STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345173	A. BUILDING _____ B. WING _____	C 04/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNN HEALTH & REHAB CENTER	201 NORTH ELLIS AVENUE DUNN, NC 28334

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation conducted 4/26/13. Event ID# 84JP11.	F 000	By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. No resident experienced any negative outcome from this cited deficiency.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, and pharmacist interview, the facility failed to manage pain by failure to ensure that pain medication Norco 5/325 mg (milligram) tablet as needed for pain was administered and Fentanyl 25 mcg (microgram) patch was applied every 72 hours for 1 of 1 sampled resident (Resident #66) reviewed for pain management. The findings included: Resident #66 was admitted into the facility on 11/29/12. Diagnoses included Generalized Pain, Chronic Pain, and End Stage Renal Disease. The quarterly minimum data set completed on 3/1/13 indicated Resident #66 was cognitively intact. The five day look back period indicated that as needed pain medication was received, offered or declined. The presence of pain per the resident pain interview stated that pain was present with a frequency of rarely. Pain was indicated as had an	F 309	F309 Criteria #1: Pain medication was obtained and administered to resident #66 as order by physician. Criteria #2: Complete audit of current residents' medication administration records were conducted by Director of Nursing and designees to identify any residents potentially at risk for a medication not being available for administration.	4/23/13 4/23/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Shelly Sims

TITLE: Administrator

(X6) DATE: 5/9/13

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.

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
	345173	A. BUILDING _____ B. WING _____	C 04/26/2013

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F 309	Continued From page 1 effect on function. Pain intensity on a numerical scale of 00 - 10 revealed a pain level intensity score of 3. The most recent care plan dated 12/31/12 identified pain as a problem. Interventions to control pain read in part "1) administer pain medication as needed, 2) assess for pain ever shift, 4) eliminate or reduce causative factors, 5) place on pain management 6) observe for non verbal signs and symptoms of pain." There was no updated or revised care plan for review after 12/31/12. A review of the medication administration record (MAR) revealed an order initiated on 3/11/13 that read "Oxycodone with Tylenol 5 mg/325 mg (milligrams) take one - two tablets by mouth every four hours as needed." The MAR indicated no administered doses for April 2013. A review of a telephone order dated 4/6/13 revealed an order that read "Norco 5/325 mg two tablets by mouth every six hours as needed for pain." A review of a telephone and hard script order signed by the physician on 4/7/13 read "Fentanyl patch 25 mcg (micrograms) apply every 72 hours." A review of a pharmacy clarification message faxed to the facility on 4/8/13 read "Attention staff: please refax the script" due to the hard script (Fentanyl patch) was covering the telephone order (Fentanyl patch). A review of the MAR for April 2013 revealed the Fentanyl patch was never applied as ordered by the physician.	F 309	Criteria #3: Narcotic Stat box will be obtained from pharmacy to ensure narcotic medications are readily available. Nurses ordering medications that require hard scripts will contact the physician for hard script and make a notation on the 24 hour report. The nurse will contact the physician if pain medication ordered is not in stat box for alternative order. Criteria #4: Education will be conducted with licensed nursing staff regarding medication administration, ordering of controlled substances, and on policy and procedures related to narcotic stat box by the Director of Nursing or designee.	5/24/13 5/24/13

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F 309	Continued From page 2 A review of the MAR revealed that Norco 5/325 mg two tablets by mouth was last administered for pain on 4/17/13 at 8:50 am, with no specific location of pain indicated, with effective results at 9:50 am. During a medication observation on 4/23/13 at 9:00 am, Resident #66 requested pain medication from Nurse #2 with facial grimace of pain at the time of the request. In an interview on 4/23/13 at 9:10 am, Nurse #2 stated that Norco as needed for pain was not available on the medication cart and that she would have to obtain the medication from the back up pharmacy. During an observation on 4/23/13 at 9:17 am, Nurse #2 informed Resident #66 that the Norco 5/325 mg tablets was not available on the medication cart and that he would have to wait until she obtained the medication from the back up pharmacy. Resident #66 replied "I'm in pain and I need my pain medication." During an observation on 4/23/13 at 9:30 am, Resident #66 was observed propelling self in the wheelchair throughout the corridor with continued facial grimace of pain. In an interview on 4/23/13 at 9:35 am, Resident #66 described his pain as "aching" on a pain scale of 00 - 10 with "10" being his current pain level to his left lower back. He indicated he'd being having pain for about 2 months to his left lower back.	F 309	Criteria #5: Director of Nursing or Designee will audit 10 resident's medication administration records to verify pain medication were administered per physician order daily x 2 weeks, weekly x 2, monthly x 2. Results from these audits will be reviewed by the facility Quality Assurance Committee for further recommendations as deemed necessary.	5/24/13

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F 309	Continued From page 3 During an observation on 4/23/13 at 9:45 am, Resident #66 was observed in the smoking area rubbing his left lower back with his hand, with continued facial grimace. In an interview on 4/23/13 at 10:10 am, Nurse #2 stated that she had called the physician to obtain a hard script for the Norco due to the medication was not available in the facility. She added the physician gave an order to administer Tylenol 500 mg two tablets by mouth for pain. She concluded that she administered the Tylenol 500 mg two tablets by mouth at 10:00 am (1 hour delay from Resident #66 initial request) for breakthrough pain. She added she was not sure why the Norco was not available at the time that Resident #66 requested for pain. In an interview on 4/23/13 at 10:15 am, Resident #66 indicated his pain level was "10 and aching" to his left lower back and that he didn't understand why his pain medication was not available when he requested it for pain. In an interview on 4/23/13 at 4:18 pm, pharmacist #1 stated per his review of Resident #66 pharmacy profile there was a telephone order on file dated 4/6/13 for Norco 5/325 mg two tablets as needed every six hours. The pharmacist indicated that the pharmacy could not dispense or send a controlled medication to the facility without the proper hard script signed by the physician. Pharmacist #1 concluded it was the facility responsibility to ensure that the hard script for a controlled medication was sent to the pharmacy, to ensure the prescribed medication was supplied to the facility by the pharmacy.	F 309		

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F 309	Continued From page 4 In an interview on 4/25/13 at 9:42 am, the assistant director of nursing (ADON) stated the facility did not have a standing order system in place for administration of medications, wherein, nurses followed a facility protocol for administration of as needed pain (PRN) medications. She elaborated the nurses were expected to contact the physician to obtain an order for such each time. The ADON indicated expectation was that pain meds were administered as ordered per the MAR and that medications were available at all times for pain management. The ADON indicated that she expected if a resident complained of pain that the medication was available on the medication cart and administered immediately. She concluded that she expected the Fentanyl clarification request form pharmacy to have been refaxed as requested on 4/8/13 to ensure the medication was received and administered as ordered. In a telephone interview on 4/26/13 at 3:05 pm, medication Nurse #3 acknowledged that she was the primary nurse for Resident #66 on 4/8/13 from 7:00 am - 7:00 pm. She indicated that she was not aware that there was an order faxed from the pharmacy on 4/8/13 that requested the telephone and hard script order for the Fentanyl patch to be refaxed to pharmacy. She indicated that she did not recall the Fentanyl patch ever applied to Resident #66 and that the night shift nurse was responsible for completing the twenty four hour chart checks to ensure physician orders were carried out. In a telephone interview on 4/26/13 at 4:15 pm, medication Nurse #4 (night nurse) acknowledged that she was the primary nurse for Resident #66	F 309		

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F 309	Continued From page 5 on 4/8/13 from 7:00 pm - 7:00 am. She stated that she recalled Nurse #3 verbally stating to her on 4/8/13 at 7:00 pm, that there was a new order received for a Fentanyl patch. Nurse #4 added that she did not follow up on the order due to she assumed that Nurse #3 "had taken care of the order". She concluded she did not recall ever applying and/or removing a Fentanyl patch from Resident #66. Resident #66 medical records concluded that the Fentanyl 25 mcg patch was never applied as ordered by the physician every 72 hours, per the MAR from 4/7/13 through 4/23/13.	F 309		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425	No resident experienced any negative outcome from this cited deficiency. F425 Criteria #1: Resident # 66's medications were clarified with physician, new orders obtained and medications were administered per physician orders. Criteria #2: Director of Nursing and designee audited nurse's stations for any faxed requests for clarification, and audited medication administration records. There are no outstanding clarifications and all residents have ordered medications.	4/23/13 4/23/13

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F 425	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and pharmacist interview, the pharmacy failed to follow up on a clarification order for Fentanyl 25 mcg (mircorgrams) patch when the facility did not respond to the pharmacy clarification request to ensure the medication was supplied for 1 of 1 sampled resident (Resident #66). The findings included: The pharmacy service agreement dated 7/12/13 in part read the responsibility of the pharmacy is to "1) Provide pharmacy products to the facility and its residents in a prompt and timely manner, 2) Deliver pharmacy products to facility daily or as otherwise may be required." Resident #66 was admitted into the facility on 11/29/12. Diagnoses included Generalized Pain, Chronic Pain, and End Stage Renal Disease. The quarterly minimum data set completed on 3/1/13 indicated Resident #66 was cognitively intact. A review of a pharmacy clarification message dated 4/8/13 revealed an attached hard script order that was faxed on top of a telephone order which made the telephone order not readable in its entirety. The telephone/hard script order was signed by the physician on 4/7/13 and read "Fentanyl Patch 25 mcg (micrograms) apply every 72 hours." A review of a pharmacy clarification message that was faxed to the facility from the pharmacy on 4/8/13 read "Attention staff - please refax - the script was covering the telephone order	F 425	Criteria#3: Clarification received from pharmacy via fax will be addressed by the licensed Nurse assigned to that resident during the shift the fax was received. Upon completion, the nurse will document the status of clarification directly on the fax and then place the fax with the 24 hour report located at the nurse's station. If clarification has not been resolved prior to end of nurse's shift, it will be passed to oncoming nurse for completion and a notation made on the 24 hour report, Follow up on completed clarifications will be made during clinical risk management rounds. Criteria #4: Current licensed Nursing staff will be educated on pharmacy and facilities practices related to clarification of orders by Director of Director of Nursing or designee.	5/24/13 5/24/13

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F 425	Continued From page 7 attached." A review of the medication administration record for April 2013 revealed Fentanyl 25 mcg patch ordered to be applied every 72 hours was not applied as ordered by the physician. In an interview on 4/23/13 at 4:18 pm, pharmacist #1 when questioned why there was no follow up from pharmacy personnel when the facility did not respond to the pharmacy's clarification request on 4/8/13 regarding the Fentanyl 25 mcg patch that was ordered by the physician to be applied every 72 hours, Pharmacist #1 indicated that pharmacy personnel was not responsible for following up with the facility related to clarification orders that the pharmacy had faxed over to the facility that sought clarification. In a telephone interview on 4/26/13 at 3:05 pm, medication Nurse #3 acknowledged that she was the primary nurse for Resident #66 on 4/8/13 from 7:00 am - 7:00 pm. She indicated that she was not aware that there was an order faxed from the pharmacy on 4/8/12 that requested the telephone and hard script order for the Fentanyl patch to be refaxed to pharmacy. She indicated that she did not recall the Fentanyl patch ever applied to Resident #66 and that the night shift nurse was responsible for completing the twenty four hour chart checks to ensure physician orders were carried out. In a telephone interview on 4/26/13 at 4:15 pm, medication Nurse #4 (night nurse) acknowledged that she was the primary nurse for Resident #66 on 4/8/13 from 7:00 pm - 7:00 am. She stated that she recalled Nurse #3 verbally stating to her	F 425	Criteria #5 Director of nursing or designee will audit pharmacy clarification orders to ensure timely response daily x 2 weeks, weekly x 2, monthly x 2. Results from these audits will be reviewed by the facility Quality Assurance Committee for further recommendations as deemed necessary.	5/24/13

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F 425	Continued From page 8 on 4/8/13 at 7:00 pm, that there was a new order received for a Fentanyl patch. Nurse #4 added that she did not follow up on the order due to she assumed that Nurse #3 "had taken care of the order." She concluded she did not recall ever applying and/or removing a Fentanyl patch from Resident #66.	F 425		

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

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JUN 10 2013
CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345173	A. BUILDING 01 - MAIN BUILDING 01 B. WING	05/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNN HEALTH & REHAB CENTER	201 NORTH ELLIS AVENUE DUNN, NC 28334

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type I -fire resident construction, three story, with no complete automatic sprinkler system. Building a replacement facility. The deficiencies determined during the survey are as follows:	K 000	By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. No resident experienced any negative outcome from this cited deficiency. K 069	
K 069 SS=E	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: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: deep fat fryer in kitchen did not have splash guard's on fryer. 42 CFR 493.70(a)	K 069	Criteria #1: A stainless steel splash guard was installed between the fryer and food processer to provide protection from grease splatter. Criteria #2: Complete audit of facility kitchen was conducted by Maintenance Director to identify any other areas/equipment needing splash guards installed to prevent splashing of hot substances. Criteria #3: All staff will be educated on identification and reporting safety concerns of equipment.	7/7/13 7/7/13 7/7/13
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.	K 076	Criteria #4: An Audit will be conducted by Maintenance Director or designee daily x2 weeks, weekly x2 and Monthly x 2 to ensure splash guard is in good repair and preventing splatter to the food processing area. Results from these audits will be reviewed by the facility Quality Assurance Committee for further recommendations as deemed necessary.	7/7/13

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

Shelly Sinclair — Administrator — 7/10/13

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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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 076	Continued From page 1 (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: oxygen cylinder was unsupported in med. room on 3rd floor. 42 CFR 483.70(a)	K 076	No resident experienced any negative outcome from this cited deficiency. K 076 Criteria #1: Oxygen cylinder was immediately removed and placed in storage that provided support. Criteria #2: Administrator and Director of Maintenance audited facility to identify oxygen cylinders potentially not being stored without support. No Oxygen cylinders were found to be stored with out support. Criteria#3: All staff will be educated on the proper storage of oxygen cylinders including the need for support. Criteria #4: Director of nursing or designee will audit facility daily x 2 weeks, weekly x 2, monthly x 2. to ensure all oxygen cylinders are stored properly with support. Results from these audits will be reviewed by the facility Quality Assurance Committee for further recommendations as deemed necessary.	7/7/13 7/7/13 7/7/13 7/7/13

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FORM APPROVED
OMB NO. 0938-0391

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

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	345178	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/23/2013

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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
K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type I -fire resident construction, three story, with no complete automatic sprinkler system. Building a replacement facility. The deficiencies determined during the survey are as follows:	K 000	By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. No resident experienced any negative outcome from this cited deficiency. K 069	
K 069 SS=E	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: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: deep fat fryer in kitchen did not have splash guard's on fryer. 42 CFR 493.70(a)	K 069	Criteria #1: A stainless steel splash guard was installed between the fryer and food processer to provide protection from grease splatter. Criteria #2: Complete audit of facility kitchen was conducted by Maintenance Director to identify any other areas/equipment needing splash guards installed to prevent splashing of hot substances. Criteria #3: All staff will be educated on identification and reporting safety concerns of equipment.	7/7/13 7/7/13 7/7/13
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.	K 076	Criteria #4: An Audit will be conducted by Maintenance Director or designee daily x2 weeks, weekly x2 and Monthly x 2 to ensure splash guard is in good repair and preventing splatter to the food processing area. Results from these audits will be reviewed by the facility Quality Assurance Committee for further recommendations as deemed necessary.	7/7/13

RECEIVED
JUN 17 2013
CONSTRUCTION SECTION

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 05/24/2013
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
	345173	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DUNN HEALTH & REHAB CENTER	201 NORTH ELLIS AVENUE DUNN, NC 28334

(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 076	Continued From page 1 (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: oxygen cylinder was unsupported in med. room on 3rd floor. 42 CFR 483.70(a)	K 076	No resident experienced any negative outcome from this cited deficiency. K 076 Criteria #1: Oxygen cylinder was immediately removed and placed in storage that provided support. Criteria #2: Administrator and Director of Maintenance audited facility to identify oxygen cylinders potentially not being stored without support. No Oxygen cylinders were found to be stored with out support. Criteria#3: All staff will be educated on the proper storage of oxygen cylinders including the need for support. Criteria #4: Director of nursing or designee will audit facility daily x 2 weeks, weekly x 2, monthly x 2. to ensure all oxygen cylinders are stored properly with support. Results from these audits will be reviewed by the facility Quality Assurance Committee for further recommendations as deemed necessary.	7/7/13 7/7/13 7/7/13 7/7/13