had not been thinking. The NA stated the danger could be cross contamination. The NA stated she would commonly wash her hands after taking off the gloves subsequent to being in contact with a resident, but she did not do that today because she was not thinking.

During an interview on 11/4/11 at 5:00 pm with the staff development coordinator, she stated that the aide should have first delivered the other resident's food. She further added that the nursing assistants were trained to wash their hands with friction and with soap and water before and after contact with residents.

During an interview with the DON on 11/4/11 at 5:15 pm, she stated that the facility's policy is that all staff thoroughly cleanse their hands with friction, soap and water. She added that the staff is trained to wash hands before and after resident

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F 441	Continued From page 47 contact and when hands are soiled. She further stated that each room has soap, comfortably hot water, disposable hand towels, and moisture barriers (lotion). She further stated that staff is in-serviced on hand washing during orientation and several times throughout the year.	F 441		

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	345291	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/30/2011

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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: 42 CFR 483.70(a) By observation on 11/30/11 at approximately noon the following corridor doors were non-compliant, specific findings include: A. The bathroom door exiting the bathroom from room 107 required more than one range of motion to exit the area. B. The bathroom door exiting the bathroom from room 105 and 503 allowed client to lock themselves into the room without access from the outside (staff did not have a key).	K 018	K018 Door knobs that require only one range of motion to exit the area have been installed on the doors sited in this deficiency. An audit of all bathroom doors have been conducted and new knobs have been installed on any doors that did not have one range of motion to exit the area The maintenance department and department heads will monitor any door knobs that are not working properly or do not have one range of motion to exit. Any knobs that need to be replaced for any reason will be replaced by the maintenance person. The maintenance person will report results of this monitoring to the quality assurance committee each month for 3 month and then quarterly thereafter for a period of 1 year.	12/22/11

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

Administrator 12/14/11

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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K 018	Continued From page 1 C. The bathroom to room 114 had a slide lock that would have prevented exit in an emergency.	K 018	K021 The fire door near room 407 has been adjusted so that it will close and latch properly. The maintenance person has audited all of the smoke and fire doors to determine if they are working properly. Any door that was not functioning properly has been adjusted to close and latch properly. The maintenance person and the administrator will check the smoke and fire doors monthly to make sure they are working properly. Any door not working properly will be adjusted. The maintenance person will report the status of any malfunctioning doors to the quality assurance committee each month for 3 months and then quarterly thereafter for a period of 1 year.	12/14/11
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 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 11/30/11 at approximately noon the following cross corridor doors were non-compliant, specific findings include: the fire door near room 407 did not latch properly when tested.	K 021		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1	K 029		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345291	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HEALTH CARE / OXFORD	500 PROSPECT AVENUE OXFORD, NC 27565

(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
K 029	Continued From page 2 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 11/30/11 at approximately noon the following hazardous area was non-compliant, specific findings include: Door closures to the 400 hall utility/soiled linen room and 400 hall clean linen closet allowed the door to remain open.	K 029	The door closer to the 400 hall utility room has been replaced and now closes the door properly. The maintenance person has checked all utility rooms for proper closers and has replaced or adjusted any that do not allow proper closing. Each month the maintenance person will check all hazardous area doors to assure that they close properly. The maintenance person will report any findings from his rounds to the quality assurance committee monthly for 3 months and then quarterly thereafter for a period of 1 year.	12/14/11
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 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 11/30/11 at approximately noon the following exit egress was non-compliant, specific findings include: courtyard exit egress to the main dining room had a dead bolt that would not allow exit from the courtyard into the building.	K 038	K038 The dead bolt has been removed from the main dining room exit into the courtyard. This will allow anyone to exit the courtyard through the dining room as well as the front living room. The maintenance person will check monthly to ensure that no additional locking mechanisms have been added to this door. Each month the maintenance person will report any negative findings to the quality assurance committee for 3 months and then quarterly thereafter for a period of 1 year.	12/14/11
K 067	NFPA 101 LIFE SAFETY CODE STANDARD	K 067		

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K 067 SS=D	Continued From page 3 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 11/30/11 at approximately noon the following Heating, Ventilating, and air conditioning (HVAC) was non-compliant, specific findings include: A. There was not an emergency shut down switch located at the nurses station. B. The HVAC system with a return near room 103 did not shut down with fire alarm activation.	K 067	K067 The fire alarm service that the facility uses has connected an emergency shut down switch to the HVAC unit located near the nurses station. When the fire alarm is activated, the HVAC will shut down as required. The maintenance person will check the system each month to ensure that it continues to shut down upon activation of the fire alarm. Any problems noted with the system will be corrected immediately. The maintenance person will report monthly any problems found during his monthly inspection to the quality assurance committee. This reporting will be each month for 3 months and then quarterly thereafter for a period of 1 year.	12/22/11
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: 42 CFR 483.70(a) By observation on 11/30/11 at approximately noon the following obstruction was observed as	K 072		

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	345291	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/30/2011

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K 072	Continued From page 4 noncompliant: specific findings include corridor doors to 300 hall linen closet, 300 water heater room and 300 hall janitor's closet 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	K072 The doors that were listed in the deficiency have had closers installed so they can not swing 180 degrees into the hallway. The maintenance person has checked all halls to check for any doors that may be a problem, and he has installed closers on those that he found to need one. The maintenance person will check doors each month to verify if any need to be repaired or replaced. The results of his monthly rounds will be reported to the quality assurance committee each month for 3 months and then quarterly thereafter for a period of 1 year.	12/14/11
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 11/30/11 at approximately noon 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. NFPA 99 3-4.4.2 Record keeping. A written	K 144		

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K 144	Continued From page 5 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	K144 A load bank test will be conducted on the diesel powered generators on January 6, 2012. This testing will be conducted by Forest Generator Service. They will conduct this testing annually in which they test the 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. The maintenance person will report the results of the load bank test to the quality assurance committee.	1/11/12