STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345115	A. BUILDING _____ B. WING _____	09/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BLVD SALISBURY, NC 28144

(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 159 SS=B	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the	F 159	F-159B Residents 3, 16 and 114 were immediately offered funds and all declined. September Statements were printed and placed in current resident files for residents 3, 16 and 114. All residents have the potential to be affected by this alleged deficient practice. Resident Council denied any concerns with access to resident funds, banking hours were changed per their request to reflect 9am to 4 pm Monday through Friday and as needed on weekends. Quarterly statements were printed for active residents for the month of September.	

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

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 159	Continued From page 1 resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on observation, record reviews, resident and staff interviews, the facility failed to provide access to resident funds during reasonable banking hours and failed to retain copies of quarterly statements for 3 of 3 sampled residents (Residents # 3, #16 and #114). The findings include: 1. Resident #3 was admitted to the facility on 11/17/10. On the quarterly Minimum Data Set (MDS) assessment, 8/8/12, he was assessed as being cognitively intact. During an interview with Resident #3 on 9/10/12 at 5:08 pm, he mentioned that he had a resident trust fund account but that he could not get his money when he needed it, including on weekends because "no one here on weekends." On 9/12/12 at 2:30 pm, an announcement was heard over the intercom system for "Resident Funding" in the front lobby. On 9/13/12 at 2:30 PM, the same announcement was heard about "Resident Funding". On 9/13/12 at 4:00pm, an announcement was heard over the intercom that "Resident Funding" was now over.	F 159	Banking hours of 9am-4pm Monday are posted at front lobby desk. The Administrator re-educated the department heads regarding resident access to funds and quarterly statement management. The Business Office Director will print quarterly statements and place in resident financial file. The weekend supervisor will be responsible for handling funds during the expanded hours and on weekends. Resident will approach the weekend supervisor for money and this was discussed during resident council. The hours have been posted and this has been discussed during resident council. The Administrator/Director of Nursing (DON) will observe accurate posting of banking hours and availability of staff to provide access to resident funds weekly for 4 weeks, then monthly for 2 months to verify residents has appropriate access to funds. An audit tool was developed.	

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F 159	Continued From page 2 The Business Office Manager was interviewed on 9/13/12 at 11:45 am. She stated that residents can do banking from 2 to 4 pm, Monday through Friday. She was also asked if she could produce a copy of the last quarterly statement for Resident #3. She stated that the last quarterly statement was sent directly from their corporate office and would have been delivered to the residents early in July, 2012. She reviewed the business file for Resident #3 and couldn ' t produce a copy. She stated that the statement was given to the resident and was not retained in the business office. The Administrator was interviewed on 9/12/12 at 4:02 pm. She stated that the residents were having a hard time remembering the banking hours so they announce over the intercom system, when the banking hours are active. She stated that they call it, "Resident Funding". A sign could be seen on the Human Resources Department door, that read, "Attention All Residents 'Resident Funding' Hours of operation are as follows: Monday-Friday 2 pm till 4 pm." She continued by stating that sometimes the facility will make an exception with banking hours when there was a planned outing scheduled. Residents would then be allowed to make withdrawals outside banking hours. The Administrator explained that there was no current system in place to provide funds to residents outside of "Resident Funding" and that she would investigate ways to offer residents, access to their funds, when requesting less then $50.00 on the	F 159	The Administrator/DON will randomly review 10 resident's financial files monthly to verify statements are printed as appropriate. The Business Office Director will correct opportunities identified as a result of these observations and correct immediately. The results of these observations and reviews will be reported during the monthly QAPI meeting by the Administrator/BOM, the committee will evaluate and make recommendations as indicated.	

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F 159	Continued From page 3 weekends. The Administrator also shared that they have already started procedures to re-issue the quarterly statements and put them in the business file. 2. Resident #16 was admitted to the facility on 8/14/10. On the annual MDS, 6/18/12 he was assessed as having a moderate cognitive impairment, but still able to make his needs known. During an interview with Resident #16 on 9/11/12 at 2:15 pm, he stated when asked about availability of resident funds on the weekends, he commented that weekend hours weren ' t available and that residents have to get their money before 5pm on Friday. On 9/12/12 at 2:30 pm, an announcement was heard over the intercom system for "Resident Funding" in the front lobby. On 9/13/12 at 2:30 PM, the same announcement was heard about "Resident Funding". On 9/13/12 at 4:00pm, an announcement was heard over the intercom that "Resident Funding" was now over. The Business Office Manager was interviewed on 9/13/12 at 11:45 am. She stated that residents can do banking from 2 to 4 pm, Monday through Friday. She was also asked if she could produce a copy of the last quarterly statement for Resident #16. She stated that the last quarterly statement was sent directly from their corporate office and would have been delivered to the residents early in July, 2012.	F 159		

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F 159	Continued From page 4 She reviewed the business file for Resident #16 and couldn ' t produce a copy. She stated that the statement was given to the resident and was not retained in the business office. The Administrator was interviewed on 9/12/12 at 4:02 pm. She stated that the residents were having a hard time remembering the banking hours so they announce over the intercom system, when the banking hours are active. She stated that they call it, "Resident Funding". A sign could be seen on the Human Resources Department door, that read, "Attention All Residents 'Resident Funding' Hours of operation are as follows: Monday-Friday 2 pm till 4 pm." She continued by stating that sometimes the facility will make an exception with banking hours when there was a planned outing scheduled. Residents would then be allowed to make withdrawals outside banking hours. The Administrator explained that there was no current system in place to provide funds to residents outside of "Resident Funding" and that she would investigate ways to offer residents, access to their funds, when requesting less then $50.00 on the weekends. The Administrator also shared that they have already started procedures to re-issue the quarterly statements and put them in the business file. 3. Resident #114 was admitted to the facility on 1/27/12. On the quarterly MDS assessment, 7/27/12, she was assessed as being cognitively	F 159		

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F 159	Continued From page 5 intact. During an interview with Resident #114 on 9/10/12 at 5:50 pm, she voiced that personal funds can only be accessed Monday through Friday, from 2:00-4:00 pm. On 9/12/12 at 2:30 pm, an announcement was heard over the intercom system for "Resident Funding" in the front lobby. On 9/13/12 at 2:30 PM, the same announcement was heard about "Resident Funding". On 9/13/12 at 4:00pm, an announcement was heard over the intercom that "Resident Funding" was now over. The Business Office Manager was interviewed on 9/13/12 at 11:45 am. She stated that residents can do banking from 2 to 4 pm, Monday through Friday. She was also asked if she could produce a copy of the last quarterly statement for Resident #114. She stated that the last quarterly statement was sent directly from their corporate office and would have been delivered to the residents early in July, 2012. She reviewed the business file for Resident #114 and couldn ' t produce a copy. She stated that the statement was given to the resident and was not retained in the business office. The Administrator was interviewed on 9/12/12 at 4:02 pm. She stated that the residents were having a hard time remembering the banking hours so they announce over the intercom system, when the banking hours are active. She stated that they call it, "Resident Funding". A sign could be seen on the Human Resources	F 159		

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F 159	Continued From page 6 Department door, that read, "Attention All Residents 'Resident Funding' Hours of operation are as follows: Monday-Friday 2 pm till 4 pm." She continued by stating that sometimes the facility will make an exception with banking hours when there was a planned outing scheduled. Residents would then be allowed to make withdrawals outside banking hours. The Administrator explained that there was no current system in place to provide funds to residents outside of "Resident Funding" and that she would investigate ways to offer residents, access to their funds, when requesting less then $50.00 on the weekends. The Administrator also shared that they have already started procedures to re-issue the quarterly statements and put them in the business file.	F 159	F-281 D The Unit Manager and/or nurse notified the physician and RP on 9/15/12 and the clarification order to discontinue Gentamycin ointment for Resident # 60 was written on 9/15/12. A medication variance report was completed. There were no adverse outcomes identified for Resident #60, the physician and responsible parties were notified. Physician orders for current residents have been reviewed by the Director of Nursing/Unit Manager to ensure orders are discontinued per policy. The review was completed 9/30/12. Licensed Nurses will be re-educated by the Director of Nursing/Unit Managers regarding receiving and transcribing physician orders appropriately by 10/11/12 and include prn nurses, nurses who were unable to attend the in-service and vacationing nurses.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and optometrist interview, the facility failed to discontinue gentamycin eye ointment as ordered for 1 (Resident #60) of 10 sampled residents. The findings included: Resident #60 was admitted to the facility on 7/16/06. Diagnoses included dementia.	F 281		

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F 281	Continued From page 7 Review of July 2012 physician orders revealed an order for gentamycin 0.1% ointment to be applied daily to eyelids as treatment for blepharitis (inflammation of the eyelids) for 12 months, starting 11/28/11 and ending 11/28/12. A note from the optometrist revealed that Resident #60 underwent an eyelash revision on 7/17/12 for the diagnosis of conjunctivitis due to trichiasis (ingrown eyelashes). Physician orders dated 7/17/12 revealed an order for gentamycin ointment to both eyes daily for 10 days. The July Medication Administration Record (MAR) read to stop the gentamycin after 7/26/12. August 2012 physician orders included gentamycin 0.1% ointment to be applied daily to eye lids for 12 months, starting 11/28/11 and ending 11/28/12. The August 2012 printed MAR was comprised of physician orders carried over from July 2012. The MAR included a printed entry for gentamycin. Handwritten next to the entry was "D/CD" (discontinued). Handwritten below "D/CD" was "Rewritten". A separate page of the August MAR included a handwritten entry for gentamycin 0.1% to both eyes, start date 11/28/11 and end date 11/28/12. The MAR was initialed to indicate the gentamycin was administered on 8/8/10 and 8/9/12. "D/CD" was handwritten on the entry and no additional dates were initialed to indicate further administration of the gentamycin. September 2012 physician orders included gentamycin 0.1% ointment to be applied daily to	F 281	The Director of Nursing/Unit Managers will randomly review 10 physicians orders weekly for 4 weeks then monthly for 2 months to verify accuracy of transcription and record on the audit tool. The nurses will correct opportunities identified as a result of these audits immediately. The DON will present the results of these audits during the monthly QAPI meeting, the committee will evaluate and make recommendations as indicated.	

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F 281	Continued From page 8 eye lids for 12 months, starting 11/28/11 and ending 11/28/12. The September printed MAR included gentamycin ointment, crossed through with a handwritten "X" and marked "D/CD". During an interview on 9/12/12 at 10:30 AM, UM (Unit Manager) #1 and the Director of Nursing (DON) indicated that they believed the gentamycin was supposed to be stopped after the 10 day course was completed in July. During a telephone interview on 9/12/12 at 11:30 AM, the optometrist indicated that his intention was for the gentamycin to be stopped on 7/27/12 and not continued through 11/28/12. He stated that the most recent order for the gentamycin should supersede the older order. During an interview on 9/13/12 at 3:02PM, Unit Manager (UM) #1 indicated that an order needed to be written to discontinue the gentamycin so that it will stop being carried forward month to month on the printed physician orders. UM #1 also indicated that the gentamycin should have been denoted as discontinued on the August and September physician orders.	F 281		
F 282 SS=B	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced	F 282		

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F 282	Continued From page 9 by: Based on observation, record review and staff interviews, the facility failed to follow care plan by not doing skin assessments consistently for 1 of 3 residents (Resident #98) with pressure ulcers and failed to remove lap buddy while feeding 1 of 1 resident (Resident #74) who maintained good body posture, during the meal. The findings include: 1.Resident #98 was admitted to the facility on 4/11/12, from the hospital, after fracturing the neck of his femur. On the admission Minimum Data Set (MDS) 4/18/12 he was assessed as having a severe cognitive impairment and required extensive assistance from staff with bed mobility, transfers and personal hygiene. On the Nursing Admission Assessment form, 4/11/12, he was identified as high risk for development of a pressure ulcer but did not have one. The April, 2012 physician orders were reviewed and called for the nurse to perform weekly head to toe skin check/assessments every week on Mondays. A care plan for non-pressure ulcers was developed for Resident #98 on 4/27/12 for pressure ulcers related to moisture/incontinence, decreased activity and impaired mobility. The goal was for Resident #98 to have no signs of skin breakdown through the next 90 days. One of the approaches to be used included: Measure and stage wound weekly using the non pressure ulcer healing assessment form. Complete a full	F 282	F-282 B Resident #98 is deceased. Resident #74 utilizes the lap tray with staff assistance and when resident is alert, the lap tray will be removed during meals and activities. All residents have the potential to be affected by this alleged deficient practice. MDS Nurses/Unit Managers will review care plans for current residents by 10/11/12 for accuracy regarding skin assessments and restraint use. All licensed and unlicensed nursing staff will be re-educated by the Director of Nursing/Unit Managers on implementation of the care plan related to skin management including completion of the weekly skin assessments and restraint management including appropriate release of physical restraints during meals and supervised activities by 10/11/12.	

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F 282	Continued From page 10 body check weekly and document. The Treatment Administration Records (TAR) for April through June, 2012 was reviewed and had no entries that the weekly assessments were done. A Head to Toe Skin Checks Form, dated 5/3/12, was signed by nurse aide #1 and revealed that Resident #98, skin was not intact on his left and right heels. He stated that the treatment nurse was notified. Two additional weeks (May 10-17, 2012) of weekly head to toe skin checks were performed by nurse aide #1. There was no other documentation that head to toe skin checks were performed outside of 5/3/12-5/17/12. A nurse's note on 5/4/12 by Nurse #8, stated that Resident #98 had noted areas on bilateral heels with a blackened-grayish wound bed, soft in texture. Resident #98 received wound care treatment by Nurse #8, Nurse # 7 and the wound specialist doctor, until his wounds healed completely on 6/18/12. On 9/13/12 at 10:12 am, Nurse #6 was interviewed. She stated that she used to work with Resident #98 on day shift and that when she received a concern from the nurse aide about any breakdown in skin, she was expected to notify the physician and responsible party, initiate treatment and informed the wound nurse as well. She stated that although the wound nurse became involved, she was still expected to do the weekly	F 282	The Director of Nursing/Unit Managers will randomly review and observe 10 residents weekly for 4 weeks and then monthly for 2 months to verify care planned interventions are implemented to include observation of weekly skin assessment completion and physical restraint release on the audit tool. Nurses and/or Unit Managers will correct opportunities identified as a result of these observations and reviews immediately. The results of these observations and reviews will be reported by the DON during the monthly QAPI meeting, the committee will evaluate and make recommendations as indicated.	

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F 282	Continued From page 11 skin assessments. She shared that she did not remember much about Resident #98's pressure ulcer. However, her signature was on the 5/10/12 Head to Toe Skin Form, along with nurse aide #1. Nurse #7 was interviewed on 9/13/12 at 10:12 am. She stated that she started doing the wound care late spring. She shared that she made a referral to the wound doctor to work with Resident #98 but the charge nurse was still expected to do the weekly Head to Toe assessments, while she administered daily wound care treatment. On 9/13/12 at 2:08 pm, Nurse #8 was interviewed. She stated that she previously served as the wound care nurse until mid-May, 2012. She first assessed Resident #98 to have bilateral unstageable pressure ulcers on his heels on 5/4/12. The Director of Nursing was interviewed on 9/13/12 at 2:40 pm. She stated that she expected the nurse aides to report all skin break down to the nurse and the nurses should document the skin condition in their notes. She shared that they had a weekly meeting to discuss pressure and non-pressure skin conditions and she did not become aware that the nurses weren ' t documenting the weekly head to toe checks on Resident #98 until their meeting on 5/17/12. She shared that they in-serviced their staff in August, on what to record on the head to toe skin checks and informed staff that only nurses should complete the form and not the nurse aides. 2. Resident # 74 was admitted to the facility on 12/5/11 with the following cumulative diagnoses: Dementia and anxiety. On the quarterly MDS,	F 282		

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F 282	Continued From page 12 6/11/12, she was assessed as being cognitively impaired and requiring extensive assistance with eating. She was also coded for using a trunk restraint. Review of her chart, produced a September, 2012 Physician's Order where it called for releasing and repositioning the lap tray during meals, care, social and other supervised activities. She also had been care planned on 12/14/11, with a recent revision on 9/6/12, to address the use of a lap buddy as a restraining device related to her risks for falls, poor safety awareness and severe dementia. The approach to be used called for observe, release and exercise at regular and frequent intervals. Also to maintain Resident #74 free during supervised meals and activities. On 9/10/12 at 12:50 pm, Resident #74 was observed sitting in a wheelchair in the dining room, with a lap buddy in place, and leaning over to the right side, appearing to be very sluggish. Nurse #2, sat next to her with the restraint in place, aroused her to awake so that he could feed her lunch. On 9/12/12 at 8:00 am, Resident #74 was observed alert, sitting with a good trunk control, in her wheelchair, in the dining room, with the Activities Assistant sitting beside her, feeding her breakfast. Resident #74 was not observed slouching, leaning forward or making attempts to stand. She sat still in her chair, during the course of the meal, with the lap buddy in place. The Activities Assistant was interviewed on	F 282		

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	345115	A. BUILDING _____ B. WING _____	09/13/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIAN CTR HEALTH & REHAB/SALISBURY	635 STATESVILLE BLVD SALISBURY, NC 28144

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F 282	Continued From page 13 9/12/12 at 8:50 am. She stated that she normally worked on weekends and it was not common for her to assist with meals. She shared that she wasn't certain of the policy of feeding residents with a restraint in place, and acknowledged that Resident #74 used her lap buddy during her meal. At 9:00 am, on 9/12/12, the Director of Nursing (D.O.N) stated that residents should not be fed with a restraint in place. She added that Resident #74's lab buddy was used more or less as a positioning device since she often leaned forward. Recently, she made a referral to therapy, to determine an alternate seat for her to use when she is lethargic; leaning forward, as opposed to when she is awake, alert and sitting erect. At 3:13 pm, the D.O.N clarified that if Resident #74 was alert and sitting straight, staff should remove the lap buddy, while feeding her. On 9/13/12 at 1:30 pm, nurse aide #2 was interviewed. He shared that Resident #74 leans forward often due to sleepiness so the lap buddy, helps to maintain her positioning while in the wheelchair. However, he stated that he was instructed that if she wasn't leaning during her meal, that her lap buddy should always be removed.	F 282		
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		

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F 332	Continued From page 14 by: Based on record review, observation and staff interview, the facility failed to ensure that medication error rate was 5% or below by not following the doctor's orders. There were four errors of fifty two opportunities resulting in a 7.69 % error rate for 3 of 6 nurses observed. The findings include: 1. Resident #53 had a doctor's order dated 06/27/06 for Calcium Carbonate -vitamin D3 - 500 mgs (milligrams) /200 mgs unit tablet - give 1 tablet by mouth twice a day with meals for osteoporosis. On 09/12/12 at 7:53 AM, Nurse # 2 was observed to prepare and to administer the medications including Calcium Carbonate 500 mgs. with D 200 mgs 1 tablet to Resident #53. The breakfast tray was served to Resident #53 at 8:50 AM. On 09/12/12 at 9:30 AM, Nurse #2 was interviewed. She stated that she tried to give the medications ordered to be given with meals close to meal time but she didn't do it this time. 2. Resident # 100 had a doctor's order dated 08/09/12 for Docusate Sodium 60mgs. (milligram)/15 ml (milliliter) syrup - give 100 mgs. via gastrostomy tube twice a day for constipation. On 09/12/12 at 8:14 AM, Nurse #2 was observed to prepare and to administer the medications including Docusate Sodium (50 mgs. /5 ml) 15 ml to Resident #100.	F 332	F-332 D Medication variance reports were completed for Residents 53, 100, 13, 58. Nurses assessed and determined there were no adverse outcomes identified for Residents 53, 100, 13, 58 . Nurses/Unit Managers notified the physicians and responsible parties. All residents have the potential to be affected to be by this alleged deficient practice. Licensed Nurses will be re-educated by the Director of Nursing/Unit Managers. The 5 rights of medication pass were in-serviced. The education will be completed by 10/11/12 and includes prn nurses, nurses who were unable to attend in-service and vacationing nurses. The Director of Nursing/Unit Managers will complete 4 medication pass observations weekly for 4 weeks then monthly for 2 months to verify accurate medication administration and documentation. Audits will be done on all shifts and weekends.	

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F 332	Continued From page 15 On 09/12/12 at 9:30 AM, Nurse #2 was interviewed. She stated that she just followed the MAR (Medication Administration Record) to give 15 ml. of Docusate Sodium. She didn't realize that the stock for Docusate Sodium was 50mgs/ 5 ml and not 60 mgs /15 ml. as ordered. 3. Resident # 13 had a doctor's order dated 03/08/12 for Ferrous Sulfate 325 mgs (65 mgs iron) tablet - give 1 tablet via gastrostomy tube daily for Anemia. On 09/12/12 at 8:25 AM, Nurse #3 was observed to prepare and to administer the medications including Iron liquid 5 ml to Resident #13. The bottle read "Iron 44 mgs/5 ml." On 09/12/12 at 11:22 AM, Nurse #3 was interviewed. She stated that Ferrous Sulfate tablet can't be crushed so she had to give the liquid form. She acknowledged that the dose given (44 mgs) was not the right dose ordered (65 mgs), so she would call the doctor to correct it. 4. Resident #58 had a doctor's order dated 07/31/12 for Calcium Acetate 667 mgs - give 1 capsule by mouth daily with meals for supplement. On 09/12/12 at 4:50 PM, Nurse #4 was observed to prepare and to administer the medications including Calcium Acetate 667 mgs to Resident #58. On 09/12/12 at 5:05 PM, Nurse #4 was	F 332	Audit results will be recorded on the audit tool. The nurse's will immediately correct the opportunities and the DON will present the audit results to the QAPI committee. The committee will evaluate and make recommendations.	

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	345115	A. BUILDING _____ B. WING _____	09/13/2012

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F 332	Continued From page 16 interviewed. She stated that the dinner cart comes around 5:45 PM and she should have waited for the tray before she administered the medications to Resident #58.	F 332	F-431 D The Unit Manager removed the expired medications from the medication carts and reordered. The nurses determined through assessment that there were no adverse outcomes identified related to this alleged deficient practice. All residents have the potential to be affected by this alleged deficient practice. The Unit Managers inspected the med carts and med rooms immediately on 9/15/12 and medications were removed and reordered. The DON re-educated the nurses and included the prn nurses and any nurses unable to attend the in-service regarding dating and labeling.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		

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F 431	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on facility policy review, observation and staff interview, the facility failed to discard expired medications in 2 (300 hall medication carts)of 6 medication carts. The findings include: The facility's policy on "Recommended Minimum Medication Storage Parameters" dated October 6, 2011 was reviewed. The policy read in part "Advair Discus - date the discus when removed from the foil pouch and discard one month after removal from foil pouch or after all blisters have been used, whichever comes first." On 09/12/12 at 3:20 PM, the two medication carts on the 300 hall were observed. On medication cart #1, an Advair with an open date of 08/08/12 was found. On the medication cart #2, two Advair with an open date of 08/08/12 and a bottle of B1 with the expiration date on 07/2012 were found. On 09/12/12 at 3:50 PM, Nurse #5 was interviewed. She stated that Advair is good until all the blisters have been used but she would call the pharmacy to verify. After calling the pharmacy, Nurse #5 stated that Advair is good for one month after opening. She acknowledged that the three Advair Discus and the B1 were expired and she would discard them.	F 431	The Director of Nursing/Unit Managers will randomly observe 4 medication storage areas weekly for 4 weeks then monthly for 2 months to verify dating, labeling and storage of medications. The results will be recorded on an audit tool. The nurses will correct the opportunities identified immediately. The DON will present the results of these observations and reviews during the monthly QAPI meeting, the committee will evaluate and make recommendations as indicated. Preparation and/or execution of this plan of correction does not constitute admission 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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	345115	A. BUILDING 01 - MAIN BUILDING 01 B. WING	10/09/2012

OCT 30 2012
CONSTRUCTION SECTION

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS Surveyor: 02249 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type II(222) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	K012 Correction for the alleged deficient practice noted as" holes in the rated roof/ceiling assembly in the nourishment room near 104" was immediate replacement of the affected ceiling tiles. The Maintenance director will survey the remainder of the building for like situations and repair upon discovery. All findings and results of repairs will be presented to and discussed during the facility Safety Committee meetings for the next three months with review and discussion of continued compliance quarterly thereafter until next annual survey.	11/21/12
K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Surveyor: 02249 Based on observation, on October 9, 2012 at approximately 1:00pm onward, there are holes in the rated roof/ceiling assembly in the nourishment room near room 104. 42 CFR 483.70(a)	K 012		
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	K 038	K038 Correction for alleged deficient practice noted as 'latching hardware on courtyard doors is not passage type" was removal of non compliant hardware and installation of blank plates to permit free passage. The Maintenance Director will survey the remainder of the building to determine any other like situations and repair upon discovery. All findings and results will be presented to and discussed during the next three monthly Safety Committee meetings with continued surveys and reviews quarterly thereafter until next annual survey.	11/21/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wendy S Ketchings — TITLE: Administrator — (X6) DATE: 10/25/12

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K 038	Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 02249 Based on observation, on October 9, 2012 at approximately 1:00pm onward, latching hardware on courtyard doors is not passage type. Residents can be locked inside interior courtyard. Door opens into room off 300 hall. 42 CFR 483.70(a)	K 038	K046 Correction for the alleged deficient practice noted as "there is no light on emergency power in three hundred hall activity room" was to remove the battery operated light and connect an unswitched fluorescent ceiling light to generator power. The	
K 046 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.	K 046	Maintenance Director will survey the remainder of the building for like areas and verify emergency lighting is present and working. Details from this survey will be presented to and discussed during monthly Safety Committee meetings for the next three months and then be reviewed quarterly thereafter until next annual survey.	11/21/12
	This STANDARD is not met as evidenced by: Surveyor: 02249 Based on observation, on October 9, 2012 at approximately 1:00pm onward, there is no light on emergency power in three hundred hall activity room - unitary light did not function during test due to dead battery pack. 42 CFR 483.70(a)		K056 Correction for the alleged deficient practice noted as 'no sprinkler in the closet behind reception desk" will be to install required	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler	K 056	sprinkler head I that area. The Maintenance director will survey the remainder of the building to locate any other like areas and add sprinklers if need.	11/21/12

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K 056	Continued From page 2 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: Surveyor: 02249 Based on observation, on October 9, 2012 at approximately 1:00pm onward, there is no sprinkler in the closet behind the reception desk - located beside administrator's office. 42 CFR 483.70(a)	K 056	K056 (cont) Any negative findings will be reported immediately to the Administrator and all findings will be reported to and discussed during monthly Safety Committee meetings for the next three months with reviews done quarterly thereafter until next annual survey. K062 Correction for the alleged deficient practice noted as "paint on the heat sensitive element of ceiling sprinkler above kitchen dishwasher area" is to replace the sprinkler	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 02249 Based on observation, on October 9, 2012 at approximately 1:00pm onward, there is paint on the heat sensitive element of ceiling sprinkler above kitchen dishwasher area. 42 CFR 483.70(a)	K 062	head with matching type or temperature rated head. The Maintenance director will survey the remainder of the building to verify no other like sprinkler heads exist and schedule replacement upon discovery. All findings will be reported to and discussed during monthly Safety Committee meetings for the next three months with reviews quarterly thereafter until next annual survey. K067 Correction for the alleged deficient practice noted as "there is no listed vent limiting device or other venting assembly for gas	11/21/12
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's	K 067	valve inside commercial gas dryer" was to install copper line vent assembly to the outside as needed.	

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K 067	Continued From page 3 specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Surveyor: 02249 Based on observation, on October 9, 2012 at approximately 1:00pm onward, there is no listed vent limiting device or other venting assembly for gas valve inside commercial gas dryer - located in laundry room. 42 CFR 483.70(a)	K 067	K067 (cont) The Maintenance Director will check monthly to make sure the line is intact and operational during routine monthly checks with those findings reported to and discussed during monthly Safety Committee meetings for the next three months with reviews to be done quarterly thereafter until next annual survey. K072 Correction for the alleged deficient practice noted as "wheelchair protruding into the corridor width at recessed wall area beside front reception desk" was to immediately remove wheelchair from affected area. Proper signage was placed in area to alert staff of improper storage. The Maintenance director and Administrative staff will monitor this and other like areas to insure continued compliance to prevent further obstructions. Observations and findings will be reported to and discussed during monthly Safety Committee meetings for the next three months with reviews quarterly thereafter until next annual survey.	11/21/12 11/21/12
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Surveyor: 02249 Based on observation, on October 9, 2012 at approximately 1:00pm onward, there is a wheelchair protruding into required corridor width at recessed wall area beside front reception desk. 42 CFR 483.70(a)	K 072		

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K 000	INITIAL COMMENTS Surveyor: 02249 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type II(222) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000		
K 029	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: Surveyor: 02249 Based on observation, on October 9, 2012 at approximately 1:00pm onward, resident rooms 313 through 318 are being used as storage rooms. The rooms are greater than one hundred square feet and are not equipped with one hour rated enclosures.	K 029	Building 2 K029 Correction for the alleged deficient practice noted as "resident rooms 313 through 318 are being used as storage rooms" was to remove all storage from these rooms and they are in a state of "admission ready". The Maintenance director will survey the remainder of the building and verify storage is in proper areas rated as needed for storage. Any negative findings will be reported immediately to the Administrator and all findings will be reported to and discussed during monthly Safety Committee meetings for the next three months and reviews to continue quarterly thereafter until next annual survey.	11/21/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wendy S Getsinger — TITLE: Administrator — (X6) DATE: 10/25/12

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K 029	Continued From page 1 42 CFR 483.70(a)	K 029		