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FORM APPROVED
OMB NO. 0938-0391

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
	345061	A. BUILDING _____ B. WING _____	C 12/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST - ACUTE CARE OF DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

(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=C	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 1. Corrective Action: The state contact information was posted on the wall of the lobby. The Resident Council Officers and Resident #66 were informed individually that the state contact information is posted on the wall of the lobby directly across from the Administrators office on 1/16/13 by the Social Worker. 2. Others with Potential to be Affected: All residents were informed that the state contact information is posted in the main lobby across from the Administrators office individually, by the Social Worker and Senior Care Partner. This information will be discussed in the next Resident Council Meeting scheduled in February by the Social Worker.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joie Keopardi | TITLE: Administrator | (X6) DATE: 1/18/13

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 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 includes a written description of the facility's	F 156	3. Measure/Systemic Change The location of the state contact information will be discussed at least twice annually in the Resident Council Meeting. The Social Worker will also inform all new residents of the location of the state contact information during her initial assessment with resident. 4. Monitoring: During monthly review of the Resident Council Meeting minutes, the Administrator will confirm that state contact information location is discussed at least twice annually. The Social Worker will document that the state contact information location was given to new residents in her Initial Assessment. A copy of the Assessment will be given to the Administrator to ensure compliance is maintained. The Social Worker is responsible to ensure compliance. 1/18/13	

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F 156	Continued From page 2 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 observation and staff interview, the facility failed to post the state contact information and failed to inform alert and oriented residents of the location of the state contact information (Resident #66). Findings include: 1. An observation on 12/17/12 at 12:30 PM. revealed that the state contact information was not posted in a prominent location. On 12/17/12 1:10 PM., Administrative staff #3 stated the information should be posted in the main lobby. A tour of the entire building was conducted. No state contact information was posted. On 12/17/12 at 1:13 PM, Administrative staff #1 stated the information should be posted in the main lobby. She said she thought it was posted and did not know why it was not on the wall. On 12/17/12 at 3:00 PM., an observation revealed	F 156		

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F 156	Continued From page 3 that the state contact information had been posted on the wall in the main lobby directly across from the Administrator's office. 2. Resident # 66 was re-admitted to the facility on 12/9/11. On the quarterly Minimum Data Set (MDS) dated 11/20/12, he was determined to be cognitively intact. On 12/21/12 at 11:15 am, during an interview, Resident #66 stated that he regularly attended the monthly Resident Council meetings and that the group has not been advised where the state agency contact information was located.	F 156		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interview, and document review the facility failed to inform 1 of 3 residents (Resident #190) when the activities he was most interested in were about to start so he could attend. The findings included: Resident #190 was admitted on 10/25/12 and	F 248		

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F 248	Continued From page 4 readmitted on 11/20/12 with diagnoses including chronic airway obstruction and diabetes. The resident was also on contact precautions for a urinary tract infection but was ambulatory and continent of urine and not on a room restriction. The Activity Evaluation dated 12/3/12 revealed current interests included bingo, playing cards (spades) and spiritual/religious activities It also revealed that doing things with groups of people was very important to Resident #190 while doing activities of interest to him was somewhat important. Review of the Activity Progress Note dated 12/3/12 revealed Resident #190 was alert and oriented and read, in part, " we will encourage resident to attend weekly bingo games on the third floor. " On 12/18/12 at 10:17 AM, interview with Resident #190 in his room on the second floor revealed that he had been to only one activity in the facility; a Christmas party. He stated that he would go to activities more often " if they would let me know they were on. " He also indicated that he occasionally went outside to smoke and that going to activities would be better that going out in the cold or just sitting in his room. Interview with Resident #190 on 12/21/12 at 9:45 AM revealed he did not know what the sheet posted on the bulletin board was about. It was brought to the resident and he was asked to read it. He put on his reading glasses and turned on the table lamp that was right beside him. He stated he could not read the typing on the page. The paper was observed to be dark green with	F 248	F248 1. Corrective Action: Resident #190 was informed of posting of his activity calendar each month on his bulletin board in his room by the Activity Director. He was also informed he would be invited to Bingo and Religious Services each time they were offered and reminded shortly before the program begins by Activity Staff. 2. Others with Potential to be Affected: All residents were informed of the Activity Calendar posted in their room by the Activity Director, Social Worker and Senior Care Partner. All residents were interviewed to discuss regularly scheduled programs that they would like to attend. A master list of activities and residents who state they would like to attend has been developed.	

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F 248	Continued From page 5 black lettering with poor contrast between the words and the paper. Further review of the December 2012 Activities Calendar revealed that during the survey, bingo had been scheduled 12/18/12 at 3:30 PM and 12/19/12 at 3:30 PM. Resident #190 said he would like to attend bingo and religious services but he had never been invited to go and did not know when they were offered. Interview with the Activities Director on 12/21/12 at 12:30 PM revealed that he usually printed the activity calendar on white paper but had done it on dark green paper for Christmas. He stated that he invited all residents to all activities before each activity however he did not have any records of residents being invited to refusing to attend. When asked if he had a list of those residents who were particularly interested in a certain activity like bingo he stated that he did but when asked to provide a copy he stated he did not know where it was. He also indicated that he did not have a roster of which residents attended which activities and said that Resident #190 had not attended any activities.	F 248	3. Measure/Systemic Change Resident Activity preferences will be added to the Nursing Assistant care guides posted in each resident closet. A list of residents who may want to attend each program will be placed at each unit nursing station each day by the Activity Director. Nursing and Housekeeping Staff will be informed of the posting on the ADL care guide and the list at the nursing station. Nursing, Housekeeping and Activity staff will be responsible to inform residents daily and assist them to programs of choice. An attendance sheet will be completed for every activity, documenting who attended and who was invited, but refused. Attendance sheets will be reviewed weekly by the Administrator for the next 4 weeks and monthly for 3 months.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident	F 250	4. Monitoring: Activity attendance numbers and refusal numbers will be brought to monthly Performance Improvement Meeting to be reviewed and recommendations made. The Activity Director is responsible to ensure compliance.	1/18/13

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F 250	Continued From page 6 and staff interviews, the facility failed to coordinate follow up dental services for 1 of 2 residents (Resident #38) requiring assistance with outpatient services. The findings include: Resident #38 was readmitted to the facility on 5/21/12. The quarterly Minimum Data Set (MDS) dated 11/9/12 assessed her as being cognitively intact. On 12/17/12 at 4:00 pm, Resident #38 was interviewed. She shared that she was fitted for dentures earlier this year and never received them. She shared she did not know the status of her dentures, although she had inquired. The medical chart was reviewed. A Dental History and Record form was found dated 4/17/12. It read that Resident #38 had requested to have dentures made at an area dental school. The social worker notes from December 2011 through May, 2012 were reviewed and did not mention any assistance with dental scheduling. On 12/20/12 at 8:45 am, a 2nd visit was made to Resident #38 who was eating breakfast. She stated that when she saw the dentist it was to have bottom dentures made as well as a partial plate for her top teeth. As of yet, she still hadn't heard anything further from staff that her dentures were ready. On 12/20/12 at 11:45 am, Administrative Staff #3 was interviewed. She stated that Resident #38 was seen at the geriatric dental clinic on 3/5/12 to have teeth filled and returned in June to have the	F 250	F250 1. Corrective Action: Resident #38 had her follow up dental appointment on 1/14/13. She received her new denture. 2. Others with Potential to be Affected: A chart audit was completed to identify any resident who was in need of a follow up from a previous dental procedure or appointment by the Unit Coordinators. 3. Measure/Systemic Change All dental appointments will be confirmed or scheduled for those identified by the Unit Coordinators. The Unit Coordinators will also notify the resident and family. A master list of residents with their most recent dental appointment, any needed follow up appointment with reason and future regular dental appointment was developed utilizing data collected in audits, by the Social Worker. The master list will be updated and maintained by the Social Worker to ensure all residents receive necessary dental services.	

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F 250	Continued From page 7 impression made for an upper plate and lower dentures. Today, she discovered that Resident #38 had a follow up appointment to be fitted for her dentures on 1/14/13, after their new social worker made a phone call. The Administrative Staff #3 provided information which documented that the facility had employed three different social workers this year which at times caused gaps in social services between the vacancies. The Administrative Staff #4 was interviewed on 12/20/12 at 5:20 pm. She stated that she was unaware before today, that Resident #38 was waiting for a follow up dental consult. There were no progress notes on her chart since August 2012, to indicate that any further coordination was necessary. She shared that when Resident #38 goes to the dental clinic next month, she will have her dentures fitted and adjustments made if necessary.	F 250	4. Monitoring: The Master dental list will be reviewed monthly at Performance Improvement meeting for the next 3 months and recommendations made as needed. The Social Worker is responsible to ensure compliance. 1/18/13 F281 1. Corrective Action: The order for Resident #140 was clarified with MD. 2. Others with Potential to be Affected: All nursing staff were educated by the Director Health Services regarding the need for thorough, accurate orders, reading the order on the Medication Administration Record before administration, orders requiring a stop date and the medication pass policy. A chart audit was completed by the Unit Coordinators to identify any current orders that are incomplete or incorrectly written.	
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 and staff interview, the facility failed to follow physician orders for 1 of 10 residents (Resident #140). The findings included: Resident #140 was readmitted to the facility on 8/27/12. Cumulative diagnoses included systemic lupus and pain in limb.	F 281		

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F 281	Continued From page 8 On 11/6/12, the physician assistant ordered Aspercreme to both knees twice a day for 1 month to treat knee pain. The November Medication Administration Record (MAR) revealed a handwritten entry: "Aspercreme, apply to bil (bilateral) knees BID (twice a day) x (times) 1 month". The start date of 11/6/12 was included. The December MAR included a typed entry for the Aspercreme x 1 month and included the start date of 11/6/12. No stop date was entered on the MAR. The MAR indicated that the resident continued to receive the Aspercreme through 9AM on 12/20/12. During an interview on 12/20/12 at 9:34 AM, Nurse #2 indicated whoever checked the new month ' s MAR usually wrote the stop date, when applicable, on the MAR. The nurse said she had not noticed that the Aspercreme was only ordered for 30 days. The nurse stated that the Aspercreme helped the resident's knee pain. On 12/20/12 the nurse contacted the physician assistant who extended the Aspercreme through 1/6/13. During an interview on 12/20/12 at 10:26 AM, Unit Manager #1 indicated that she should have written a stop date on the December MAR when she did the new month check. She added that the nurses on the cart should also read the orders on the MAR when administering meds.	F 281	3. Measure/Systemic Change The Unit Coordinators will be checking all new orders daily to ensure accuracy and completeness. The second check on the monthly order's will be completed by a Nurse from another unit to ensure accuracy and completeness. Any discrepancies in orders will be recorded on a medication audit sheet. 4. Monitoring: Any discrepancies found and corrected on any order will be recorded on a medication audit sheet. All medication audit sheets will be reviewed weekly by Director Health Services to ensure corrections were made and staff educated or disciplined if needed. Audits will continue for 3 months. All medication audit sheets will be reviewed in the monthly Performance Improvement Meeting to look for trends and ensure corrections are made. The Director of Health Services is responsible to ensure compliance. 1/18/13	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		

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F 282	Continued From page 9 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to implement care plan interventions for 2 (Residents #155 and #133) of 5 residents at risk for accidents. The findings include: 1. Resident #155 was admitted to the facility on 9/6/12. Cumulative diagnoses included dementia, seizure disorder, abnormality of gait, arthritis and osteoporosis. The admission Minimum Data Set (MDS) dated 9/13/12 and quarterly MDS dated 12/12/12 revealed that Resident #155 had moderate impairment in cognitive skills, required extensive assistance of 2 persons for transfer and extensive assistance of 1 person for walking. The care plan dated 9/13/12 revealed a problem of risk for falls related to generalized weakness, history of seizures and poor safety awareness. Interventions included place call bell within easy reach, cue for safety awareness, assist for toileting and transfers as needed and keep environment safe. On 12/10/12 the intervention "sensory alarm while in wheelchair" was added. Observation on 12/19/12 at 2:28PM revealed Resident #155 up in hall in wheelchair attempting to stand. No alarm was in place. The wheelchair	F 282	F282 1. Corrective Action: The sensory chair alarm was put in place on wheelchair for Resident #155. The floor mat was put in place on the floor next to the bed for Resident #133. Both Nursing Assistants were re-educated by the Unit Coordinator to review the ADL care guide daily for specific information regarding special equipment needs and their responsibility to ensure they are in place. 2. Others with Potential to be Affected: All Nursing Assistants were educated by the Unit Coordinators regarding their responsibility to read ADL care guides at start of each shift. They must review for changes and to ensure needed equipment is available and in use for each resident. All Nurses were educated by the Director of Health Services regarding their responsibility to ensure special equipment is in place, per the care plan each shift for each resident.	

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F 282	Continued From page 10 was unlocked and moved backward when the resident attempted to stand. When asked, the resident stated she was trying to get up and did not believe she needed any assistance. During an interview on 12/19/12 at 2:30 PM, Nursing Assistant (NA) #1 said that she was assigned to care for Resident #155. NA #1 indicated she was not aware that the resident should have a chair sensor alarm. She further stated that if a chair sensor alarm was ordered, it should be in her room and written on the care guide inside the resident's closet door. The care guide was then observed to include "chair sensor alarm". NA #1 stated she would let the nurse know. During an interview on 12/19/12 at 2:50 PM, the hall nurse (Nurse #5) stated that Resident #155 now had a chair alarm in place. The nurse added that the alarm was started on 12/10/12 after the resident had transferred herself from the chair to her bed, and should be used whenever the resident was up in her wheelchair. On 12/20/12 at 11:12 AM, Resident #155 was observed in her wheelchair with the alarm on. 2. Resident #133 was admitted to the facility on 10/18/12. Cumulative diagnoses included: cerebral vascular accident, delirium, systolic heart failure and hypertension. The admission Minimum Data Assessment (MDS) dated 10/25/12 revealed him to be cognitively intact requiring extensive assistance with bed mobility, locomotion and transfers.	F 282	3. Measure/Systemic Change An audit sheet was developed to document all special equipment needs for each resident. Audit placed on MAR for each medication cart. Nurse on cart is responsible to check that equipment is in use per care plan, on each shift. The Unit Coordinators will check audit sheets weekly for 4 weeks and monthly for 3 months to ensure equipment is checked and in place. Any discrepancies found will be addressed with Nursing Assistant and Nurse through further education and discipline. Audits will be discussed with Director of Health Services weekly/monthly and through out audit period of 4 months total. 4. Monitoring: All audits will be reviewed in monthly PI meeting for recommendations and to ensure compliance. The Director of Health Services is responsible to ensure compliance.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIHEALTH POST - ACUTE CARE OF DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

(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 282	Continued From page 11 The medical chart was reviewed and revealed that since his admission, Resident #133 has had five falls, with his most recent occurring on 12/21/12. The incident reports were reviewed and noted that he often had confusion, disorientation and impaired judgment at the time of his falls. A Care Plan was developed for him on 11/7/12. It identified potential for injury from falls, as a problem area, due to a history of falls, use of oxygen and decreased safety awareness. His goal was to have no fall, resulting in injuries for 90 days. Approaches to be used included adding a floor mat next to his bed, on 12/7/12. On 12/20/12 at 7:12 am, Resident #133 was observed asleep in bed with no floor mat in place. On 12/21/12 at 10:30 am, Resident #133 was observed lying down in bed, awake. His shoes were off, his wheelchair was positioned next to his bed; the floor mat was not in place. On 12/21/12 at 10:32 am, Nurse #7 was interviewed. He stated that he overlooked the floor mat not being in place when he gave Resident #133 his medications earlier. He searched his room and found the floor mat rolled up in the closet area. He unrolled the mat and placed it next to Resident #133's bed. On 12/21/12 at 10:35 am, Nurse Aide #2 was asked about the floor mat for Resident #133. She stated that she did not know that he used a floor mat. She stated that the aides used care guides	F 282		

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F 282	Continued From page 12 to familiarize themselves with the resident's needs. The care guide for Resident #133 was hanging inside of his closet and had instructions written on it to use a floor mat for special equipment. On 12/21/12 at 12:24 pm, Nurse #8 was interviewed. She stated that she expected for the nurse aides to check safety devices and to read the care guides daily. She also stated that the nurses should be familiar enough with the resident's care and treatment, since they were the key to addressing new interventions.	F 282		
F 323 SS=D	483.25(h) FREE OF ACCIDENT 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 observation, staff interview and record review, the facility failed to implement a sensory pad alarm (Resident #155) and fall mat (Resident #133) for 2 of 5 residents with a history of falls. The findings include: 1. Resident #155 was admitted to the facility on 9/6/12. Cumulative diagnoses included dementia, seizure disorder, abnormality of gait, arthritis and osteoporosis.	F 323	F323 1. Corrective Action: The sensory chair alarm was put in place on wheelchair for Resident #155. The floor mat was put in on the floor next to the bed for Resident #133. Both Nursing Assistants were re-educated by the Unit Coordinator to review the ADL care guide daily for specific information regarding special equipment needs and their responsibility to ensure they are in place. 2. Others with Potential to be Affected: All Nursing Assistants were educated by the Unit Coordinators regarding their responsibility to read Nursing Assistant care guides at start of each shift. They must review for changes and to ensure needed equipment is available and in use for each resident. All Nurses were educated by the Director of Health Services regarding their responsibility to ensure special equipment is in place, per the care plan each shift for each resident.	

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F 323	Continued From page 13 The admission Minimum Data Set (MDS) dated 9/13/12 and quarterly MDS dated 12/12/12 revealed that Resident #155 had moderate impairment in cognitive skills, required extensive assistance of 2 persons for transfer and extensive assistance of 1 person for walking. The care plan dated 9/13/12 revealed a problem of risk for falls related to generalized weakness, history of seizures and poor safety awareness. Interventions included place call bell within easy reach, cue for safety awareness, assist for toileting and transfers as needed and keep environment safe. A care plan update on 9/16/12 revealed Resident #155 fell due to ambulating without assistance. No injury was noted. Intervention included staff education regarding the need for assistance and that resident has cognitive deficits. A care plan update on 11/21/12 revealed Resident #155 fell in the bathroom. No injury was noted. Intervention included re-education with resident to use call bell for assistance, and resident to be supervised while in bathroom. On 12/10/12 the intervention "sensory alarm while in wheelchair" was added. Observation on 12/19/12 at 2:28PM revealed Resident #155 up in hall in wheelchair attempting to stand. No alarm was in place. The wheelchair was unlocked and moved backward when the resident attempted to stand. When asked, the resident stated she was trying to get up and did not believe she needed any assistance.	F 323	3. Measure/Systemic Change An audit sheet was developed to document all special equipment needs for each resident. Audit placed on Medication Administration Record for each medication cart. Nurse on cart is responsible to check that equipment is in use per care plan, on each shift. The Unit Coordinators will check audit sheets weekly for 4 weeks and monthly for 3 months to ensure equipment is checked and in place. Any discrepancies found will be addressed with Nursing Assistant and Nurse through further education and discipline. Audits will be discussed with Director Health Services weekly/monthly and through out audit period of 4 months. 4. Monitoring: All audits will be reviewed in monthly Performance Improvement meeting for recommendations and to ensure compliance. The Director of Health Services is responsible to ensure compliance.	1/18/13

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F 323	Continued From page 14 During an interview on 12/19/12 at 2:30 PM, Nursing Assistant (NA) #1 said that she was assigned to care for Resident #155. NA #1 indicated she was not aware that the resident should have a chair sensor alarm. She further stated that if a chair sensor alarm was ordered, it should be in the resident's room and written on the care guide inside the resident's closet door. No alarm was observed in the resident's room. The care guide was then observed to include "chair sensor alarm". NA #1 stated she would let the nurse know. During an interview on 12/19/12 at 2:50 PM, the hall nurse (Nurse #5) stated that Resident #155 now had a chair alarm in place. The nurse added that the alarm was started on 12/10/12 after the resident had transferred herself from the chair to her bed, and should be used whenever the resident was up in her wheelchair. On 12/20/12 at 11:12 AM, Resident #155 was observed in her wheelchair with the alarm on. 2. Resident #133 was admitted to the facility on 10/18/12. Cumulative diagnoses included: cerebral vascular accident, delirium, systolic heart failure and hypertension. The admission Minimum Data Assessment (MDS) dated 10/25/12 revealed him to be cognitively intact requiring extensive assistance with bed mobility, locomotion and transfers. The medical chart was reviewed and revealed that since his admission, Resident #133 has had five falls, with his most recent occurring on	F 323		

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F 323	Continued From page 15 12/21/12. The incident reports were reviewed and noted that he often had confusion, disorientation and impaired judgment at the time of his falls. A Care Plan was developed for him on 11/7/12. It identified potential for injury from falls, as a problem area, due to a history of falls, use of oxygen and decreased safety awareness. His goal was to have no fall, resulting in injuries for 90 days. Approaches to be used included adding a floor mat next to his bed, on 12/7/12. On 12/20/12 at 7:12 am, Resident #133 was observed to be asleep in bed, with no floor mat in place. On 12/21/12 at 10:30 am, Resident #133 was observed lying down in bed, awake. His shoes were off, his wheelchair was positioned next to his bed; the floor mat was not in place. On 12/21/12 at 10:32 am, Nurse #7 was observed on the hallway, passing medication. He was approached and questioned about Resident #133 ' s fall interventions. He entered Resident #133 ' s room and commented that he failed to realize that the floor mat wasn ' t in place when he administered his medications earlier. He searched the room and could not find the floor mat. On 12/21/12 at 10:35 am, Nurse Aide #2 was asked about the floor mat for Resident #133. She stated that she did not know that he used a floor mat. She stated that the aides used care guides to familiarize themselves with the resident ' s	F 323		

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F 323	Continued From page 16 needs. The care guide for Resident #133 was hanging inside of his closet and had instructions written on it to use a floor mat for special equipment. On 12/21/12 at 10:40 am, Nurse #7 returned to state that he located the floor mat for Resident #133 in his room, on the floor, between the closets. He unrolled it and placed it next to his bed, on the floor. On 12/21/12 at 12:24 pm, Nurse #8 was interviewed. She stated that she expected for the nurse aides to check safety devices and to read the care guides daily. She also stated that the nurses should be familiar enough with the resident ' s care and treatment, since they were the key to addressing new interventions.	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:	F 356		

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F 356	Continued From page 17 o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and staff schedules, the facility failed to post accurate staffing data. Observation of the "Daily Nursing Hours" posting on 12/21/12 at 8:30 AM revealed 2 registered nurses (RNs) scheduled to work on the 7-3 shift that day. Review of resident care assignments only accounted for 1 RN. During an interview on 12/21/12 at 8:55 AM, Administrative staff #2 stated that she always included the admissions nurse on the staff posting as a direct care provider. Administrative staff #2 acknowledged that the admissions nurse did not have a direct care assignment and now understood that the admissions nurse should not be included in the daily posting.	F 356	F356 1. Corrective Action: The Daily Nursing Hours posting for 12/21/12 was corrected and reposted. 2. Others with Potential to be Affected: Directions for calculating daily nursing hours was clarified with the Night Supervisor by the Administrator to only include direct care staff and ensure accuracy of daily posting. 3. Measure/Systemic Change Daily Nursing Hours will be posted each morning by the Night Supervisor with direct care staff numbers. The posting will be checked by DHS each day for accuracy. Any discrepancy will be corrected and reposted. 4. Monitoring: The Administrator will sign off on daily posting as presented by DHS for next month to ensure accuracy. The DHS is responsible to ensure compliance. 1/18/13	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	Continued From page 18 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	F441 1. Corrective Action: Nurse #4 cleaned the glucometer with a bleach wipe when it was brought to her attention by the Surveyor. 2. Others with Potential to be Affected: All Nurses were re- educated regarding policy to clean glucometers by the Director of Health Services. All Nurses demonstrated understanding. All new Nurses will be educated regarding policy and demonstrate understanding during orientation. 3. Measure/Systemic Change: Audits will be conducted weekly for 4 weeks to include observation of Nurses demonstrating proper technique while cleaning glucometers. After the first month, audits will continue monthly for 3 months to ensure understanding of the procedure.	

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F 441	Continued From page 19 Based on observation, staff interview and facility policy, the facility failed to sanitize a glucometer prior to use for 1 of 3 nurses (Nurse #4) observed performing blood glucose checks. The findings included: The facility policy entitled, "Diabetes Monitoring: Blood Glucose Equipment & Supplies", last revised 1/11, included, "Glucometer Cleaning and Disinfecting Procedure: Accuchecks/glucometers or other blood sugar monitor devices will be cleaned and disinfected in the following manner before and after each patient/resident use." "1. Wash hands. 2. Put on clean gloves. 3. Clean the outside of the glucometer with isopropyl alcohol wipe (70%-85%) or a lint free cloth dampened with soapy water. 4. Disinfect the meter with a bleach solution wipe (>0.5% sodium hypochlorite) or spray a 1:10 bleach solution on a paper towel. 5. Remove gloves & wash hands after clean glucometer." On 12/19/12 at 12:07 PM, Nurse #4 was observed preparing to perform a blood glucose check. Nurse #4 used 2 alcohol wipes to wipe the glucometer, then placed it in a plastic cup. Next she gathered a lancet, testing strip and the cup with the glucometer and walked towards the resident's door. Nurse #4 was stopped and interviewed at this time. She stated she normally wiped the glucometer with a bleach wipe but there were none on the cart so she decided to just use the alcohol wipes. Nurse #4 added that was to be the first blood glucose check on her shift. The nurse	F 441	4. Monitoring: Audits will be reviewed by Director Health Services weekly/monthly to ensure compliance with procedure and education and/or discipline if procedure is not followed. Results of the audits will be reviewed in monthly PI Meeting and recommendations made as needed. The Director Health Services is responsible to ensure compliance. 1/18/13	

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F 441	Continued From page 20 stated she would wipe the glucometer with a bleach wipe prior to using it. During an interview on 12/21/12 at 10:50 AM, Administrative staff #2 indicated she expected staff to clean and disinfect glucometers before and after each use.	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to obtain lab work for one of ten sampled residents (a complete blood count (CBC) ordered to be obtained on October 10/29/12 for Resident.#90). Findings include: Resident #90 was admitted to the facility 4/22/11. Cumulative diagnoses included: Hypothyroidism, history of rectal cancer, diabetes and use of Coumadin (anticoagulant medication). A consultant pharmacist recommendation dated 10/23/2012 requested that a complete blood count (CBC) be obtained due to the use of vitamin B12 and Cymbalta (an antidepressant medication). A review of the medical record revealed a physician's order for a CBC to be done on 10/29/2012. The medical record was reviewed and there were no laboratory results for a CBC	F 502	F502 1. Corrective Action: The Complete Blood Count for Resident #90 was obtained and result are addressed and in chart. 2. Others with Potential to be Affected: All resident charts will be audited for last 3 months to check lab orders, ensure lab results have been obtained and are documented in the lab books. Audits completed by Unit Coordinators.	

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F 502	Continued From page 21 done on 10/29/2012. On 12/20/12 at 11:35 AM., Administrative staff # 2 stated the medical record for Resident #90 had been checked and the CBC ordered on 10/29/2012 had not been obtained. She said the laboratory log for 10/29/12 was unable to be located. Administrative staff # 2 stated the CBC should have been obtained on 10/29/12 as ordered by the physician. On 12/21/12 at 9:57 AM., the pharmacy consultant stated she followed up on recommendations the nest month that she visited and expected that all of her recommendations had been done and/or re-requested on the next visit. She said she did not realize that the CBC had not been done on 10/29/12 as ordered by the physician.	F 502	3. Measure/Systemic Change: All Lab orders will be checked daily by Unit Coordinators to ensure lab order is recorded in lab book, lab has been drawn and results have been received. Any deviation from the system found will be recorded on an audit sheet for correction. Audit sheet corrections will be reported to the Director Health Services for review. Audits will be conducted weekly for 4 weeks to review lab orders, lab results received and documented in lab books. After 4 weeks audits will continue monthly for 3 months to ensure all labs ordered are obtained.	
F 519 SS=E	483.75(n) TRANSFER AGREEMENT WITH HOSPITAL In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate, as determined by the attending physician; and medical and other information needed for care and treatment of residents, and, when the transferring facility deems it appropriate, for determining whether such residents can be adequately cared for in a less expensive setting than either the facility or	F 519	4. Monitoring: Audits will be reviewed by Director Health Services weekly/monthly to ensure compliance with lab monitoring process. Results of the audits will be reviewed in monthly Performance Improvement Meeting and recommendations made as needed. The Director Health Services is responsible to ensure compliance. 1/18/13	

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F 519	Continued From page 22 the hospital, will be exchanged between the institutions. The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to send complete medical information (completed medication administration records) needed for the care and treatment of three of three residents sent to the hospital emergency room (Resident #176, #112, #108) . Findings include: 1. Resident #176 was admitted to the facility 8/22/12. Cumulative diagnoses included: Coronary Artery disease, hypertension Diabetes and Cerebrovascular accident (CVA) on 8/20/12 with left hemiparesis. Hospital records revealed a feeding tube was placed on 8/20/12. A medical record review revealed a physician communication tool (type of nursing note used for acute medical situations) dated 12/5/12 at 9:00 AM. stated Resident #176's physician was notified due to a change in medical condition. Resident #176 had decreased speech, speech was slurred and confusion was noted by the nursing staff. Resident #176 did not consume her morning meal. Her blood glucose at 6:00 AM. was documented as 81. Resident #176 was transported to (name) emergency room for	F 519	F519 1. Corrective Action: The Nurses were informed immediately to send a copy of the entire Medication Administration Record, including when medications were given and initials of Nurse giving medications whenever a resident was discharged, by the Director of Health Services. 2. Others with Potential to be Affected: All Nurses received education regarding sending a copy of the entire Medication Administration Record when discharging a resident. Education completed by the Director of Health Services. Nurses are required to complete a Transfer checklist when discharging a resident, which includes the Medication Administration Record. A copy of the checklist will be made by Nurse for each discharge and turned in to the Director Health Services for review.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 519	Continued From page 23 evaluation. A report of her condition was called to the (name) Transfer Center. On 12/19/12 at 10:34 AM., Administrative staff #2 stated when a resident was transferred to the hospital, the latest history and physical, the last laboratory results, the face sheet, and the Medication Administration Record (MAR) would be sent with the resident. Administrative staff #2 said the facility staff made a copy of the MAR and would cut off the information regarding when the medications had been administered. She stated the facility staff had been doing it that way since she had been employed at the facility and she did not correct it. Administrative staff #2 stated she had never had any complaints from the hospital so they had continued to send the MAR information without the initials that documented what medications had been administered to the resident prior to their transfer to the hospital. She said she became aware this week that the hospital had an issue with not receiving the complete MAR for another resident and she expected nursing staff to send complete records that included the entire MAR with initials for continuity of care. On 12/19/12 at 10:47 AM., Nurse #1 stated she was the nurse who sent Resident #176 to the hospital on 12/5/12. She stated she sent a packet with the resident to the hospital. The information sent included the latest laboratory results, the transfer form, the latest physician's progress noted and the medication administration record (MAR). Nurse #1 stated the MAR was sent with only the names of the medication visible. The documentation of the medications that had been administered prior to the transfer	F 519	3. Measure/Systemic Change: Each transfer checklist will be reviewed and initialed after each discharge by the Unit Coordinators to ensure complete information went with the resident. Checklists will then be given to the Director Health Services daily for review. Any incomplete checklist will result in further education for Nurse responsible. 4. Monitoring: All checklist reviews will be discussed in monthly Performance Improvement meeting for any further recommendations and to ensure compliance. The Director Health Services is responsible to ensure compliance.	

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	345061	A. BUILDING _____ B. WING _____	C 12/21/2012

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was blanked out. Nurse #1 stated she was trained to cover the initials on the MAR when sending a resident to the hospital by other nursing staff who worked on the floors.

On 12/19/12 at 11:11 AM., Nurse #2 stated, when a resident was sent to the emergency room, the MAR was sent without the initials that indicated what medications had been administered to the resident prior to the transfer. Nurse #2 stated the initials of the nursing staff were private information and the facility nursing staff was not supposed to share what medications the resident did or did not take prior to the transfer. Nurse #2 said she had always been under the impression that they were not to send the MAR with the initials.

2. Resident #112 was admitted to the facility 9/22/11 and readmitted 3/9/12. Cumulative diagnoses included: Chronic Obstructive Pulmonary Disease (COPD), Diabetes Mellitus (DM) and Vascular Dementia. Resident #112 was sent to (name) emergency department on 12/19/12 for evaluation for evaluation for respiratory failure and sinus bradycardia (slow heart rate).

On 12/19/12 at 10:34 AM., Administrative staff #2 stated when a resident was transferred to the hospital, the latest history and physical, the last laboratory results, the face sheet, and the Medication Administration Record (MAR) would be sent with the resident. Administrative staff #2 said the facility staff made a copy of the MAR and would cut off the information regarding when the medications had been administered. She stated the facility staff had been doing it that way since

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F 519	Continued From page 25	F 519		

she had been employed at the facility and she did not correct it. Administrative staff #2 stated she had never had any complaints from the hospital so they had continued to send the MAR information without the initials that documented what medications had been administered to the resident prior to their transfer to the hospital. She said she became aware this week that the hospital had an issue with not receiving the complete MAR for another resident. She stated Resident #112 was sent to the hospital this morning and she believed the complete MAR was sent with the resident. She expected nursing staff to send complete records that included the entire MAR with initials for continuity of care.

On 12/19/12 at 10:40 AM., Administrative staff #2 stated she had been informed that the nursing staff sent the MAR without initials for Resident #112 when she was transferred to the hospital emergency room.

3. Resident #108 was admitted on 1/12/11 with diagnoses including depression, hypertension and cardio vascular accident.

Review of the Emergency Medical Services (EMS) report dated 12/17/12 revealed : " Pt (patient) was found with a string from medical device wrapped around her neck had indicated to staff that she was trying to kill herself. " " Staff member advised us that she is on Ativan (an anti-anxiety medication) daily and additional PRN (as needed). They refused to tell us her last dose another staff member cut her medical records in half with sissors, cutting off when she has gotten her meds (medications). , if she is still on her meds and most of her past medical history. We

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F 519	Continued From page 26 were told by staff at the nursing home that EMS and (initials of hospital) staff did not need to know what her complete history was and if she is being treated with On 12/19/12 at 10:34 AM., Administrative staff #2 stated when a resident was transferred to the hospital, the latest history and physical, the last laboratory results, the face sheet, and the MAR would be sent with the resident. Administrative staff #2 said the facility staff made a copy of the MAR and would cut off the information regarding when the medications had been administered. She stated the facility staff had been doing it that way since she had been employed at the facility and she did not correct it. Administrative staff #2 stated she had never had any complaints from the hospital so they had continued to send the MAR information without the initials that documented what medications had been administered to the resident prior to their transfer to the hospital. She said she became aware this week that the hospital had an issue with not receiving the complete MAR for Resident #108. She then stated that she expected nursing staff to send complete records that included the entire MAR with initials for continuity of care. On 12/20/12 at 12:20 PM Nurse #9 was interviewed and stated that on 12/17/12 when Resident # 108 needed to be sent to the hospital she had started getting the packet of information ready to send with the resident to the hospital. When questioned about whether she provided the entire Medication Administration Record (MAR), including the part where doses given were initialed she said that the oncoming nurse had completed the packet and cut that section of the	F 519		

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F 519	Continued From page 27 MAR. She further stated that it was facility policy not to send that section of the MAR when residents are transferred to hospital.	F 519		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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	345061	A. BUILDING 02 - MAIN BUILDING B. WING _____	01/25/2013

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UNIHEALTH POST - ACUTE CARE OF DURHAM	3100 ERWIN ROAD DURHAM, NC 27705

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 New Health Care section of the LSC and its referenced publications. This building is Type III(211) construction, five story building , with a complete automatic sprinkler system.	K 000	K029 1. Corrective Action: The temporary storage rooms 336,337,320 and 321 have storage items removed and are now back in order with original room furniture. 2. Others with Potential to be Affected: All rooms in facility were checked to ensure storage items were not being placed in rooms without closures. 3. Measure/Systemic Change All rooms in facility will be check weekly for the next four weeks and monthly for 3 months to ensure any room being used as storage has a closure. 4. Monitoring: Weekly/monthly room check documentation will be given to the Administrator for review. Results of documentation will be reviewed in Monthly Performance Improvement Meeting for needed follow up or new recommendations. The Director of Maintenance is responsible for compliance.	2/8/13
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Friday 1/25/13 at approximately 8:00 AM onward the following was noted: 1) The corridor door to resident rooms 336, 337, 320 and 321 will need closures due to the rooms being used for temporary storage at this time.	K 029		
K 050 SS=D	42 CFR 483.70 NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded	K 050		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joee Leopardi — TITLE: Administrator — (X6) DATE: 2/8/13

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 050	Continued From page 1 announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on observation on Friday 1/25/13 at approximately 8:00 AM onward the following was noted: 1) Based upon document review, fire drill documention could not be provided for 2nd and 3rd shift of the 1st quarter and 1st shift of the 4th quarter in calendar year 2012. 42 CFR 483.70	K 050	K050 1. Corrective Action: Fire Drill documentation was found and placed with other drill documentation for 2nd and 3rd shift of 1st quarter and 1st shift of 4th quarter. Director of Maintenance was educated on the importance of maintaining appropriate records in the right place and completing all required fire drills quarterly. 2. Others with Potential to be Affected: All fire drills will be scheduled with the Administrator for the next quarter. A review of the documentation will be completed after the drill to ensure documents are in place. Review will be completed by the Administrator. 3. Measure/Systemic Change Quarterly fire drills on each shift will be reviewed for the next 3 quarters to ensure they are completed and documentation is in appropriate location. 4. Monitoring: Results of the fire drills will be reviewed in Monthly Performance Improvement Meeting for needed follow up or new recommendations. The Director of Maintenance is responsible for compliance. 3/1/13	
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. This STANDARD is not met as evidenced by: Based on observation on Friday 1/25/13 at approximately 8:00 AM onward the following was	K 056		

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K 056	Continued From page 2 noted: 1) There is a sprinkler head in the clean side of the laundry room rated for 200 degrees intermediate environment in place of a 155 degree head rated for ordinary environment. 2) The sprinkler heads in the laundry area were not clean and maintained in good condition. 3) The sprinkler eschusions were missing for the sprinkler heads located in the data room 2nd floor, electrical room 1st floor, resident room 342 bathroom. 42 CFR 483.70	K 056	K056 1. Corrective Action: The sprinkler head in the clean side of the laundry room is scheduled to be replaced next week with a 155 degree rated head. The sprinkler heads in the laundry area have been cleaned. The sprinkler eschusions that were missing in the data room 2nd floor, electrical room 1st floor and resident room 342 bathroom will be replaced on February 11th.	
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. 18.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation on Friday 1/25/13 at approximately 8:00 AM onward the following was noted: 1) Upon review of the inspection report the low pressure alarm for the sprinkler system was not connected to the fire alarm panel.	K 062	2. Others with Potential to be Affected: All sprinkler heads will be checked for appropriate rated head, cleanliness and eschusions. Any found deficient will be fixed, cleaned or replaced. The Director of Maintenance will complete this facility wide audit and make corrections as needed. 3. Measure/Systemic Change Facility audits to check for appropriate rated sprinkler heads, cleanliness and eschusions will be completed monthly for the next three months by the Director of Maintenance.	
K 072 SS=D	42 CFR 483.70 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	K 072	4. Monitoring: Results of the monthly audits will be reviewed in Monthly Performance Improvement Meeting for needed follow up or new recommendations. The Director of Maintenance is responsible for compliance.	3/1/13

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K 072	Continued From page 3 exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation on Friday 1/25/13 at approximately 8:00 AM onward the following was noted: 1) In front of the exit door on the third floor front stairwell there was resident chair and equipment stored in the corridor. 42 CFR 483.70	K 072	K062 1. Corrective Action: The low pressure alarm for the sprinkler system will be connected to the fire alarm panel during vendor visit scheduled for next week. 2. Others with Potential to be Affected: There are no other low pressure alarms or sprinkler systems in the facility. 3. Measure/Systemic Change: The vendor will check the low pressure alarm to ensure it is connected to the sprinkler system during each quarterly inspection. Check will be documented on the vendor report and reviewed by the Director of Maintenance. 4. Monitoring: Documentation of the quarterly checks by the vendor will be reviewed in Quarterly Performance Improvement Meeting for needed follow up or new recommendations. The Director of Maintenance is responsible for compliance.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation on Friday 1/25/13 at approximately 8:00 AM onward the following was noted: 1) The generator annunicator panel when tested was not operational. 42 CFR 483.70	K 144		3/1/13

K072

1. Corrective Action:
   The exit door on the third floor in front of the stairwell was cleared of the chair and other equipment.

2. Others with Potential to be Affected:
   All other exit doors were check for any equipment stored in area of egress.

3. Measure/Systemic Change:
   The exit doors will be audited daily for 4 weeks and weekly for 3 months to ensure the means of egress are clear. all staff were educated on the need to maintain a clear means of egress at all exit doors.

4. Monitoring:
   Audits will be reviewed weekly by Administrator to review for compliance. Weekly and monthly audits will be reviewed in Quarterly Performance Improvement Meeting for needed follow up or new recommendations. The Director of Maintenance is responsible for compliance.

3/1/13

K144

1. Corrective Action:
   The generator annunicator panel was corrected and is now operational. This was completed by vendor Yancey Power systems of January 29, 2013.

2. Others with Potential to be Affected:
   This is the only generator in the facility.

3. Measure/Systemic Change:
   The annunicator panel will be checked weekly for 4 weeks and monthly for 3 months by the Maintenance Director to ensure it is operational. This will be documented during generator checks and reviewed by the Administrator each time.

4. Monitoring:
   Generator checks will be reported to Quarterly Performance Improvement Meeting for needed follow up or new recommendations. The Director of Maintenance is responsible for compliance.

2/8/13