STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345317	A. BUILDING _____ B. WING _____	C 04/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & RETIREMENT	204 DAIRY RD CLAYTON, NC 27520

(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 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:	F 156	F156 Resident #39 was discharged on 2/1/12. Resident #63 was discharged on 4/26/12. Resident #81 was discharged on 1/20/12. ABN (Advanced Beneficiary Notice) training was held on 4/27/12. Residents receiving Medicare A or Medicare supplemental insurance policies and residents pending discharges are at risk for the same alleged deficient practice. Residents receiving Medicare A or Medicare supplemental insurance policies and residents pending discharges reviewed M-F during the interdisciplinary team meeting. ABN (Advanced Beneficiary Notice) are given to responsible parties as needed. Audits of the ABN for upcoming discharges, change in SNF level of care or exhaustion of benefits will be conducted weekly times 4 weeks. The audit will ensure notice was given to the Responsible Party regarding change in benefits.	4/27/12 5/14/12 5/14/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melissa Sullivan	Administrator	5/26/12

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.

I.B. K.J. M.R.

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F 156	Continued From page 1 A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This	F 156	The Administrator will review the results of the weekly audits, analyze for patterns/trends and report findings monthly times 3 months to the Quality Assessment and Assurance Committee. The Quality Assessment and Assurance Committee will evaluate the effectiveness of the plan based on trends identified and develop/implement additional interventions as needed to ensure continued compliance.	5/14/12

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F 156	Continued From page 2 includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide notice of Medicare non-coverage for 3 (Residents # 81, 63 and 39) of 3 discharged residents reviewed for liability notices. The finding is: Review of the discharge records for residents # 39, # 63 and # 81 revealed there were no "Notice of Medicare Provider Non-Coverage" forms in the records. Review of the facility policy entitled Medicare Denial Letter dated March 2006 revealed "Medicare denial letters must be used to notify the resident of Medicare non-coverage at the time of admission or for notification of termination of the benefits prior to discontinuing a covered Part A stay". Interview with the Admissions Coordinator on 4/19/12 at 3:30 PM revealed the letters should be	F 156		

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F 156	Continued From page 3 in the discharge records but was unable to locate them. She stated the business office manager was new to the position. Interview with the business office manager at 3:45 PM on 4/19/12 revealed she did not know about providing a "Notice of Medicare Provider Non-Coverage" to residents upon discharge. At 3:50 PM on 4/19/12 the social worker stated that provison of the non-coverage notices was not her responsibility. Interview with the Administrator at 4:45 PM on 4/19/12 revealed the previous business office manager left the position in October, 2011 and no one had received notices in the last 6 months. At 5:00 PM on 4/19/12 the administrator further stated that she was responsible for ensuring residents received the notices. It was her responsibility to delegate the task and she did not.	F 156		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in	F 157	F157 Resident #15's physician and family member was notified of bruises on 4/9/12. On 4/17/12 and 4/19/12, nurse #1 was re-educated by the Administrator on the necessity of physician and responsible party notification regarding notification of change to include incidents/accidents.	4/9/12 4/19/12

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F 157	Continued From page 4 §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, staff and family interviews the facility failed to notify the family and the physician on 04/06/12 when bruises were initially noted on Resident #15 's chest, arm and trunk. This was evident in 1 of 4 residents in the survey sample who had changes in condition. (Resident # 15) The findings Review of the facility undated policy for Abuse revealed in part;"reporting bruises of unknown origin would be reported immediately to the supervisor. The family and physician were to be notified timely. The mandatory reporting to the state should be done in 24 hours and an investigation should be started immediately " . Resident #15 was admitted to the facility on 06/25/03 with diagnosis of Alzheimer's disease.	F 157	**Residents with the potential to be affected by the alleged deficient practice:** Licensed nursing staff will be re-educated on the requirements for notification of change to include contacting the physician and responsible party when an incident/accident occurs. **Systematic Measures:** The Director of Nursing/designee will review the 24 hour report and incident/accident reports during the Interdisciplinary Team meeting Monday thru Friday. The weekend supervisor/designee will review the reports on Saturday and Sunday to ensure physician and responsible party notification has occurred with changes of resident's condition to include incidents/accidents. The Director of Nursing, Assistant Director of Nursing	5/17/12 5/7/12

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F 157	Continued From page 5 According to the minimum data set annual assessment dated 0 9/19/11 revealed Resident #15 was totally dependent on the staff for all (activities of daily living) ADLs, such as toileting, eating, dressing and transfers. She was incontinent of bowel and bladder. She was non verbal and unable to communicate her needs. Review of the Resident #15's care plans revealed she was at risk for skin impairment, increased bleeding, bruising and injury related to anticoagulant therapy. The intervention included the Nursing Assistants (NA) to notify the Nurse if bruising was noted. Review of the Nurses ' Notes (NN) dated 04/06/12 at 6:00 AM in part revealed: "observed resident to have darkened purple area on left breast side of her left body. No open areas in skin noted. Area does have swelling also in part of purple areas. When observed during toileting resident was lying on right side with left arm folded towards stomach/ ab (abdomen). No signs of wincing or pain when examined. Will notify day nurse to cont (continue) observe." Review of the 24 hour report for 04/05/12 third shift revealed documentation "Noted bruised area on resident's left breast unknown cause to me, Dark purple and IR (incident report) done. "On 04/06/12 first shift documentation revealed "lg (large) purple bruise on L (left) breast". During an interview with Nurse # 3 on 04/18/12 at 9:53 AM, she indicated she came in on Friday (04/06/12, worked the first shift) and got a report from Nurse #1 that Resident #15 had a large	F 157	and Staff Development Coordinator or designee will conduct random audits of a minimum of 10 charts weekly times 4 weeks to monitor for changes in resident's condition. Negative findings will be addressed if/when noted. The results of the weekly audits will be reviewed by the Interdisciplinary Team during the Interdisciplinary Team Meeting Monday thru Friday. The Director of Nursing will review the results of the weekly audits, analyze for patterns/trends and report findings monthly times 3 months to the Quality Assessment and Assurance Committee. The Quality Assessment and Assurance Committee will evaluate the effectiveness of the plan based on trends identified and develop/implement additional interventions as needed to ensure continued compliance.	5/14/12 5/17/12

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F 157	Continued From page 6	F 157		

bruised area on her chest. Nurse #3 continued that she observed Resident #15 's whole left breast was purple and documented it on the 24 hour report. Nurse # 3 stated "I know it was not there on Wednesday (04/05/12) when I last worked". Nurse # 3 stated "Resident #15 did not appear to be in pain, because she did not grimace".

During a telephone interview with Nurse #1 on 04/19/12 at 11:39 AM revealed she forgot to call the doctor and the family, but she documented the bruises in her Nurses' Note, placed the information on the 24 hour report and completed the incident report. She stated "I reported this information to the weekend supervisor, the oncoming nurse and also the DON when I gave her the incident report."

There was no documentation in the NN or the medical record on 04/06/12 that the family or the physician was notified.

Review of the NN dated 04/09/12 at 3:00 PM revealed in part: "called by the NA (nursing assistant) to evaluate res. (resident) w/ (with) discoloration to r (right) elbow, same noted to L (left) UE (upper extremity) - ecchymotic, pain noted w/ (with) movement. Area yellowish in color no pain noted upon palpitation, r (right arm with redness. Family called and made aware of above as well as MD (physician)".

During an interview on 04/19/12 @ 9:21 AM with Nurse # 2, she indicated NA #1 reported the resident had a new bruise on her right elbow, arm, upper extremities and chest wall. She called the physician and requested pain medication and

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F 157	Continued From page 7 x-rays. Nurse # 2 stated "Resident # 15 looked like she was in pain, when she moved her arm to assess her, she was grimacing, and I gave her Tylenol". "I called the family and she spoke to Resident #15 's son. She stated that " I reported the findings to the DON and ADM". She indicated she believed the bruising occurred when Resident # 15 was being repositioned in her geri chair, when she was pulled up in the chair the NA ' s must have grabbed her under arms. During an interview with the DON (director of nursing) on 04/19/12 at 10:00 AM, the DON stated "the incident report Nurse #1 completed on 04/06/12 was missing. The DON continued on 4/9/12 an incident report was written because Nurse #2 reported what I (DON) thought was a new area on the resident 's chest, and that is when I started my investigation. The 24 hour report to the state was completed. Nurse #2 notified the family and the physician at that time (04/09/12). The DON indicated she should have made sure the family and physician were notified on 04/06/12. Her expectation was that the family and physician are notified when a change occurs with any resident. During an interview with the Administrator on 04/19/12 at 3:00 PM, she indicated her expectation was that Nurse #1 was to notify the family and physician as soon as they noted the bruises. She also indicated she expected the DON would have followed up to make sure the notification procedure was followed for the 24 hour reporting too. .	F 157		
F 225	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	F 225		

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F 225 SS=D	Continued From page 8 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, 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.	F 225	F225 Resident #15's incident of unknown origin was reported to the state on 4/12/12. The investigation was completed on 4/18/12. Re-education on timely reporting was provided to the Administrator, Director of Nursing and Assistant Director of Nursing on 4/18/12 by the Regional Clinical Director. Re-education on abuse and reporting will be provided to staff by the Director of Nursing Staff Development Coordinator or designee. Incidents/accidents, concerns, new orders and 24 hour reports are reviewed M-F at the clinical interdisciplinary meeting. The results are documented and reviewed by the Administrator and/or DON to determine if an event should be reported.	4/12/12 4/18/12 4/18/12 5/29/12 5/25/12

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F 225	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to report bruises of unknown origin within the 24 hour time frame. The facility failed to begin the investigation of the unknown bruises for three days. This was evident for 1 of 1 resident with bruises of unknown origin. (Resident #15) The findings Review of the facility undated policy for Abuse revealed in part; "reporting bruises of unknown origin would be reported immediately to the supervisor. The family and physician were to be notified timely. The mandatory reporting to the state should be done in 24 hours and an investigation should be started immediately". Resident #15 was admitted to the facility on 06/25/03 with diagnosis of Alzheimer 's disease. According to the minimum data set annual assessment dated 9/19/11 revealed Resident #15 was totally dependent on the staff for all ADL, toileting, eating, dressing and transfers. She was incontinent of bowel and bladder. She was non verbal and unable to communicate her needs. Review of the Resident #15's care plans revealed she was at risk for skin impairment, increased bleeding, bruising and injury related to anticoagulant therapy. The intervention included the Nursing Assistants (NA) to notify the Nurse if bruising was noted.	F 225	The Administrator will review the results of the weekly audits, analyze for patterns/trends and report findings monthly times 3 months to the Quality Assessment and Assurance Committee. The Quality Assessment and Assurance Committee will evaluate the effectiveness of the plan based on trends identified and develop/implement additional interventions as needed to ensure continued compliance.	5/14/12

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F 225	Continued From page 10 Review of the Nurses ' Notes (NN) dated 04/06/12 at 6:00 am in part revealed: "observed resident to have darkened purple area on left breast most of lateral frontal side of left breast. No open areas in skin noted. Area does have swelling also in part of purple areas. When observed during toileting resident was lying on right side with left arm folded towards stomach/ ab (abdomen). No signs of wincing or pain when examined. Will notify day nurse to cont (continue) observe." Review of the 24 hour report for 4/6/12 third shift revealed documentation "Noted bruised area on resident ' s left breast unknown cause to me, Dark purple and IR (incident report) done". During an interview with the DON (director of nursing) on 4/19/12 at 10:00 AM, the DON stated "the report to the state was made on 04/09/12. I did not make a 24 hour report on Monday 04/06/12 when the bruises were initially identified. It was my responsibility to begin an investigation and submit the report within 24 hours of the report of these bruises". During a telephone interview with Nurse #1 on 4/19/12 at 11:39 AM revealed she forgot to call the doctor and the family, but she documented the bruises in her Nurses ' Note, placed the information on the 24 hour report and completed the incident report. She stated "I reported this information to the weekend supervisor, the oncoming nurse and also the DON when I gave her the incident report ".	F 225		

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F 225	Continued From page 11 During an interview with the Administrator on 4/19/12 at 3:00 PM, she indicated her expectation was that DON would have submitted the 24 hour report and begun the investigation of the bruises on 04/06/12.	F 225		
F 285 SS=B	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort. A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission; (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. (ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission-- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and	F 285	F285 Resident #113 received PASARR approval from 4/23/12 thru 4/30/12. Resident #113 was discharged on 4/26/12. An in-service was conducted 5/1/12 on PASARR authorization codes and the corresponding timeframes/restrictions. An audit was conducted 5/1/12 to ensure all current residents had PASARR numbers that had no restrictions. Each new admission will be reviewed by the Admission Coordinator and/or designee to ensure PASSAR authorization codes and if restrictions are followed.	4/23/12 5/1/12 5/1/12 5/1/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345317	A. BUILDING _____ B. WING _____	C 04/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & RETIREMENT	204 DAIRY RD CLAYTON, NC 27520

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F 285	Continued From page 12 (B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation. For purposes of this section: (i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at §483.102(b)(1). (ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to obtain the Pre-Admission Screen and Annual Resident Review (PASRR) recommendations for specialized services that had expired for one of seven resident (Resident # 113) reviewed for PASRR. The findings are: Medical record review revealed Resident #113 was admitted to the facility on 1/29/12 with diagnoses including MR (Mental Retardation), The prior approval form (FL2) was not in the current medical record. The FL2 is a form completed as a preadmission to the facility. An interview with the Director of Social Work on 04/19/12 at 2:30 pm revealed that the facility receives the FL2 Form with the PASRR number from the transferring facility (hospital) upon the resident ' s admission to the facility. The Director	F 285	The Administrator will review the results of the weekly audits, analyze for patterns/trends and report findings monthly times 3 months to the Quality Assessment and Assurance Committee. The Quality Assessment and Assurance Committee will evaluate the effectiveness of the plan based on trends identified and develop/implement additional interventions as needed to ensure continued compliance.	5/14/12

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	345317	A. BUILDING _____ B. WING _____	C 04/19/2012

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F 285	Continued From page 13 of Social Work stated that she was in the process of contacting the provider links for a new PASRR number for Resident #113 as the current PASRR number had expired. She further revealed that she realized this on Monday, 4/16/12. She continued that Resident # 113 was not receiving CAP Services (Community Assistance Program) thru DSS (Department of Social Services) or any other services for a diagnosis of MR while she was in an Assisted Living facility before coming to the Nursing Home. Interview with the Admissions Coordinator on 4/19/12 at 3:50 pm stated she did not recognize the " E " at the end of the PASRR number to mean the number expired in 30 days. (Resident # 113 ' s PASRR number expired 2/29/12). Interview with the Administrator on 4/19/12 at 4:30 PM confirmed that obtaining the specific recommendations for residents with mental retardation provided by the PASRR II would be necessary in assuring that the facility provides services to meet the residents' physical and mental health needs. It was her expectation that this information is completed by the Admissions Coordinator. She further revealed that she had been without staff in the Business office for about a month and other staff were obtaining information for proper billing and the PASRR information was not being obtained.	F 285		

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JUN 06 2012
CONSTRUCTION SECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345317	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CENTER HLTH & RETIREMENT	204 DAIRY RD CLAYTON, NC 27520

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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 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: A. Based on observation on 05/18/2012 the door to the Storage room on the service hall failed to close and latch. 42 CFR 483.70 (a)	K 029	K029 The door to the Storage room on the service hall was repaired on 5/18/12. All facility interior doors will be checked for proper closure and latching by 6/22/12. Facility doors will be checked for closure and latching monthly by the Maintenance Supervisor and/or designee. The Maintenance Supervisor will report and present to QA&A committee monthly x 3 months.	5/18/12 6/22/12
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: A. Basedn observation on 05/17/2012 the court yard for the Altzheimer's unit had two locked doors and a locked gate that did not meet the locking requirements. This court yard must have emergency lighting and if the gate is a required exit there must be a hard surface pathway to the	K 038	K038 The two locked doors and the locked gate for the Alzheimer's unit will be upgraded to meet the locking requirements by 7/2/12. Emergency lighting in this courtyard will be completed by 7/2/12. The gate door is not a required exit for emergency therefore, a hard surface pathway is not needed. The Maintenance Supervisor will inspect all exterior doors on a monthly basis to ensure locking requirements are met. Courtyard lights will be tested	7/2/12 7/2/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Melissa Sullivan	Administrator	6/4/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined tha other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 day 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 1 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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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
	345317	A. BUILDING 01.- MAIN BUILDING 01 B. WING _____	05/18/2012

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K 038	Continued From page 1 public way. 42 CFr 483.70 (a)	K 038	monthly by the Maintenance Supervisor to ensure they meet emergency lighting standards. The Maintenance Supervisor will report and present to QA&A committee monthly x 3 months.	