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

JUL 0 6 2012

PRINTED: 06/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345149	A. BUILDING ______ B. WING ______	C 06/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & RETIREMENT	4911 BRIAN CENTER LANE WINSTON-SALEM, NC 27106

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F 204 SS=D	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG	F 204		7/6/12

F 204 SS=D 483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG

A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

This REQUIREMENT is not met as evidenced by:
Based on staff and resident interviews and record review, the facility failed to ensure that the post discharge information provided to the resident reflected the current needs of 1 of 1 resident reviewed for community discharge. (Resident#135) Findings included:

Resident#135 was admitted to the facility on 3/23/12, after an acute hospitalization for the treatment of CHF (congestive heart failure) and chronic obstructive pulmonary disease (COPD).

Review of the History and physician dated 3/27/12 revealed in part that resident was " volume overload [an excessive fluid in the body] " with a weight loss of 20 pounds.

Review of the medical record revealed her diet was a no added salt and was maintained on a 2000 cc (cubic centimeters) per 24 hours fluid restriction.

Review of the adult nurse practitioner ' s (ANP#1) progress notes for discharge planning dated 6/5/12 and the physician orders dated 6/5/12 revealed resident was to be discharged home with physical therapy, occupational therapy and a home health nursing aide.
Review of the ANP#2 ' s progress note dated

F 204

1. Corrective action has been accomplished for the alleged deficient practice involving resident #135. Resident #135 has received appropriate discharge planning and instruction and follow up with Social Services since discharge to determine appropriate transition has been completed and documentation of discharge planning and instruction has been reviewed an updated.
2. All residents being discharged from the facility have the potential of being affected by this alleged deficient practice. The Social Services Director/designee will audit all discharges during the last 30 days.
3. The Administrator/designee will re-educated all Department Heads and Licensed Nurses on the appropriate methods for preparing a resident for discharge including resident education of medications and ongoing treatments and documentation of discharge planning activities utilizing the Post Discharge Plan of Care based on the Discharge and Transfer policy. The Social Services Director/designee

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

Administrator | 7/2/12

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 204	Continued From page 1 6/6/12 revealed in part that staff was concerned about resident's decreased oxygen saturation level at 71% on room air. ANP#2's written assessment indicated hypoxia which is a condition characterized by a lack of oxygen in bodily tissue related to CHF and COPD. The ANP#2 ' s plan was to regain (increase) the oxygen levels on home oxygen and to monitor the resident ' s weight. Review of the " Post-Discharge Plan of Care " (PDPC) form dated 6/6/12 that was signed by the resident on discharge revealed under the section " Dietary and Nutritional Needs " food/fluids was listed as regular. There was no instruction of a 2000 cc/24 hrs fluid restriction. The PDPC form (clinical portion) was written by the social worker. Review of the nursing daily skilled summary form dated 6/6/12 at 1:25 p.m. revealed Resident#135 was alert and oriented times three, discharged home and understood discharge summary (PDPC). Interview via the phone (in the presence of ANP#1) on 6/7/12 at 10:15 a.m. with ANP#2(who authored the progress notes dated 6/6/12) revealed Resident#135 was seen by her on 6/6/12 because of her oxygen saturation levels below 70 %. ANP#2 indicated that she did not treat the resident after discharge from the facility and indicated that the resident was to see her primary physician for after care instructions. ANP#2 indicated she wanted the primary care doctor to set perimeters for how much weight she should gain. After the phone conversation ANP#1 indicated that monitoring of the resident's weight after discharge should have been added	F 204	will review each planned discharge as part of the morning Department Head meeting to ensure an Interdisciplinary approach and appropriate documentation. 4. The Social Services Director/designee will monitor the Post Discharge Plan of Care 3 times per week for 4 weeks, then weekly for 8 weeks to verify documentation of discharge planning and instruction on the Post Discharge Plan of Care. The results of this monitoring will be reported in the monthly Quality Assurance (QA) Committee meeting for 3 months then quarterly. The committee will evaluate and make further recommendations as indicated. The QA&A committee will evaluate the effectiveness of the plan based on outcomes identified and will re-adjust the plan as needed to ensure continued compliance. Date of Compliance July 6, 2012. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 204	Continued From page 2 to the initial discharge instructions. Interview on 6/7/2012 at 11 a.m. with Nurse#4 and Nurse#3 (nurse who discharged the resident) was held. Nurse#3 indicated that upon discharge from the facility she explained to resident her medications, purpose of the medications, and that she was on a fluid restriction. Nurse#3 indicated that she had not included any instructions to the resident about monitoring her weight. Continued interview with Nurse#3 indicated that "I should have discussed with her about her how she should be monitoring her weight." Interview on 6/7/12 at 11:50 a.m. with the Social worker revealed she just spoke with Resident#135 over the phone and she indicated that she knew about her monitoring of weights, fluid restriction, diet and medications. Interview on 6/7/12 at 11:55 a.m. with Resident#135 via the phone revealed she received upon discharge a list of medications and the times to be taken, dietary instructions and physical therapy instructions. Resident#135 indicated she was not told about the fluid restriction. Resident#135 indicated that she was unaware of monitoring her weight until the social worker called her this morning. Interview on 6/8/12 at 10:45 a.m. with the corporate representative, director of nurses (DON) and the administrator revealed that the interdisciplinary team was expected to complete portions of the PDPC form that the resident signs and acknowledges. The DON indicated that nursing was expected to complete the clinical	F 204	**" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 204	Continued From page 3 portions and provide information significant to the resident ' s condition upon discharge.	F 204		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to ensure an incident which resulted in a fracture was reported for three days for 1 (Resident # 58) of 3 residents in the survey sample reviewed for accidents. The findings include: Resident # 58 had diagnoses including end stage dementia. The 3/7/12 care plan revealed the resident had a potential for injury and impaired mobility related to predisposing factors which included end stage dementia. The care plan indicated the resident required use of a mechanical lift for transfers with 2 person assistance. The Minimum Data Set (MDS) dated 3/19/12 indicated the resident had severe cognitive impairment, behavioral symptoms and was totally dependent on staff for all Activities of Daily Living including transferring and was not ambulatory.	F 309	F309 1. Corrective action has been accomplished for the alleged deficient practice involving resident #58 by providing appropriate medical intervention and follow up as well an ongoing monitoring for appropriate transfers. 2. All residents requiring assistance with transfers have the potential of being affected by the alleged deficient practice. -The DON/designee will complete an observation of all residents to verify the appropriate lift and transfer methods are used. -The DON/designee will complete an audit of all residents and staff to verify appropriate Incident and Accident reporting has occurred during the last 30 days. 3. -The SDC/designee will re-educate all Nursing Staff on the appropriate techniques for lifts **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	7/6/12

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F 309	Continued From page 4 The MDS also indicated resident #58 had unclear speech, was rarely/never understood and unable to verbalize pain. The 5/7/12 Change of Condition Report noted that the resident #58's right leg/knee area was bruised and more swollen than the left leg. Review of Nurses' Notes dated 5/7/12 indicated the resident's family was phoned to inform them that the resident was being sent to the emergency room for an X-ray of the right lower extremity to rule out a fracture. The resident returned to the facility with EMS and was transferred from the stretcher to the bed. There was a soft boot on the right leg wrapped in ace bandage. Review of accident report dated 5/7/12 revealed nursing assistant (NA) #1 was showering resident #58 when she observed the right lower leg to be bruised and swollen. The resident was confused and unable to verbalize and an X-ray of the right leg was obtained. Review of the 5/7/12 radiology report revealed the resident had moderately severe diffuse osteopenia (low bone density) and an acute minimally displaced fracture involving the proximal tibial metaphysis (the top portion of the shin bone). The Disciplinary Action Record dated 5/8/12 and completed by the director of nursing (DON) noted that on 5/4/12 NA #4 did not follow her assignment to deliver care. Resident #58 was care planned for a mechanical lift for transfers. The NA attempted to transfer the resident with a	F 309	and transfers with return demonstration. -The SDC/designee will re-educate all Staff on Reportable Incidents and Accidents. 4. The DON/designee will randomly monitor appropriate transfer techniques utilized by the Resident Care Specialist weekly for 12 weeks. The DON/designee will randomly interview residents and staff to verify appropriate Incident and Accident reporting weekly for 12 weeks. The results of the audits and monitoring will be reported in the monthly Quality Assurance (QA) Committee meeting monthly for 3 months. The committee will evaluate and make further recommendations as indicated. Date of Compliance July 6, 2012. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 309	Continued From page 5 gait belt and injured her right leg resulting in a fracture. NA #4 did not report the accident/incident until questioned on 5/8/12, 4 days later. She did not follow the "No Lift Policy." Observation of a transfer by a Physical Therapy Assistant (PTA) and NA #1 was conducted at 11:00 AM on 6/7/12. Resident #58 was transferred with a mechanical lift. A soft cast was in place on the right leg and both lower extremities were guarded by NA #1 during the transfer. An interview with NA #1 was conducted following the transfer and she stated that she has always transferred the resident with a mechanical lift. On 6/7/12 at 4:11 PM Nurse #1 revealed that on 5/7/12 NA #1 came to her and told her the resident had a bruise. She assessed the resident and her range of motion. The bruise was yellow and blue. She called the physician and obtained an order for a mobile X-ray. An interview with the director of nursing (DON) at 5:30 PM on 6/7/12 revealed the bruise on resident #58 was identified on 5/7/12. Nurse #1 reported it to her about 7:30 - 8:00 AM. She began the accident report and called the family and the physician. The physician ordered the X-ray. The mobile X-ray report was inconclusive. She called the physician again and an order was obtained from the medical director to send the resident to the emergency room for an evaluation and X-ray. The resident was sent late in the afternoon and returned later at night with a soft cast on. The DON stated she called the weekend supervisor who told her that the resident was not out of bed all weekend. She then checked the	F 309	**" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 309	Continued From page 6 assignment sheets and determined that the last time the resident was out of bed was 5/4/12. The NA (#4) who cared for the resident on 5/4/12 was interviewed by the DON and NA #4 told her that she transferred the resident from bed without the mechanical lift. When NA #4 looked down the hall and didn't see anyone in the hallway she decided to get the resident up on her own. She lifted her under her arms and tried to stand and pivot the resident. NA #4 told the DON that she did not drop her but sat her down hard in the chair. When the DON questioned NA #4 regarding not reporting the incident the NA said she did not report it to anyone because she looked at resident #58 and didn't see anything wrong with her. An interview with the assistant director of nursing (ADON) at 5:45 PM on 6/7/12 revealed he conducted inservices for mechanical lift transfers and assignment sheets after the incident. He completed no other inservices as of 6/7/12 because he thought those were the most important issues. On 6/7/12 at 6:00 PM the DON stated that inservices were conducted on the topics of mechanical lifts and assignment sheets. No other education was done as a follow up to resident #58's incident. On 6/8/12 at 2:45 PM interviews were conducted with the Administrator and DON. The Administrator stated that his expectation regarding changes or incidents was that the DON or unit nurse would be notified immediately. He also indicated that he expected to be notified if the DON was unavailable. The DON stated that she expected that all incidents would be reported immediately to a supervisor, the DON or ADON.	F 309	**" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=G	Continued From page 7 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews the facility failed to ensure a resident was transferred with a mechanical for 1 (resident # 58) of 3 residents reviewed for accidents. The findings include: Resident # 58 had diagnoses including end stage dementia and osteopenia (low bone density). The Physical Therapy Evaluation dated 3/5/12 revealed the resident should be transferred with a mechanical lift. The 3/7/12 care plan revealed the resident had a potential for injury and impaired mobility related to predisposing factors which included end stage dementia. The care plan indicated the resident required use of a mechanical lift for transfers with 2 person assistance. The Minimum Data Set dated 3/19/12 indicated the resident had severe cognitive impairment, behavioral symptoms and was totally dependent on staff for all Activities of Daily Living including transferring and was not ambulatory.	F 323	F323 1. Corrective action has been accomplished for the alleged deficient practice involving resident #58 by providing appropriate medical intervention and follow up as well an ongoing monitoring for appropriate transfers. 2. All residents requiring assistance with transfers have the potential of being affected by the alleged deficient practice. -The DON/designee completed an observation of all residents to verify the appropriate lift and transfer methods are used. -The DON/designee completed an audit of all residents and staff to verify appropriate Incident and Accident reporting has occurred during the last 30 days. 3. -The SDC/designee will re-educate all Nursing Staff on the appropriate techniques for lifts and transfers with return demonstration. -The SDC/designee will re-educate all Staff on Reportable **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	7/6/12

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F 323	Continued From page 8 The Resident Care Specialist Assignment sheet dated 5/4/12 was reviewed and indicated the resident was to be transferred with a mechanical lift. The 5/7/12 Change of Condition Report noted that the resident #58's right leg/knee area was bruised and more swollen than the left leg. Review of Nurses' Notes dated 5/7/12 indicated the resident's family was phoned to inform them that the resident was being sent to the emergency room for an X-ray of the right lower extremity to rule out a fracture. The resident returned to the facility with EMS and was transferred from the stretcher to the bed. There was a soft boot on the right leg wrapped in ace bandage. Review of accident report dated 5/7/12 revealed nursing assistant (NA) #1 was showering resident #58 when she observed the right lower leg to be bruised and swollen. The resident was confused and unable to verbalize and an X-ray of the right leg was obtained. Review of the 5/7/12 radiology report revealed the resident had moderately severe diffuse osteopenia and an acute minimally displaced fracture involving the proximal tibial metaphysis (the top portion of the shin bone). The Disciplinary Action Record dated 5/8/12 and completed by the DON noted that on 5/4/12 NA #4 did not follow her assignment to deliver care. Resident #58 was care planned for a mechanical lift for transfers. The NA attempted to transfer the	F 323	Incidents and Accidents. 4. The DON/designee will randomly monitor appropriate transfer techniques utilized by the Resident Care Specialist weekly for 12 weeks. The DON/designee will randomly interview residents and staff to verify appropriate Incident and Accident reporting weekly for 12 weeks. The results of the audits and monitoring will be reported in the monthly Quality Assurance (QA) Committee meeting monthly for 3 months. The committee will evaluate and make further recommendations as indicated. Date of Compliance July 6, 2012 **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 323	Continued From page 9 resident with a gait belt and injured her right leg resulting in a fracture. NA #4 did not report the accident/incident until questioned on 5/8/12, 4 days later. She did not follow the "No Lift Policy. " Observation of a transfer by a Physical Therapy Assistant (PTA) and NA #1 was conducted at 11:00 AM on 6/7/12. Resident #58 was transferred with a mechanical lift. A soft cast was in place on the right leg and both lower extremities were guarded by NA #1 during the transfer. An interview with NA #1 was conducted following the transfer and she stated that she has always transferred the resident with a mechanical lift. On 6/7/12 at 3:50 PM NA #2 stated she always transferred resident #58 with a mechanical lift and 2-4 people depending on the resident's behavior. She added that sometimes the resident yelled out more and she couldn't verbalize pain so they used an extra staff to transfer the resident. At 3:52 PM on 6/7/12 Nurse #1 stated that the resident was transferred with a mechanical lift and 2 people. She further stated that resident # 58 had been transferred with a mechanical lift since she was working there, almost 4 years, and the resident had never been able to bear weight. On 6/7/12 at 4:02 PM NA #3 revealed the resident was transferred with a mechanical lift and 2 people. She added that the resident could not stand or walk and use of the mechanical lift is identified on the assignment sheet. She had never transferred the resident without the mechanical lift and didn't know of anyone who had. On 6/7/12 at 4:11 PM Nurse #1 revealed that on	F 323	**" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 323	Continued From page 10 5/7/12 NA #1 came to her and told her the resident had a bruise. She assessed the resident and her range of motion. The bruise was yellow and blue. She called the physician and obtained an order for a mobile X-ray. An interview with the director of nursing (DON) at 5:30 PM on 6/7/12 revealed the bruise on resident #58 was identified on 5/7/12. Nurse #1 reported it to her about 7:30 - 8:00 AM. She began the accident report and called the family and the physician. The physician ordered the X-ray. The mobile X-ray report was inconclusive. She called the physician again and an order was obtained from the medical director to send the resident to the emergency room for an evaluation and X-ray. The resident was sent late in the afternoon and returned later at night with a soft cast on. The DON stated she called the weekend supervisor who told her that the resident was not out of bed all weekend. She then checked the assignment sheets and determined that the last time the resident was out of bed was 5/4/12. The NA (#4) who cared for the resident on 5/4/12 was interviewed by the DON and NA #4 told her that she transferred the resident from bed without the mechanical lift. When NA #4 looked down the hall and didn't see anyone in the hallway she decided to get the resident up on her own. She lifted her under her arms and tried to stand and pivot the resident. NA #4 told the DON that she did not drop her but sat her down hard in the chair. The NA did not report it to anyone because she looked at resident #58 and didn't see anything wrong with her. She also said that she transferred the resident previously without using the mechanical lift. When the DON asked NA #4 if she looked at her assignment sheet she told her that she knew the resident was to be transferred	F 323	**" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345149	A. BUILDING ____ B. WING ____	C 06/08/2012

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F 323	Continued From page 11 with a mechanical lift. When the DON was asked what her expectations were regarding transferring of residents she replied that if the resident has been evaluated as needing a mechanical lift for transferring, the resident was to be transferred with the mechanical lift because it is the only safe method to transfer the resident. An interview with the assistant director of nursing (ADON) at 5:45 PM on 6/7/12 revealed he conducted inservices for mechanical lift transfers and assignment sheets since the incident. He further stated that no other inservices had been completed as he thought those were the most important issues. On 6/7/12 at 6:00 PM the DON stated that inservices were conducted on the topics of mechanical lifts and assignment sheets.	F 323		
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	F 329	F329 1. Corrective action has been accomplished for the alleged deficient practice involving resident #79 and #133. Medication error forms were completed for the missed and inaccurate doses of medication administered to Resident #79 and #133. No adverse outcomes have been identified. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	7/6/12

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F 329	Continued From page 12 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with physician, nurse practitioner, consultant pharmacist, dispensing pharmacy manager and facility staff, the facility failed to ensure a resident did not receive three times the ordered dosage of metoprolol succinate (medication used to manage the heart rate). (Resident #79). This was evident in 1 of 8 sampled residents reviewed for unnecessary drugs. Findings include: Resident #79 was admitted to the facility on 05/02/12 with diagnoses including hypertension and depression. Review of the Discharge Orders from the hospital dated 05/02/12 included orders for metoprolol succinate (Toprol XL) (medication to treat high blood pressure) 50 milligram (mg) tablet (tab) er (extended release) 24hr (once a day), one tab by mouth daily for heart rate. Review of the handwritten (by Nurse #4) Admission Orders that were faxed to the pharmacy and written on the Medication Administration Record (MAR) dated 05/02/12 included orders for metoprolol succinate X 150	F 329	2. All residents have the potential to be affected by the alleged deficient practice. 3. The SDC/designee will re-educate all Licensed Nurses on Medication Management Administration techniques including transcribing orders, administration of medications, and documentation of medication administration. 4. The DON/designee will complete Medication Administration observations 3 times per week for 4 weeks, then weekly for 8 weeks. The results of the audits and monitoring will be reported in the monthly Quality Assurance (QA) Committee meeting monthly for 3 months. The committee will evaluate and make further recommendations as indicated. Date of Compliance: July 6, 2012. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 329	Continued From page 13 mg XR (extended release) per 24h, 1 tab po (by mouth) daily for heart rate. The Physician Order Sheet (printed and sent to the facility by the pharmacy) dated 06/05/12 included orders for metoprolol succinate 50 mg (milligrams) three tabs orally every morning. Review of the June 2012 MAR dated 06/01/12 included orders for metoprolol succinate X 150 mg XR (extended release) qd, give 3 tabs. Review of the May and June MAR 2012 revealed metoprolol succinate X150 mg po qd was signed by the medication nurse daily indicating the medication was administered. On 06/08/12 at 10:16 AM Nurse #3 was observed administering Resident #79 150 mg (3 tabs) of the extended release metoprolol succinate XL. During an interview on 06/08/12 at 12:25 PM with Nurse # 4 who transcribed the admission order to the MAR and sent the orders to the pharmacy stated " I transcribed the order as it was written " Toprol XL 50 mg ER qd (every day) " . The dispensing pharmacy filled it and sent the medication to the facility for administration. I did not clarify this order when it came from the dispensing pharmacy. " Observation on 6/8/12 at approximately 2 p.m. of Resident #79 ' s Blister pack of metoprolol succinate medication supplied by the dispensing pharmacy read: Metoprolol SU 50 mg tab SR (extended release) 24H. The dispensing instructions read: Take 3 tabs (150 mg) by mouth every day. Dx: (diagnosis) heart rate.	F 329	**" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 329	Continued From page 14	F 329		

During an interview on 06/08/12 at 2:40 PM with Nurse # 3 who administered medication to Resident #79 stated " I read the order as give 3 tablets of the 50 mg tablets of metoprolol succinate, so that is what I gave the resident " . She continued; " I check the resident ' s heart rate daily and place the heart rate on my daily nurses ' note. I did not question the medication delivered by the dispensing pharmacy for the resident. "

A review of the daily nursing sheets from 05/02/12 until 06/08/12 revealed the pulse rate was documented on her daily nurse notes. The pulse rate ranged from 56- 72 beats per minute.

During an interview with the physician on 06/08/12 at 1:43 PM; the physician reviewed the MAR, and the resident's original order from the hospital dated 05/02/12 and indicated the metoprolol succinate 50 mg was written as " XL " . The physician stated " she (resident #79) should not have gotten 150 mg a day. " The physician further stated " you can see that the "l" was taken as a "1" so the resident was receiving a higher dose than I wanted to begin with " . The physician then reviewed Resident #79 ' s blood pressure (BP) and pulse rate (P) and stated " she (resident #79) was tolerating it. " But the physician repeated " she (the resident) should be receiving the medication metoprolol succinate 50 mg po q am (every morning). " " The physician stated " I will change the order to metoprolol succinate 100 mg po q d and make sure the nurses check the resident ' s BP and P q shift (every shift). There are a number of possible side effects of metoprolol succinate, including a slow

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F 329	Continued From page 15 heart rate, diarrhea, tiredness, and dizziness. " An interview with the Adult Nurse Practitioner (ANP) on 06/08/12 at 2:44 PM, indicated she reviewed Resident #79 ' s initial order for Toprol (metoprolol succinate) XL 50 mg q d. The ANP reviewed the order as it was transcribed on the MAR by Nurse # 4, and indicated Nurse # 4 wrote the order and added XR. The ANP indicated she signed (indicating her approval) the June 2012 MAR which was the renewal of the original orders. She (ANP) stated " I did not review the previous month ' s MAR for updating; I should have checked the renewal orders against the original orders. I now will double check the original orders for clarification before I sign off on any orders " . The ANP stated "she (resident # 79) should not have been getting that dose." "I will now go back and review the original orders; I am unsure why the pharmacy did not clarify this order." During an interview with the DON on 06/08/12 at 3:34 PM revealed her expectation was that the medication would have been verified by the staff when it was received from the pharmacy. An unsucessful attempt to interview Nurse #6 who was responsible for checking June MARs and orders was unsucessful.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced	F 332	F332 1. Corrective action has been accomplished for the alleged **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	7/6/12

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F 332	Continued From page 16 by: Based on observations, record reviews and staff interviews the facility failed to ensure a medication error rate less than 5% as evidenced by 4 medication errors out of 50 opportunities involving 2 residents (Residents #79 and #133). The findings include: 1.a Resident #79 had diagnoses including hypertension and dementia. The Physician Order Sheet dated 6/5/12 included orders for metoprolol (management of the pulse rate) 50 mg (milligrams) XL (extended release) tablets 24 hours orally every morning. Observation on 6/8/12 at 10:16 AM Nurse #3 administered (3) 50 mg (milligrams) XL (extended release) tablets which equaled to 150 mg. Interview on 6/8/12 at 1:43 p.m. with the attending physician indicated that the resident should not have been administered metoprolol 150 mg XL, but should have recieved only metoprolol 50 mg XL. 1.b Resident #79 had diagnoses including hypertension and dementia. The Physician Order Sheet dated 6/5/12 included orders for metoprolol (for high blood pressure) 50 mg (milligrams) three tabs orally every morning. Review of the undated list entitled Medications Not To Be Crushed indicated time release form of metoprolol was not to be crushed. It indicated that metoprolol (time release form) is scored and may be broken in half.	F 332	deficient practice involving resident #79 and #133. Medication error forms were completed for the missed and inaccurate doses of medication administered to Resident #79 and #133. No adverse outcomes have been identified. 2. All residents have the potential to be affected by the alleged deficient practice. 3. The SDC/designee will re-educate all Licensed Nurses on Medication Management Administration techniques including transcribing orders, administration of medications, and documentation of medication administration. 4. The DON/designee will complete Medication Administration observations 3 times per week for 4 weeks, then weekly for 8 weeks. The results of the audits and monitoring will be reported in the monthly Quality Assurance (QA) Committee meeting monthly for 3 months. The committee will evaluate and make further recommendations as indicated. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 332	Continued From page 17 On 6/8/12 at 10:16 AM Nurse #3 crushed the time release metoprolol and placed it in a medication cup and mixed it with other medications in pudding. The nurse entered the resident's room, stood in front of the resident and started to pick up the spoonful of medications in the pudding. When stopped and questioned about time release medications prior to administration of the crushed medication Nurse #3 stated that medications that are time release should not be crushed. She further stated that she must have been nervous. At 9:30 AM on 6/8/12 the DON stated that her expectation is that time release medications should not be crushed and there is a list of medications that should not be crushed in the front of the Medication Administration Records. An interview with the pharmacist on 6/8/12 at 10:55 AM revealed the time release form of metoprolol should not be crushed. 1.c Resident #79 had diagnoses including hypertension and dementia. The Physician Order Sheet dated 6/5/12 included orders for buproban (for depression)150 mg orally every morning. Review of the undated list entitled Medications Not To Be Crushed indicated the time release form of buproban was not to be crushed. It also indicated as a time release formulation, buproban can irritate mucus membranes. On 6/8/12 at 10:16 AM Nurse #3 crushed time release buproban, placed it in a medication cup	F 332	Date of Compliance: July 6, 2012. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 332	Continued From page 18 and mixed it with other medications in pudding. The nurse entered the resident's room, stood in front of the resident and started to pick up the spoonful of medications in the pudding. When stopped and questioned about time release medications prior to administration of the crushed medication Nurse #3 stated that medications that are time release should not be crushed. She further stated that she must have been nervous. At 9:30 AM on 6/8/12 the DON stated that her expectation is that time release medications should not be crushed and there is a list of medications that should not be crushed in the front of the Medication Administration Records. An interview with the pharmacist on 6/8/12 at 10:55 AM revealed the time release buproban should not be crushed. 2. Resident #133 had diagnoses including chronic pulmonary disease and dementia. Review of the Physician Order Sheet dated 6/5/12 revealed an order for saline nasal spray 2 sprays three times a day for allergies. On 6/7/12 at 10:00 AM Nurse #3 was observed to administer saline nasal spray to resident #133. The nurse administered one spray in each nostril. When interviewed following administration of the resident's medications Nurse #3 was asked how many sprays were ordered. Nurse #3 rechecked the resident's Medication Administration Record (MAR) and stated it read two sprays per nostril. When questioned why only one spray was given she stated she usually gives two sprays.	F 332	**" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 332	Continued From page 19 An interview with the director of nursing (DON) on 6/8/12 at 9:30 AM revealed that her expectation was that the correct dose of medication should be given.	F 332		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of 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 observations, record review and interviews with physician, consultant pharmacist, dispensing pharmacy manager and facility staff, the dispensing pharmacy failed to clarify a physician order for metoprolol succinate (medication used to manage the heart rate)	F 425	F425 1. Corrective action has been accomplished for the alleged deficient practice involving resident #79. Medication error forms were completed for the missed and inaccurate doses of medication administered to Resident #79. No adverse outcomes identified. 2. All residents have the potential to be affected. 3. -Pharmacy Consultant was in-serviced on requirements and expectations of F425 and F428 tags. Areas of review for the in-service were the following: 1. Reviewing Medication Administration Records and Physician Order Sheets during the monthly Medication Regimen Review. 2. Identifying that medication orders are transcribed completely and accurately. 3. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	7/6/12

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F 425	Continued From page 20 resulting in the resident receiving three times the ordered dosage of metoprolol succinate per the dispensing instructions of the pharmacy. (Resident #79). This was evident in 1 of 8 sampled residents reviewed for unnecessary drugs. Findings include: Resident #79 was admitted to the facility on 05/02/12 with diagnoses including hypertension and depression. Review of the Discharge Orders from the hospital dated 05/02/12 included orders for metoprolol succinate (Toprol XL)(to manage the heart rate) 50 milligram (mg) tablet (tab) er (extended release) 24hr (once a day), one tab by mouth daily for heart rate. Review of the handwritten (by Nurse #4) Admission Orders that were faxed to the paharmacy and on the Medication Administration Record (MAR) dated 05/02/12 included orders for metoprolol succinate X 150 mg XR (extended release) per 24h, 1 tab po (by mouth) daily for heart rate. The Physician Order Sheet (printed and sent to the facility by the pharmacy) dated 06/05/12 included orders for metoprolol succinate 50 mg (milligrams) three tabs orally every morning. Review of the June 2012 MAR dated 06/01/12 included orders for metoprolol succinate X 150 mg XR (extended release) qd, give 3 tabs. Observation on 6/8/12 at approximately 2 p.m. of Resident #79 ' s Blister pack of metoprolol	F 425	Reviewing medication orders for clinical appropriateness. 4. Reporting all noted discrepancies to facility administration. - The SDC/designee will re-educate all Licensed Nurses on Medication Management Administration techniques including transcribing orders, administration of medications, and documentation of medication administration. 4. A second consultant will conduct the Medication Regimen Review at the facility for 3 months. Reporting all noted discrepancies to facility administration. The DON/designee will review MD orders daily and verify transcription and appropriate medication delivery. The results of the audits and monitoring will be reported in the monthly Quality Assurance (QA) Committee meeting monthly for 3 months. The committee will evaluate and make further recommendations as indicated. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 425	Continued From page 21 succinate medication supplied by the dispensing pharmacy read: Metoprolol SU 50 mg tab SR (extended release) 24H. The dispensing instructions read: Take 3 tabs (150 mg) by mouth every day. Dx: (diagnosis) heart rate. Review of the May and June MAR 2012 revealed metoprolol succinate X150 mg po qd was signed by the medication nurse daily indicating the medication was administered. On 06/08/12 at 10:16 AM Nurse #3 was observed administering Resident #79 150 mg (3 tabs) of the extended release metoprolol succinate XL. During an interview on 06/08/12 at 12:25 PM with Nurse # 4 who transcribed the admission order to the MAR and sent the orders to the pharmacy stated " I transcribed the order as it was written " Toprol XL 50 mg ER qd (every day) ". The dispensing pharmacy filled it and sent the medication to the facility for administration. I did not clarify this order when it came from the dispensing pharmacy. " An interview on 06/08/12 at 2:40 PM with Nurse # 3 (who administered medication to Resident #79) stated " I read the order as give 3 tablets of the 50 mg tablets of metoprolol succinate, so that is what I gave the resident ". She continued; " I did not question the medication delivered by the dispensing pharmacy for the resident. " An interview with the director of nursing (DON) and the Administrator on 06/08/12 at 1:05 PM occurred to clarify what actual medication was being administered. The DON requested the physician be contacted to determine the correct	F 425	**" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345149	A. BUILDING ______ B. WING ______	C 06/08/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 425	Continued From page 22 medication dose for Resident # 79. During an interview with the physician on 06/08/12 at 1:43 PM; the physician stated " she (resident #79) should not have gotten 150 mg a day. " The physician further stated " you can see that the "l" was taken as a "1" so the resident was receiving a higher dose than I wanted to begin with " . But the physician repeated " she (the resident) should be receiving the medication metoprolol succinate 50 mg po q am (every morning). " " There are a number of possible side effects of metoprolol succinate, including a slow heart rate, diarrhea, tiredness, and dizziness. " During a telephone interview on 06/08/12 at 3:30 PM with the dispensing pharmacy manager she stated "it is nothing short of a transcription error, the pharmacist who read the original order should have questioned this order before filling it. They just must have misinterpreted the order as it was written " . An interview with the DON on 06/08/12 at 3:34 PM revealed her expectation was that the medication would have been verified by the staff when it was received from the pharmacy. She also would have expected the dispensing pharmacy to have clarified this medication order before filling it.	F 425	F428 1. Corrective action has been accomplished for the alleged	7/6/12
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428	**" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 428	Continued From page 23 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with physician, consultant pharmacist, dispensing pharmacy manager and facility staff, the consultant pharmacist failed to report to the facility a transcription error of metoprolol succinate (medication used manage the heart rate) where a resident received three times the ordered dosage of the medication. (resident #79). This was evident in 1 of 8 sampled residents reviewed for unnecessary drugs. Findings include: Resident #79 was admitted to the facility on 05/02/12 with diagnoses including hypertension and depression. Review of the Discharge Orders from the hospital dated 05/02/12 included orders for metoprolol succinate (Toprol XL) (medication to treat high blood pressure) 50 milligram (mg) tablet (tab) er (extended release) 24hr (once a day), one tab by mouth daily for heart rate. Review of the handwritten (by Nurse #4) Admission Orders on the Medication Administration Record (MAR) that was also faxed to the pharmacy dated 05/02/12 included orders	F 428	deficient practice involving resident #79. Medication error forms were completed for the missed and inaccurate doses of medication administered to Resident #79. No adverse outcomes identified. 2. All residents have the potential to be affected. 3. Pharmacy Consultant was in-serviced on requirements and expectations of F425 and F428 tags. Areas of review for the in-service were the following: 1. Reviewing Medication Administration Records and Physician Order Sheets during the monthly Medication Regimen Review. 2. Identifying that medication orders are transcribed completely and accurately. 3. Reviewing medication orders for clinical appropriateness. 4. Reporting all noted discrepancies to facility administration. - The SDC/designee will re-educate all Licensed Nurses on Medication Management Administration techniques including transcribing orders, administration of medications, **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 428	Continued From page 24 for metoprolol succinate X 150 mg XR (extended release) per 24h, 1 tab po (by mouth) daily for heart rate. The Physician Order Sheet (printed and sent to the facility by the pharmacy) dated 06/05/12 included orders for metoprolol succinate 50 mg (milligrams) three tabs orally every morning. Review of the June 2012 MAR dated 06/01/12 included orders for metoprolol succinate X 150 mg XR (extended release) qd, give 3 tabs. Observation on 6/8/12 at approximately 2 p.m. Resident #79 ' s Blister pack of metoprolol succinate medication supplied by the dispensing pharmacy read: Metoprolol SU 50 mg tab SR (extended release) 24H. The dispensing instructions read: Take 3 tabs (150 mg) by mouth every day. Dx: (diagnosis) heart rate. Review of the May and June MAR 2012 revealed metoprolol succinate X150 mg po qd was signed by the medication nurse daily indicating the medication was administered. Review of the consultant pharmacy monthly medication review dated 5/30/12 revealed no documentation regarding the dose of the metoprolol succinate. During a telephone interview on 06/08/12 at 1:25 PM with the consulting pharmacist, he stated " the medication ordered is not the same as the medication prescribed by the physician. It would be considered a medication dispensing error. " He further stated " I must have missed that during my monthly review. "	F 428	and documentation of medication administration. 4. A different consultant will conduct the Medication Regimen Review at the facility for 2 months. The DON/designee will review MD orders daily and verify transcription and appropriate medication delivery. The results of the audits and monitoring will be reported in the monthly Quality Assurance (QA) Committee meeting monthly for 3 months. The committee will evaluate and make further recommendations as indicated. Date of Compliance July 6, 2012. **" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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F 428	Continued From page 25 During an interview with the physician on 06/08/12 at 1:43 PM; the physician stated " she (resident #79) should not have gotten 150 mg a day. " The physician reviewed the pharmacy consultant sheet and stated "he did not pick up the medication error when he did the consult." The physician stated " I will change the order to metoprolol succinate 100 mg po q d and make sure the nurses check the resident ' s BP and P q shift (every shift). There are a number of possible side effects of metoprolol succinate, including a slow heart rate, diarrhea, tiredness, and dizziness. " During a telephone interview on 06/08/12 at 3:30 PM with the dispensing pharmacy manager she stated "it is nothing short of a transcription error, the pharmacist who read the original order should have questioned this order before filling it. They just must have misinterpreted the order as it was written " . She continued; " I would have expected the medication record regime review done by the facility should have found this error " . An interview with the DON (Director of Nurses)on 06/08/12 at 3:34 PM revealed she would have expected the consulting pharmacist to have found this order on his review and questioned it.	F 428	**" Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law."**	

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	345149	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/22/2012

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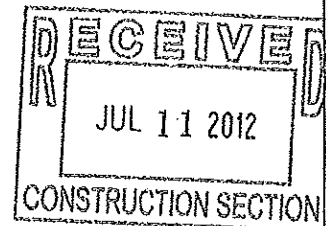
K 045 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation on Friday 6/22/12 between 10:00 AM and 1:00 PM the following was noted: 1) Additional illumination is need at the right rear exit discharge door and the pathway to the public way. Lighting must be arranged to provide light from the exit discharge leading to the public way (parking lot). The walking surfaces within the exit discharge shall be illuminated to values of at least 1 ft-candle measured at the floor. Failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candles in any designated area. NFPA 101 7.8.1.1, 7.8.1.3, and 7.8.1.4. 42 CFR 483.70(a)	K 045	K045 1. Correction for the alleged deficient practice noted as additional lighting needed at the right rear exit discharge door and the pathway to the public way. Installed floodlights in rear of building to illuminate exit and the pathway to public way. Floodlights were tied into the backup generator for emergency egress lighting. 2. Site review to see if other areas deficient. 3. The results of this will be reported in Quality Assurance (QA) Committee meeting for 3 months then quarterly for 1 year. The Committee will evaluate and make further recommendations as indicated. Correction date of July 2, 2012.  	
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	K052 1. Correction for the alleged deficient practice noted of the Fire Alarm pull station located next to the break room rear exit door not working. Pull station next to break room rear exit door repaired and working. 2. Tested all pull stations for potential problems.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE Administrator | (X6) DATE 7/9/12

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 052	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation on Friday 6/22/12 between 10:00 AM and 1:00 PM the following was noted: 1) The Fire Alarm pull station located next to the breakroom rear exit door did not operate when tested. 42 CFR 483.70(a)	K 052	3. The results of this will be reported in Quality Assurance (QA) Committee meeting for 3 months then quarterly for 1 year. The Committee will evaluate and make further recommendations as indicated. Correction date of June 26, 2012	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on Friday 6/22/12 between 10:00 AM and 1:00 PM the following was noted: 1) In the kitchen in front of the hood there are sprinkler heads in the facility rated for	K 056	K056 Correction for the alleged deficient practice noted of 1. In the kitchen in front of the hood there are sprinkler heads in the facility rated for intermediate temperature classification, Glass Bulb Color of Green temperature rating of (200 degree F) in place of ordinary Temperature Classification, Glass Bulb Color of Red temperature rating of (155 degree F). Sprinkler heads Bulb Color of Green (200 degree F) replaced with Bulb Color of Red temperature rating of (155 degree F). Correction date of August 6, 2012. 2. Sprinkler heads installed in the Therapy Room smoke compartment were a mixture of glass bulb standard response heads and standard fused heads. Facility will need to verify that the heads are equal in response time and temperature. Sprinkler heads or head replaced to match per NAPA 101, 4.6.12.1 Correction date of August 6, 2012.	

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K 056	Continued From page 2 Intermediate Temperature Classification, Glass Bulb Color of Green temperature rating of (200° F) in place of Ordinary Temperature Classification, Glass Bulb Color of Red temperature rating of (155°F). 2) Sprinkler heads installed in the Therapy Room smoke compartment were a mixture of glass bulb standard response heads and standard fused heads. Facility will need to verify that the heads are equal in response time and temperature or replace heads to match each other.NAPA 101, 4.6.12.1 Every required sprinkler system shall be continuously maintained improper operating condition. NFPA 13, 5-3.1.5.2 3) Sprinkler heads will need to be installed both rear entrances. (Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in depth per NFPA 13 section 5-13.8.1.) 42 CFR 483.70(a)	K 056	3. Sprinkler heads need installed at both rear entrances. Sprinkler heads installed at both rear entrances per NFPA 13 section 5-13.8.1 4. The results of this will be reported in Quality Assurance (QA) Committee meeting for 3 months then quarterly for 1 year. The Committee will evaluate and make further recommendations as indicated. Correction date of August 6, 2012.	