

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

APR 29 2013

PRINTED: 04/19/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345196	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/04/2013
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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VISTA HEALTH PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 106 MOUNTAIN VISTA RD DENTON, NC 27239
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F 221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and staff interviews the facility failed to identify the use of a table top tray on a geri chair as a restraint, and provided no medical symptom for the restraint use. and did not assess the table top tray as a restraint for one (Resident #48) of four sampled residents with restraints.</p> <p>The findings included: Resident #48 was admitted to the facility on 4/28/10 with diagnoses of Acute Renal Failure, History of Dementia and Congestive Heart Failure.</p> <p>Review of an assessment dated 3/1/12 for the use of side rails revealed one side rail was used and Resident #48 was "up ad lib" (as desired). There were no other assessments of potential restraints.</p> <p>Review of Nursing Annual/Update Assessment dated 12/9/12 revealed functional abilities for ambulation by "self" and "travels" by "self" and Transfers - "self". No assistance was required for these Activities of Daily Living (ADLs).</p> <p>Review of the Quarterly Minimum Data Set</p>	F 221	<p>Disclaimer</p> <p>Mountain Vista Health Park submits this Plan of Correction (PoC) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this PoC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services (CMS), the State of North Carolina or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. The Provider has not had any remedies imposed against it as a result of the alleged deficiencies. Without such remedies, the Provider will not be granted an appeal before the U.S. Department of Health and Human Services Departmental Appeals Board to challenge the alleged deficiencies cited in the CMS-2567.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Kathy McDonald
TITLE
Administrator
(X6) DATE
04/25/13

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 221	<p>Continued From page 1</p> <p>(MDS) dated 3/5/13 indicated Resident #48 had short and long term memory impairment and severe impairment in daily decision making abilities. Resident #48 required total assistance by staff with eating, personal hygiene and toileting. Resident #48 could transfer and walk in the hallway with supervision, and could walk in her room independently. The use of a chair that prevents rising as a restraint was not assessed on the MDS.</p> <p>Review of the care plan updated 3/13/13 revealed a problem of dysphagia and ongoing weight loss due to refusal/poor meal intake related to terminal Alzheimer's and anorexia. The approaches included for staff to ensure she was out of bed to a reclining chair for all meals. This required the use of Geri-chair with a table top tray (attached tray on chair) for meal times to maintain resident in sedentary position for improved intake. Staff were to ensure the tray was removed after meal completion.</p> <p>Review of the medical record revealed, no restraint assessment for the use of the table top tray attached to the geri chair and no identified medical necessity or diagnosis for the use of the restraint.</p> <p>During initial tour on 4/1/13 at 10:45 AM Resident #48 was observed in a geri chair with a table top tray attached to the chair.</p> <p>Observations on 4/1/13 at 12:33 PM revealed Resident #48 was being wheeled by a direct care staff member down the hall. An administrative nursing staff member stopped the direct care staff and informed her Resident #48 could walk.</p>	F 221	<p>F221</p> <p>It has been the philosophy and normal practice of this facility to assess and identify items or devices that could be considered a restraint. The facility has an established Restraint Program with policies and procedures designed to meet these goals. Restraint use monitoring, physician reviews, consultant reviews, quality assurance monitoring, and staff training are examples of the many components utilized.</p> <p>The findings reference "the facility failed to identify one of four sampled residents with restraints." Other than resident #48 there was in fact only one resident (resident #40) identified with restraint use.</p> <p>On 04/05/13 a restraint assessment for the use of a tray table for Resident #48 was initiated. Following the assessment the decision was to utilize other approaches with Resident #48 to enhance eating and discontinue the use of a tray table. The medical record has an updated comprehensive assessment and plan of care.</p> <p>Director of Nursing (DoN), Staff Development Coordinator (SDC) and Charge nurses reviewed all residents to ensure no other unidentified situations involving tray tables or other devices that might be considered a restraint existed. None existed.</p>		

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F 221	<p>Continued From page 2</p> <p>Resident #48 walked with hand held assistance of one staff to the dining room. In the dining room, Resident #48 sat in the geri chair. The table top tray was attached over the resident 's lap. The resident was unable to rise from the chair. She was observed tapping her foot, scooting herself away from the table and putting her head down on the tray. She remained seated in the geri chair with the table top tray in place from 12:40 PM to 1:16 PM. The staff in the dining room had not served her tray, or attempted to feed her. The tray was served at 1:16 PM by a direct care staff member. The food was not placed on the lap buddy. Resident #48 refused to eat and did not attempt to feed herself. The table top tray was removed from the geri chair after the refusal to eat.</p> <p>Observations on 4/3/13 at 12:30 PM revealed Resident #48 walked from her room to the dining room with hand held assistance of one staff member. Resident #48 walked approximately 120 feet. At 12:35 PM Resident #48 sat in the geri chair and direct care staff placed the table top tray on the chair. No food or drink was provided for this resident until she received her food tray at 1:12 PM. The food and drink was removed from Resident #48 and the direct care staff proceeded to assist another resident. Resident #48 remained in the geri chair with the table top tray in place on the chair.</p> <p>Observations on 4/4/13 at 8:55 AM revealed she was sitting in her room in the geri chair, with an aide feeding her breakfast. Resident # 48 was holding her head upright and accepting the food. The geri chair tray was not in use during this meal time.</p>	F 221	<p>DoN and SDC provided refresher training from 04/05/13 through 04/11/13 to the nursing staff concerning the use of a table tray, restraints, how restraint definitions apply and the corresponding supporting documentation. MDS nurse re-reviewed the guidelines in the RAI manual to assure accurate coding.</p> <p>Charge nurse, DoN, SDC and/or Administrator will monitor all residents at least 2 times per week for 2 weeks, at least 1 time per week for 2 weeks and at least monthly for 2 months to determine if devices that might be considered a restraint are used. If so, the following will be reviewed 1) MDS to assure accurate coding, 2) Restraint is addressed in the plan of care, 3) Medical symptom for the use of a restraint is documented. These findings will be reviewed and discussed in the facility Quality Assessment and Assurance (QAA) Committee.</p> <p>Completion Date: 04/19/13</p>	
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F 221	<p>Continued From page 3</p> <p>Observations on 4/4/13 at 12:49 PM revealed resident #48 ambulated with hand held assistance of one staff into the dining room. At 12:52 PM the resident sat in the geri chair and the tray was placed on the chair. The chair was scooted up to the table. Direct care staff #1 served the tray and attempted to feed the resident from 1:02 PM to 1:04 PM. The food was removed from the table top tray on the geri chair and direct care staff #1 began feeding another resident. Resident #48 remained in the geri chair with the table top tray table in place</p> <p>Interview with direct care staff #2 on 4/4/13 at 1:30 PM revealed she had provided care for Resident #48 on 4/1/13. Direct care staff #2 explained the tray table was to keep Resident #48 in the geri chair at meal time. The resident would get up and leave during the meal. She could not get up and leave with the tray over the chair. The tray was to be removed after a meal.</p> <p>Interview with MDS nurse #2 on 4/4/13 at 1:35 PM revealed the most current care plan was in front of the nurse's notes. That care plan gave instructions for Resident #48 to have a tray placed on the geri chair. She further explained the tray table on the geri chair was for meal times only. The MDS nurse and floor nurse went to the dining room to view Resident #48. Both nurses stated the tray table should have been removed after the resident had eaten. The floor nurse spoke to the direct care staff #3. The floor nurse stated the aide was going to try and feed her some more. Both nurses stated the table top tray would be a restraint if it was not removed after the meal.</p>	F 221			

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F 221	Continued From page 4 Interview on 4/4/13 at 1:40 PM with direct care staff #1, who provided meal assistance on 4/4/13, revealed the table top tray was to keep Resident #48 in the geri chair during meals. She stated she knew the table top tray was supposed to be removed and she had not done that. Interview with MDS nurse #2 on 4/4/13 at 2:00 PM revealed the tray would not be a restraint if a resident would be able to feed themselves. The most recent MDS was reviewed with MDS Nurse #2 which assessed Resident #48 as requiring total assistance with eating. MDS Nurse #2 explained Resident #48 did vary in her physical functioning, but would hold a spoon, sometimes her liquids, or she would do her own cups. If she feeds herself a few bites and the staff follow up and complete the meal, the MDS would be coded as total assistance. The interview continued with questions regarding a decline since the 3/5/13 MDS assessment. Observations were shared with the MDS nurse #2 of the resident not attempting to eat or drink or of staff not offering food or drink while seated with the table top in place. MDS nurse #2 was not able to state if Resident #48 had experienced a decline or had stop feeding herself.	F 221			
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	F 356			

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F 356	<p>Continued From page 5</p> <p>resident care per shift:</p> <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. <p>o Resident census.</p> <p>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:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and record review the facility failed to post accurate daily staff postings in a clear and readable format for 6 consecutive days.</p> <p>Findings included:</p> <p>On 4/1/13 at 10:00am an initial tour of the facility was conducted. The daily staff posting was posted at the nurse's station between Spring and Summer halls. Staff posting was listed for the dates 3/30/13 - 4/1/13. It was noted that on each</p>	F 356	<p>F 356</p> <p>The facility believed it was posting the nurse staffing data as required. Once the facility was made aware of the concern regarding the posting requirements, the Administrator revised the form utilized and the information posted for April 4th.</p> <p>The form utilized to post nurse staffing data was revised to include hours instead of number of staff. (See attached form.)</p> <p>The Director of Nursing (DoN) instructed staff, involved in gathering and displaying nurse staffing information, on the form revision. The nurse staffing information consistent with the guidelines has been posted since April 4, 2013.</p> <p>The DoN or designee will monitor the displayed posting at least twice a week through the month of April to assure guidelines are met.</p> <p>As part of the Quality Assessment and Assurance (QAA) process, a report will be provided to the QAA committee regarding the compliance monitoring.</p> <p>Completion date: 04/05/13</p>	04/05/13	

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F 356	Continued From page 6 day the total and actual number of staff hours, for licensed and unlicensed staff, was not listed on the posting. The posting listed the resident census, the nursing hours per patient day (NHPPD), and full-time equivalents (FTE's). On 4/2/13 - 4/4/13 the daily staff postings did not list the total and actual number of staff hours. The Director of Nursing (DON) was interviewed on 4/4/13 at 1:52pm regarding the posting of staff hours. She indicated that she monitors to be sure that the form is posted, does not complete it herself, and that it is completed daily by the "nurse supervisor on the Spring hall. Today is was [Registered Nurse (RN) #1]." She stated, "I remember when we first started doing this form and my thoughts are, "Who can really understand these numbers anyway?" The DON indicated that she was not aware that the total and actual number of staff hours should be listed on the posting in a clear and readable format. On 4/4/13 at 2:15pm, RN#1 was interviewed and indicated that she completed the staff posting on the days that she works. She indicated that she was not aware that the total and actual number of staff hours should be listed on the posting in a clear and readable format.	F 356		
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	F 431		

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F 431	<p>Continued From page 7</p> <p>controlled drugs is maintained and periodically reconciled.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, pharmacy consultant interview and policy review the facility failed to maintain temperatures in the medication refrigerator between 36 degrees Fahrenheit to 46 degrees Fahrenheit to prevent compromise of the integrity of the insulins. The facility failed to have a door covering the freezer with insulins stored in the top shelf compartment to the refrigerator</p>	F 431	<p>F431</p> <p>The facility utilizes a clinical pharmacy to provide the system and services of licensed pharmacists that are in accordance with state and federal guidelines related to drugs and biologicals, their records, labeling and storage. There are multiple checks and balances to monitor the various drug and biological systems.</p> <p>To ensure consistent storage temperatures, the log was amended to remind staff responsible for monitoring and recording temperatures of the recommended temperature range.</p> <p>Licensed nurses were retrained by the Director of Nursing (DoN) from 04/04/13 through 04/11/13 on the medication refrigerator temperature range and what to do if a reading is out of range.</p> <p>The medication room refrigerator was replaced with one that had a freezer compartment with a separate door.</p> <p>The DoN or Designee will be responsible to audit the temperature log weekly to ensure compliance. The Licensed Pharmacist will continue to audit medication room monthly including log as an additional check.</p> <p>The DoN or Designee will provide a report to the facility Quality Assurance Committee monthly for the next quarter and/or until satisfied that the desired results are achieved.</p> <p>Completion Date: 04/12/13</p>	04/12/13
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F 431	<p>Continued From page 8 door. This was for one of one medication refrigerators.</p> <p>The findings included:</p> <p>Review of a document " Medication Storage and Security " which was not dated, gave instructions on medication storage. " Medications that require refrigeration will be kept in the medication room refrigerator. The temperature shall be maintained at 36-46 degrees F. (Fahrenheit) ... "</p> <p>Observations on 4/2/13 of the refrigerator in the medication room at 11:00 AM revealed multidose insulin vials were stored on the shelf compartments on the inside of the refrigerator door. The freezer was frosted with ice accumulation and had no door to block the freezer air from the insulins on the inside of the refrigerator door. The top shelf was near the freezer compartment when closed. There were five opened multidose insulins stored in this top shelf compartment. Review of an insert for one of the insulins revealed manufacturer ' s recommendations were to keep the insulin from freezing temperatures. The refrigerator temperature control logs for the months of March 2013 and April 2013 were posted on the wall of the medication room. Review of the recorded temperature checks revealed the following: 3/1/13 , 3/9 and 3/14/13 temperatures were 32 degrees F, 3/2, 3/3, 3/5, 3/7, 3/12, 3/13/13 temperatures were 34 degrees F; and on 4/1/13 temperature was 34 degrees F. There were three days in March with no recorded temperature checks. The remaining days had temperatures in the specified ranges.</p>	F 431		

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F 431	Continued From page 9 Interview with nurse #3 on 4/1/13 at 11:05 AM revealed she was not aware the medication refrigerator temperature should be at 36 degrees. Further interview revealed she was not aware insulin multidose vials should not be kept at freezing temperatures or the medication would be compromised. Follow up interview with Administrative nursing staff #1 on 4/2/13 at 1:45 PM revealed she had checked the policy for medication storage and the temperature and it was supposed to be 36 degrees Fahrenheit to 46 degrees Fahrenheit. She was not aware the refrigerator temperatures had been too cold. An interview was conducted by phone on 4/4/13 at 9:52 AM with the pharmacy consultant regarding medication storage in the refrigerator. The consulting pharmacist does check the temperatures of the medication refrigerator during her visits. She had not noticed temperatures being out of range at her monthly visits to the facility. The pharmacy consultant was not sure the exact range of the temperatures but freezing would be too cold.	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345196	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/04/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VISTA HEALTH PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 106 MOUNTAIN VISTA RD DENTON, NC 27239		
(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 441	<p>Continued From page 10</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and policy review one of five nurses failed to wash her hands between tasks that involved invasive procedures and medication administration observed during medication administration (Resident #41) and a direct care staff member failed to wash her hands between resident to resident care during dining (Resident #50 and</p>	F 441	<p>F441</p> <p>It has been the philosophy and normal practice of this facility to maintain an Infection Control program that provides a safe, sanitary and comfortable environment that helps prevent the development and transmission of disease and infection. The facility has an established Infection Control Program with policies and procedures designed to maintain these goals. Data regarding infections, physician reviews, consultant reviews, quality assurance monitoring and staff training are examples of the many components utilized.</p> <p>Refresher training was provided to licensed nurses by the Director of Nursing (DoN) and Staff Development Coordinator (SDC) on glove use and handwashing procedures including but not limited to while performing tasks involving invasive procedures and medication administration.</p> <p>Refresher training was provided to nursing staff by DoN and SDC on infection control practices including but not limited to handwashing procedures and glove use during feeding assistance, utensil handling and handling of soiled items for avoidance of potential cross contamination.</p> <p>After re-training Nurse #4's technique was observed by DoN and SDC. Nurse #4 demonstrated correct technique proficiency in handwashing techniques during tasks involving invasive procedures and medication administration.</p>		

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F 441	Continued From page 11 #30) and after touching soiled clothing protectors and returning to assist with feeding. The findings include: 1. Review of the policy with instructions for hand washing included: " Methods of Compliance " no date. " A. Work Practices ... #2. Hand washing - This facility ensures that all employees wash hands using soap, running water and friction in the following situations: b. Immediately after or as soon as feasible following contact with blood or other potentially infectious materials (other skin should be washed with soap and water and mucous membranes flushed with water after such contact); c. Immediately or as soon as feasible after removal of gloves or other personal protective equipment. During medication pass on 4/2/13 at 3:45 PM with Nurse #4 observations of a finger stick blood sugar was performed on Resident # 41. Nurse #4 returned to the medication cart, disposed of the glucose strip and lancet, stored the glucometer in its container, removed her gloves and began to prepare the insulin injection. After the insulin was administered to Resident #41, nurse #4 disposed of the syringe, removed her gloves and started to proceed with the next resident ' s finger stick blood sugar check. Interview with nurse #4 at 3:49 PM on 4/2/13 revealed she usually uses the hand sanitizer, but was nervous being watched during med pass. Nurse #4 stopped, washed her hands before proceeding with the next finger stick blood sugar	F 441	After refresher training Nurse Aide #1's technique was observed by charge nurses, DoN and SDC. Nurse Aide #1 demonstrated correct technique proficiency in handwashing techniques during feeding, handling of utensils and handling of soiled items. DoN/or designee will observe at least two licensed staff weekly during medication/treatment administration to assure compliance with handwashing policy for 1 month. The Pharmacy consultant will also observe at least two licensed staff as stated above, during routine monthly visits for 3 months The Quality Assessment and Assurance (QAA) committee will review the observation reports monthly for the next three months. Completion Date 04/18/13	04/18/13

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F 441	<p>Continued From page 12 check.</p> <p>Interview with Administrative nurse staff #1 on 4/4/13 at 2:35 PM revealed the nurse should have washed her hands after the finger stick was completed and after the injection was administered. Her hands should be washed after any invasive procedure.</p> <p>2. The facility's infection control policy related to hand washing procedures, which was undated, indicated that employees are expected to wash their hands using soap, running water and friction immediately after, or as soon as feasible, following contact with potentially infectious materials and immediately, or as soon as feasible, after removal of gloves or other personal protective equipment. It further indicated that hand washing facilities are " readily accessible to employees at the facility " including in the kitchen and activity room.</p> <p>On 4/3/13 at 1:20 pm, Nursing Assistant (NA) #1 was observed during the lunch meal in the dining room. She was wearing gloves and feeding Resident #50 a peanut butter and jelly sandwich and soup. NA#1 wiped the mouth of Resident #50 with the resident's bib. NA #1 patted Resident #50 on the shoulder, walked to Resident #30's table, picked up Resident #30's cup by the mouth of the cup and moved it closer to the resident. She did not change gloves or wash her hands in between the residents. A hand washing area was located in the dining room, to the right side of the door leading from the dining room into the kitchen.</p>	F 441			

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F 441	Continued From page 13 On 4/3/13 at 1:25 pm, NA #1 picked up dirty trays, plates, cups, and utensils from various tables in the dining room and placed the dirty items in the food cart. She did not change gloves or wash her hands after handling the dirty items. On 4/3/13 at 1:27 pm, NA #1 walked back to Resident #30. She picked up the resident's ice cream cup, picked up her spoon, placed it in the ice cream cup and handed it to the resident. She did not change gloves or wash her hands before handling the resident's ice cream cup or spoon. On 4/3/13 at 1:30 pm NA #1 was interviewed and indicated she washes her hands in between residents and after feeding them. On 4/4/13 at 10:00 am the DON was interviewed regarding infection control. She indicated that she was the infection control representative for the facility. She indicated that staff wear gloves when feeding residents and are trained to change gloves and wash hands in between feeding residents.	F 441		
F 468 SS=E	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to equip 2 of 2 corridors with firmly secured handrails (summer corridor, spring hall corridor).	F 468	F468 It has always been the practice of this facility to maintain handrails throughout the facility that are securely affixed. The facility has policies and procedures designed to maintain this goal. The facility has an established Quality Assessment & Assurance Program (QAA) which includes the monitoring of environmental and physical plant areas. Handrails are evaluated at least monthly as part of the QAA/Safety reviews. The current handrails were installed with a renovation project less than 5 years ago. The movement referenced has not changed or deteriorated in condition since installation and was found to be in compliance over the past 4 Annual and Life Safety inspections.	

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F 468	Continued From page 14 The findings include: Observation on 4-4-12 at 1:00pm revealed 13 loose handrails on 2 of 2 corridors. 1 handrail located outside of the facilities utility room revealed 1 exposed nail as evidenced by a bracket screw being exposed. Further observation revealed 1 handrail with the metal exposed located across from the nursing station. Loose handrails were observed outside resident rooms (spring corridor) 48, 49, 53, 55, 58, 59 and out side resident rooms (summer corridor) 60, 62, 64, 71, and 73. During an interview on 4-4-13 at 1:15pm, the Maintenance Director indicated he was made aware of needed repairs by work orders submitted by staff or requests from residents. The Maintenance Director further indicated he had not observed any work orders in regards to loose handrails. The Maintenance Director revealed that he periodically checked corridor handrails to identify potential maintenance concerns. On 4-4-13 at 1:16pm, the Maintenance Director observed handrails and indicated they were loose. The Maintenance Director further indicated that handrails may have become loose by furniture that was moved throughout the facility. The maintenance director provided examples of hospital beds and other medical devices that are repeatedly pushed up against the handrails. During an interview on 4-4-13 at 3:54pm, the Administrator revealed handrails were a part of	F 468	The facility respectfully disputes the findings and asserts the intent of this regulation was being met. Both sides of the facility corridors were equipped with handrails that were safely secured per manufacture's recommendations. The handrail is a high impact molded material widely used throughout the United States in healthcare corridors. The design allows for movement while maintaining integrity and safety. The findings would appear to encompass a difference in opinion of what constitutes the meaning of firmly secure. The 2567 uses words "loose" or "not secure" to apply to a slight movement of the high impact molded portion of the handrail but ignores that after repeated weight bearing attempts (in excess of 250 lbs.) the handrails remained securely fastened to the wall and did not remotely present a non-secure or unsafe situation. Further the provider would like the record to reflect a dispute with staff comments reflected in the findings. The conversations referenced with the Maintenance Director and Administrator does not convey the wording or context of those conversations. An example being the Maintenance Director didn't say hospital beds and other medical devices are repeatedly pushed up against the handrails. Nor did he		

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F 468	Continued From page 15 the facility Quality Assurance Review process. The Administrator indicated that the Maintenance Director performed his own Quality Assurance Review on the facility handrails. On 4-4-13 at 4:00pm, the Administrator observed handrails and indicated that not many residents use the handrails. The Administrator identified the handrails as a "A little loose." The Administrator further indicated that items pushed up against the handrails could be the cause for handrails to become loose.	F 468	imply the handrails were not firmly secure or unsafe. Nor did the Administrator say "not many residents use the handrail." The Administrator said, although handrails are an important safety feature, I'm not aware of any of our current residents who choose to use the handrails. They either walk in the middle of the corridor or use a walker or other assistive devices. Or that the handrails were "A little loose." The administrator said I disagree you say a little loose I would call it slight movement. Although we disagree with the findings the following plan of correction was implemented: On 04/04/13 the round corner cover and cover fastener referenced was adjusted and the referenced gap between the joint improved by maintenance. All handrails in the facility have been re-assessed by maintenance with input from the manufacturer's representative to ensure compliance with manufacturer's specifications for life safety compliance regarding being properly secured. Maintenance will monitor handrails weekly for function and safety for a month. Since handrails were already a part of the monthly safety review that report will continue to be assessed as a part of the monthly QAA process.	04/19/13	

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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 Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, one story, with a complete automatic sprinkler system.	K 000	Mt. Vista Health Park submits this Plan of Correction (PoC) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this PoC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services (CMS), the State of North Carolina or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.		
K 018 SS=D	The deficiencies determined during the survey are as follows: NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: 42 CFR 483.70(a)	K 018			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Kathy McDonald

TITLE

Administrator

(X8) DATE

05/14/13

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 018	Continued From page 1 By observation on 4/30/13 at approximately noon the following corridor doors were observed as non-compliant, specific findings include; A. The door handle to the nursing facility conference room/oxygen storage was missing. B. The door to the clean linen room on the nursing facility side did not close and latch tightly in it's frame.	K 018	K 018 The provider strives to ensure all doors that should latch do so. The facility has policies and procedures designed to maintain these goals. Maintenance work orders, routine maintenance checks, safety committee audits and meetings, and various quality assurance measures are examples of the many components utilized. Doors are evaluated at least monthly as part of the Quality Assessment & Assurance (QAA) Program and safety inspections.	
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025	The two referenced doors were in the process of being repaired by maintenance. Parts had to be ordered. The needed hardware was ordered prior to the survey. The hardware had arrived the day before. The new hardware was installed by maintenance on the day of the survey (04/30/13). Remaining doors were evaluated for latching. No other non-latching doors were found.	
K 045 SS=D	This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 4/30/13 at approximately noon the following fire/smoke barrier was observed as non-compliant, specific findings include; penetration with cable wires had not been sealed to maintain barrier. (Attic access was in summer hall group bath.) NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in	K 045	Facility staff members were reminded to report any non-latching doors by completing a maintenance form.	

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K 045	Continued From page 2 darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 4/30/13 at approximately noon the following corridor doors were observed as non-compliant, specific findings include; A. A single light bulb at the discharge from the activities room B. Lighting must be arranged to provide light from the exit discharge leading to the public way (parking lot). The walking surfaces within the exit discharge shall be illuminated to values of at least 1 ft-candle measured at the floor. Failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candles in any designated area. NFPA 101 7.8.1.1, 7.8.1.3, and 7.8.1.4.	K 045	K018 CONTINUED Doors are monitored monthly as part of the facility safety inspections conducted by the Maintenance Director or designee. Facility safety inspections are reviewed monthly by the QAA Committee. Completion Date: 04/30/13	
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	K 025 The provider strives to ensure penetrations in any smoke barrier are sealed with fire rated material to ensure smoke resistance. The facility has policies and procedures designed to maintain these goals. Routine maintenance checks, safety committee audits and meetings, and various quality assurance measures are examples of the many components utilized. Smoke barriers are inspected at least monthly for non-sealed penetration as part of the Quality Assessment & Assurance (QAA) Program and safety inspections. Maintenance used fire rated caulk to seal the hole around the cable wire in the attic on 04/30/13.	

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K 052	Continued From page 3 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 4/30/13 at approximately noon the following fire alarm system was observed as non-compliant, specific findings include; A. The audible signal had a broken wire and did not sound with loss of power, sprinkler tamper nor loss of battery back-up. B. The telephone line to the fire alarm panel could not be tested for compliance without a quick disconnect.	K 052	K025 CONTINUED The hole around the cable was an isolated oversight. Maintenance re-checked the remaining smoke barrier walls for other potential non-sealed penetrations. No additional non-sealed areas were found. Maintenance will assess all areas after any outside service/repairs to ensure penetrations are sealed. Completion Date: 04/30/13	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 066	K 045 It has always been the goal and practice of the facility to provide means of egress illumination. The facility has policies and procedures designed to maintain this goal. The facility has an established Quality Assessment & Assurance Program (QAA) Program which includes the monitoring of environmental and physical plant areas. Egress illumination is evaluated at least monthly as part of the QAA/ Safety inspections. Maintenance replaced the fixture referenced at the Activities Room exit on 05/01/13 with a multiple bulb fixture to ensure continued illumination in the event of a single bulb failure.	

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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)	(X6) COMPLETION DATE
K 066	Continued From page 4	K 066	Other exit discharge fixtures were evaluated. One additional fixture (at the back of the building at the exit sidewalk) was replaced with a multiple bulb fixture.	
K 069 SS=D	<p>This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 4/30/13 at approximately noon the following smoking regulations were observed as non-compliant, specific findings include;</p> <p>A. Ashtrays of noncombustible material and safe design per paragraph 3 above were not provided in the front smoking area.</p> <p>B. A metal container with a self-closing cover into which ashtrays can be emptied in the smoking area per paragraph 4 above was not provided in the front smoking area.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96</p> <p>This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 4/30/13 at approximately noon the following cooking facilities per NFPA 96 was observed as non-compliant, specific findings include; there was not a class "K" fire extinguisher located in the kitchen area.</p>	K 069	<p>The exit discharge walking surfaces on the back of the building were lit by lights supplied by the power company (pole lights) which exceed walkway lighting requirements. Two additional fixtures connected to the facility's emergency generator system will be added on 05/21/13 to ensure walkway lighting in the event of a power failure.</p> <p>Egress lights are monitored monthly as part of the facility safety inspections conducted by the Maintenance Director or designee.</p> <p>Facility safety inspections are reviewed monthly by the QAA Committee.</p> <p>Completion Date: 05/21/13</p>	

K 066

It has always been the intent and normal practice of the facility to provide ashtrays of safe design, made from noncombustible materials and maintain metal containers with self-closing covers into which ash trays can be emptied into. The facility has policies and procedures designed to maintain these goals. The facility has an established Quality Assessment & Assurance Program (QAA) Program which includes the monitoring of environmental and physical plant areas. Smoking safety is evaluated at least monthly as part of QAA/ Safety audits.

The ashtray(s) at the front smoking area were replaced on 05/16/13 with ashtray(s) made of noncombustible material and the metal container used for the emptying of ashes was replaced with a self closing container.

The other smoking areas were reviewed for ashtray(s) and ash receptacle(s) that meet the standard. No other areas needed replacing.

Clarification was given to facility staff members regarding ashtrays and containers designed to meet the standard. Staff members were instructed to report to maintenance the presence of any not meeting the standard.

The Housekeeping Supervisor will monitor ashtrays and metal containers weekly for the next month and then monthly for the next 2 months.

Completion Date: 05/18/13

K069

It has always been the intent and practice of the facility to provide required fire extinguishers. The facility has policies and procedures designed to maintain this practice. Routine maintenance checks, Fire Marshal inspections, outside vendor inspections, safety committee audits and meetings, and various quality assurance measures are examples of the many components utilized. The fire extinguishers and fire suppression system is checked monthly by the maintenance staff and bi-annually by an outside contract vendor as part of the Quality Assessment & Assurance (QAA) Program and safety inspections.

Although the facility had been informed by the contract vendor and Fire Marshal that the hood suppression system provided the required Class-K extinguishing coverage, a Class-K fire extinguisher was mounted in the kitchen on 05/02/13.

The maintenance staff will check the extinguisher monthly and be inspected by a licensed inspector at least annually.

Completion Date: 05/02/13

K 052

The provider strives to ensure proper functioning of the fire alarm system. The facility has policies and procedures designed to maintain these goals. Routine maintenance checks, safety committee audits and meetings, fire marshal inspections and various quality assurance measures are examples of the many components utilized. The fire alarm system is checked monthly by the maintenance staff and bi-annually by an outside contract vendor as part of the Quality Assessment & Assurance (QAA) Program and safety inspections.

The provider strives to ensure the electrical wiring and equipment is in accordance with state and federal regulations.

The alarm was properly functioning on 04/25/13 as the contract vendor had conducted a review of the fire equipment. The audible signal was functioning during that service visit.

Maintenance replaced the broken wire on 04/30/13.

Although testing of the monitoring line could have been done through several already available options, the fire alarm vendor installed on 5/29/13 05/15/13 a test mechanism switch for ease/convenience.

Monthly facility safety and bi-annual vendor inspections are reviewed monthly by the QAA Committee.

Completion Date: 05/15/13
5/30/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345198	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VISTA HEALTH PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 106 MOUNTAIN VISTA RD DENTON, NC 27239		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 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 Existing Health Care section of the LSC and its referenced publications. This building is Type III construction one story, with a complete automatic sprinkler system.	K 000	Mt. Vista Health Park submits this Plan of Correction (PoC) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this PoC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services (CMS), the State of North Carolina or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/2 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: 42 CFR 483.70(a)	K 018			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Kathy McDonald

TITLE

Administrator 05/14/13

(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.

DRW

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345196	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 04/30/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VISTA HEALTH PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 105 MOUNTAIN VISTA RD DENTON, NC 27238		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 018	Continued From page 1 By observation on 4/30/13 at approximately noon the following corridor doors were observed as non-compliant, specific findings include; A. The door handle to the nursing facility conference room/oxygen storage was missing. B. The door to the clean linen room on the nursing facility side did not close and latch tightly in it's frame.	K 018	K 018 The provider strives to ensure all doors that should latch do so. The facility has policies and procedures designed to maintain these goals. Maintenance work orders, routine maintenance checks, safety committee audits and meetings, and various quality assurance measures are examples of the many components utilized. Doors are evaluated at least monthly as part of the Quality Assessment & Assurance (QAA) Program and safety inspections.		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4	K 025	The two referenced doors were in the process of being repaired by maintenance. Parts had to be ordered. The needed hardware was ordered prior to the survey. The hardware had arrived the day before. The new hardware was installed by maintenance on the day of the survey (04/30/13). Remaining doors were evaluated for latching. No other non-latching doors were found.		
K 045 SS=D	This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 4/30/13 at approximately noon the following fire/smoke barrier was observed as non-compliant, specific findings include; penetration with cable wires had not been sealed to maintain barrier. (Attic access was in summer hall group bath.) NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in	K 045	Facility staff members were reminded to report any non-latching doors by completing a maintenance form.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345196	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01: MAIN BUILDING 01 B. WING: _____		(X3) DATE SURVEY COMPLETED 04/30/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VISTA HEALTH PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 106 MOUNTAIN VISTA RD DENTON, NC 27239		
(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 REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 045	Continued From page 2 darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 4/30/13 at approximately noon the following corridor doors were observed as non-compliant, specific findings include; A. A single light bulb at the discharge from the activities room B. Lighting must be arranged to provide light from the exit discharge leading to the public way (parking lot). The walking surfaces within the exit discharge shall be illuminated to values of at least 1 ft-candle measured at the floor. Failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candles in any designated area. NFPA 101 7.8.1.1, 7.8.1.3, and 7.8.1.4.	K 045	K018 CONTINUED Doors are monitored monthly as part of the facility safety inspections conducted by the Maintenance Director or designee. Facility safety inspections are reviewed monthly by the QAA Committee. Completion Date: 04/30/13		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4	K 052	K 025 The provider strives to ensure penetrations in any smoke barrier are sealed with fire rated material to ensure smoke resistance. The facility has policies and procedures designed to maintain these goals. Routine maintenance checks, safety committee audits and meetings, and various quality assurance measures are examples of the many components utilized. Smoke barriers are inspected at least monthly for non-sealed penetration as part of the Quality Assessment & Assurance (QAA) Program and safety inspections. Maintenance used fire rated caulk to seal the hole around the cable wire in the attic on 04/30/13.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345186	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 04/30/2013
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VISTA HEALTH PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 106 MOUNTAIN VISTA RD DENTON, NC 27239	
(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 ENTRY)	(X5) COMPLETION DATE
K 052	Continued From page 3.	K 052	K025 CONTINUED	
K 068 SS=D	<p>This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 4/30/13 at approximately noon the following fire alarm system was observed as non-compliant, specific findings include;</p> <p>A. The audible signal had a broken wire and did not sound with loss of power, sprinkler tamper nor loss of battery back-up. B. The telephone line to the fire alarm panel could not be tested for compliance without a quick disconnect.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoking regulations are adopted and include no less than the following provisions:</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p>	K 066	<p>The hole around the cable was an isolated oversight. Maintenance re-checked the remaining smoke barrier walls for other potential non-sealed penetrations. No additional non-sealed areas were found.</p> <p>Maintenance will assess all areas after any outside service/repairs to ensure penetrations are sealed.</p> <p>Completion Date: 04/30/13</p> <p>K 045</p> <p>It has always been the goal and practice of the facility to provide means of egress illumination. The facility has policies and procedures designed to maintain this goal. The facility has an established Quality Assessment & Assurance Program (QAA) Program which includes the monitoring of environmental and physical plant areas. Egress illumination is evaluated at least monthly as part of the QAA/ Safety inspections.</p> <p>Maintenance replaced the fixture referenced at the Activities Room exit on 05/01/13 with a multiple bulb fixture to ensure continued illumination in the event of a single bulb failure.</p>	

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VISTA HEALTH PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 108 MOUNTAIN VISTA RD DENTON, NC 27299		
(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)	(X5) COMPLETION DATE	
K 066	Continued From page 4 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 4/30/13 at approximately noon the following smoking regulations were observed as non-compliant, specific findings include; A. Ashtrays of noncombustible material and safe design per paragraph 3. above were not provided in the front smoking area. B. A metal container with a self-closing cover into which ashtrays can be emptied in the smoking area per paragraph 4 above was not provided in the front smoking area.	K 066	K045 CONTINUED		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3, 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 4/30/13 at approximately noon the following cooking facilities per NFPA 96 was observed as non-compliant, specific findings include; there was not a class "K" fire extinguisher located in the kitchen area.	K 089	Other exit discharge fixtures were evaluated. One additional fixture (at the back of the building at the exit sidewalk) was replaced with a multiple bulb fixture. The exit discharge walking surfaces on the back of the building were lit by lights supplied by the power company (pole lights) which exceed walkway lighting requirements. Two additional fixtures connected to the facility's emergency generator system will be added on 05/21/13 to ensure walkway lighting in the event of a power failure. Egress lights are monitored monthly as part of the facility safety inspections conducted by the Maintenance Director or designee. Facility safety inspections are reviewed monthly by the QAA Committee. Completion Date: 05/21/13		

K 066

It has always been the intent and normal practice of the facility to provide ashtrays of safe design, made from noncombustible materials and maintain metal containers with self-closing covers into which ash trays can be emptied into. The facility has policies and procedures designed to maintain these goals. The facility has an established Quality Assessment & Assurance Program (QAA) Program which includes the monitoring of environmental and physical plant areas. Smoking safety is evaluated at least monthly as part of QAA/ Safety audits.

The ashtray(s) at the front smoking area were replaced on 05/16/13 with ashtray(s) made of noncombustible material and the metal container used for the emptying of ashes was replaced with a self closing container.

The other smoking areas were reviewed for ashtray(s) and ash receptacle(s) that meet the standard. No other areas needed replacing.

Clarification was given to facility staff members regarding ashtrays and containers designed to meet the standard. Staff members were instructed to report to maintenance the presence of any not meeting the standard.

The Housekeeping Supervisor will monitor ashtrays and metal containers weekly for the next month and then monthly for the next 2 months.

Completion Date: 05/18/13

K069

It has always been the intent and practice of the facility to provide required fire extinguishers. The facility has policies and procedures designed to maintain this practice. Routine maintenance checks, Fire Marshal inspections, outside vendor inspections, safety committee audits and meetings, and various quality assurance measures are examples of the many components utilized. The fire extinguishers and fire suppression system is checked monthly by the maintenance staff and bi-annually by an outside contract vendor as part of the Quality Assessment & Assurance (QAA) Program and safety inspections.

Although the facility had been informed by the contract vendor and Fire Marshal that the hood suppression system provided the required Class-K extinguishing coverage, a Class-K fire extinguisher was mounted in the kitchen on 05/02/13.

The maintenance staff will check the extinguisher monthly and be inspected by a licensed inspector at least annually.

Completion Date: 05/02/13

K 052

The provider strives to ensure proper functioning of the fire alarm system. The facility has policies and procedures designed to maintain these goals. Routine maintenance checks, safety committee audits and meetings, fire marshal inspections and various quality assurance measures are examples of the many components utilized. The fire alarm system is checked monthly by the maintenance staff and bi-annually by an outside contract vendor as part of the Quality Assessment & Assurance (QAA) Program and safety inspections.

The provider strives to ensure the electrical wiring and equipment is in accordance with state and federal regulations.

The alarm was properly functioning on 04/25/13 as the contract vendor had conducted a review of the fire equipment. The audible signal was functioning during that service visit.

Maintenance replaced the broken wire on 04/30/13.

Although testing of the monitoring line could have been done through several already available options, the fire alarm vendor installed on 05/15/13 a test mechanism switch for ease/convenience.

Monthly facility safety and bi-annual vendor inspections are reviewed monthly by the QAA Committee.

Completion Date: 05/15/13

5/30/13

5/30/13