JUL 18 2013

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

PRINTED: 07/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 06/20/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	321 EAST CARVER STREET DURHAM, NC 27704

(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. Event ID F19N11.	F 000		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and resident interview, the facility failed to inform an alert and oriented resident that a medication (Percocet) was changed to crush; and failed to allow the resident input regarding the decision for the medication change for 1 of 1 resident (Resident #185). The findings included: Resident #185 was admitted into the facility on 2/21/12. Diagnoses included chronic pain. The quarterly minimum data set (MDS) completed on 5/18/13 indicated Resident #185 was cognitively intact. The MDS indicated no swallowing problems or behaviors. A review of the telephone order dated 5/10/13 read "Please crush Percocet and put in apple sauce to aide compliance." A review of the nurse's notes dated 5/10/13 written by Nurse #2 at 3:13 pm read "order	F 242	THIS RESPONSE AND PLAN OF CORRECTION IS BEING SUBMITTED PURSUANT TO THE APPLICABLE FEDERAL AND STATE REGULATIONS. NOTHI NG CONTAINED HEREIN SHALL BE CONSTRUED AS AN ADMISSION THAT THE FACILITY VIOLATED ANY FEDERAL OR STATE REGULATION, OR FAILED TO FOLLOW ANY APPLICABLE STANDARD OF CARE.	

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

Administrator 7/17/13

...v deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ... 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 242	Continued From page 1 regarding administration of Percocet resident aware." A review of the medication administration record dated 5/11/13 - 5/19/13; 5/21/13 - 5/31/13, 6/1/13 - 6/18/13 revealed Percocet was administered crushed. In an interview on 6/18/13 at 2:55 pm, Resident #185 revealed "several weeks ago" when he requested Percocet for "knee pain" Nurse #1 administered the medication to him-crushed and mixed in apple sauce. He added when he inquired why his medication was crushed Nurse #1 informed him that Nurse #2 had received an order from Physician #1 to administer the medication crushed with applesauce. Resident #185 stated that he was not informed or made aware that his Percocet order had been changed to be administered as such. In an interview on 6/18/13 at 3:10 pm, Nurse #2 stated on May 10, 2013 between "12 noon - 1:00 pm" she handed Resident #185 "Percocet two whole tablets" as needed for "leg pain" in a medication cup. Nurse #2 stated that she directed the resident to take the medication in front of her, and he walked away "not sure where he went" without her observing the Percocet taken by mouth. She concluded that she notified physician #1 of her concerns and received an order to "crush Percocet and administer in apple sauce." In an interview on 6/19/13 at 3:01 pm, Nurse #2 indicated she informed physician #1 on 5/10/13 due to he was physically present in the building that Resident #185 did not to take his Percocet after she handed it to him. Thereafter, she added	F 242	1. Resident #185 was notified of the change in the order for medication to be crushed. 2. An audit of notification of changes in medication orders will be completed by July 13th to ensure no other patients were affected. 3. Education will be provided to nursing staff by Director of Nursing and/or designee regarding notification of change in medication orders by 7/17/13, with instructions for nurses being ineligible to work until education has been received to ensure compliance with this requirement.	

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F 242	Continued From page 2 that physician #1 verbally informed her that he changed the Percocet to be administered crush. Nurse #2 acknowledged that she did not make the resident aware that the medication order was changed by the physician. She also acknowledged that the nurse's note she wrote on 5/10/13 at 3:13 pm that read "order regarding administration of Percocet resident aware" that she did not inform Resident #185, and was not sure why she documented that she did. In an interview on 6/19/13 at 4:20 pm, the director of nursing accompanied by the assistant director of nursing revealed her expectation was that the resident be informed of the medication change and included in the decision for the Percocet to be crushed prior to the order being carried out. In an interview on 6/20/13 at 10:13 am, Resident #185 stated that he felt "belittled and that Nurse #2 did not trust him." He indicated that he expected to have been notified before the decision was made to crush his Percocet. He concluded he was his own responsible party and was capable of conveying his needs.	F 242	4. Ongoing monitoring of notification of changes in medication orders will be conducted weekly for 90 days to ensure compliance with this requirement. All findings will be reported to QA&I committee monthly for review.	7/17/13
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review,	F 250		

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F 250	Continued From page 3 psychologist and staff interviews, the facility failed to obtain a psychiatric consultation as ordered by the physician for 2 of 10 residents reviewed for unnecessary medications (Resident #85 and Resident #2). The findings included: 1) Resident #85 was admitted to the facility on 4/3/13 with cumulative diagnoses including dementia with psychosis (paranoia), insomnia, and a history of falls prior to admission. The admission Minimum Data Set (MDS) dated 4/10/13 indicated the resident had moderately impaired cognitive skills for daily decision making. The MDS also revealed Resident #85 was independent with most activities of daily living (ADLs) including bed mobility, transfers, and ambulation. No mood or behavior symptoms were noted at the time of the initial MDS assessment. Resident #85 ' s admission medications included lorazepam (an antianxiety medication) 0.5 milligrams (mg) once daily and quetiapine (an antipsychotic medication indicated for bipolar disorder, schizophrenia or psychosis) 100 mg once daily. Review of the medical record revealed that on 5/23/13, the resident ' s physician changed the order for lorazepam from being a regularly scheduled medication to being dosed once daily only as needed (PRN) at bedtime for insomnia. No changes had been made to the medication order for quetiapine. On 5/23/13, the physician also wrote and signed an order in the medical record for a " psychiatric consult regarding	F 250	1. Psychiatric consult was completed for residents #2 July 1st, & is planned for completion on or before July 26th, 2013 for resident #85. 2. A review of patients with orders for psychiatric consults will be completed by July 17th to ensure no other patients were affected. Findings will be reported to QA&I for review. A Psyche referral tracking log will be put in to place by July 17 for streamlining of referral tracking and follow up.	

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F 250	Continued From page 4 dementia / quetiapine prescription. " Further review of Resident #85 ' s medical record on 6/19/13 revealed documentation of the completion of a psychiatric consultation had not been placed in the resident ' s chart. An interview with the facility ' s consultant psychologist was conducted on 6/19/13 at 1:20 PM. The psychologist indicated all psychiatric consultation notes were sent to the facility and placed on the resident ' s chart. Once a facility submitted a referral for consultation, it would typically take a week (or less) for the resident to be seen. He noted an exception to this would be if the resident ' s Responsible Party (RP) had declined having the psychiatric consultation done. An interview was conducted with the Unit Coordinator on 6/19/13 at 2:34 PM. During this interview, the Unit Coordinator described the usual procedure followed when a psychiatric consultation was ordered by the physician. A follow-up interview was conducted with the Unit Coordinator on 6/19/13 at 4:03 PM. At that time, the Unit Coordinator indicated a referral for a psychiatric consultation had not been completed for Resident #85. She provided further details on the referral process for obtaining a psychiatric consultation and indicated that the nurse on duty was responsible for notifying either the Social Worker (SW) or the Unit Coordinator to initiate this referral process. She also noted that any nurse on duty could initiate the referral process herself after checking to be sure there was a signed consent on file for that resident.	F 250	3. Education to nursing staff regarding psychiatric consult orders are scheduled will be conducted by the Director of Nursing and/ or designee will be completed by 7/17/13, with instructions for nurses being ineligible to-work until education is received.to ensure compliance with this requirement. 4. Ongoing monitoring of orders for psychiatric consults being scheduled will be conducted weekly for 90 days to ensure compliance with this requirement. Findings will be reported to QA&I monthly for review.	7/17/13

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F 250	Continued From page 5 An interview was conducted with the DON on 6/20/13 at 8:30 AM. During this interview, the DON acknowledged, " there may be a facility process issue or breakdown " in regards to the initial referral process and follow-up for psychiatric consultations. An interview was conducted with the facility ' s SW on 6/20/13 at 8:43 AM. During this interview, the SW indicated the facility contracts with a psychiatric medical group to provide consultative services for residents. She indicated the referral consisted of a physician ' s order and a signed consent (signed by either the resident or the Responsible Party). The SW stated that while she was the " overall contact person or liaison " for the facility in processing the referrals for psychiatric consultations, she also noted that other team members had been assisting in this process. The SW indicated she would like to work with the nursing administration staff to look at streamlining the process. An interview was conducted with the facility ' s Administrator on 6/20/13 at 11:07 AM. During this interview, the Administrator stated he wanted to make sure " our system is working ", in regards to processing referrals and obtaining psychiatric consultations. He also indicated a need to identify " a point person to insure the psychiatric consultations have been taken of. " 2) Resident #2 was admitted to the facility on 6/24/91 with cumulative diagnoses including traumatic brain injury, severe dementia, depression and anxiety. The quarterly Minimum Data Set (MDS) dated 5/15/13 indicated the resident had severely impaired cognitive skills for	F 250		

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F 250	Continued From page 6	F 250		

daily decision making. The MDS also revealed Resident #2 was totally dependent on staff for all of his activities of daily living (ADLs). No mood or behavior symptoms were noted at the time of the most recent quarterly MDS assessment.

A review of Resident #2 ' s current medication regimen included the following: citalopram (an antidepressant) 40 milligrams (mg) once daily for depression; benztropine (a medication used to treat abnormal involuntary movements experienced as a side effect from a drug) 0.5 mg once daily; lorazepam (an antianxiety medication) 0.5 mg three times daily; divalproex sodium (a medication which can be used to treat mood disorders) 250 mg three times daily; and haloperidol (a medication used to treat psychosis) 1 mg twice daily.

A review of Resident #2 ' s medical records revealed a Physician Progress Note dated 3/19/13 which indicated a previous Gradual Dose Reduction (GDR) for the resident ' s psychotropic medications had failed. Psychotropic medications are those medications which affect the mind, emotions, and/or behavior. The 3/19/13 Physician Progress Note also indicated, "could use psych input again for possible GDRs. " On 3/19/13 the physician wrote the following order: " Consult Psychiatry regarding psychiatrics, question GDR, yelling, agitation. "

On 5/19/13, Resident #2 ' s physician initiated a GDR trial for haloperidol. The dose of haloperidol was reduced from 1.5 mg to 1 mg taken twice daily.

Further review of Resident #2 ' s medical record

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F 250	Continued From page 7 on 6/19/13 revealed documentation of the completion of a psychiatric consultation had not been placed in the resident ' s chart. An interview with the facility ' s consultant psychologist was conducted on 6/19/13 at 1:20 PM. The psychologist indicated all psychiatric consultation notes were sent to the facility and placed on the resident ' s chart. Once a facility submitted a referral for consultation, it would typically take a week (or less) for the resident to be seen. He noted an exception to this would be if the resident ' s Responsible Party (RP) has declined having the psychiatric consultation done. An interview was conducted with the Unit Coordinator on 6/19/13 at 2:34 PM. During this interview, the Unit Coordinator described the usual procedure followed when a psychiatric consultation was ordered by the physician. The Unit Coordinator recalled the circumstances of the missed referral for Resident #2 ' s consultation and provided a copy of the referral form faxed to the psychiatry service on 5/15/13. The Unit Coordinator reviewed the resident ' s chart and confirmed there was no documentation of a psychiatric consult being completed. She stated, " Typically it takes one week or so ...one month is more than the usual. I can follow up on it. " An interview was conducted with the DON on 6/20/13 at 8:30 AM. During this interview, the DON acknowledged, " there may be a facility process issue or breakdown " in regards to the initial referral process and follow-up for psychiatric consultations.	F 250		

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F 250	Continued From page 8 An interview was conducted with the facility ' s SW on 6/20/13 at 8.43 AM. During this interview, the SW indicated the facility contracts with a psychiatric medical group to provide consultative services for residents. She indicated the referral consisted of a physician ' s order and a signed consent (signed by either the resident or the Responsible Party). The SW stated that while she was the " overall contact person or liaison " for the facility in processing the referrals for psychiatric consultations, she also noted that other team members had been assisting in this process. The SW indicated she would like to work with the nursing administration staff to look at streamlining the process. A follow-up interview with the SW was conducted on 6/20/13 at 9:18 AM. The SW reported she had just been contacted by the facility ' s Psychiatry Service and they indicated the referral for Resident #2 (dated 5/15/13) had been lost " on their end " but would be processed at this time. The SW reiterated that she would need to work with the nursing administration staff to look at the facility ' s protocol and see what kind of a checklist may be put into place to insure appropriate follow-up on referrals. The SW stated that once the referral has gone off, " the facility ' s role would be to check into or follow-up on it if not yet done in the time frame expected. " An interview was conducted with the facility ' s Administrator on 6/20/13 at 11:07 AM. During this interview, the Administrator stated he wanted to make sure " our system is working " in regards to processing referrals and obtaining psychiatric consultations. He also indicated a need to identify " a point person to insure the	F 250		

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F 250	Continued From page 9 psychiatric consultations have been taken of. " The Administrator noted the facility needs to look at the referral process if a consult has been missed or there has been a delayed response to a referral for a consultation.	F 250	1. Opened vial of tuberculin purified protein (PPD) has been discarded. The Advair Discus has been dated on the date openned and/ or discarded appropriately. 2. A comprehensive review of open dates on PPD and Advair Discus' will be completed by July 13th to ensure no other patients were affected. Findings will be reported to QA&I monthly for review. 3. Education will be provided to the nursing staff by the Director of Nursing and/ or designee regarding dating PPD and Advair Discus' by 7/13/13 with instructions to nurses being ineligible to work until education is received to ensure compliance with this requirement. Findings will be reported to QA&I monthly for review.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	F 431		

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F 431	Continued From page 10 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to label medications with an expiration date in 3 of 9 medication carts (200 Front Hall, 200 Back Hall and 100 Back Hall Medication Carts); and failed to store medications as specified by the manufacturer in 1 of 9 medication carts (100 Front Hall medication cart). The findings included: 1) An observation of the 100 Front Hall medication cart on 6.20/13 at 10:45 AM revealed an opened vial of tuberculin purified protein derivative (PPD) injectable solution was stored on the cart. Tuberculin PPD is used for skin testing in the diagnosis of tuberculosis. The manufacturer ' s product information indicated both unopened and opened vials of Tuberculin PPD should be stored in the refrigerator at 36o - 46o Fahrenheit. During an interview with Nurse #3 on 6/20/13 at 10:45 PM, the nurse indicated the vial of tuberculin PPD injectable solution should not be stored on a medication cart and acknowledged it needed to be kept in the refrigerator. The nurse indicated she believed this vial would need to be discarded. During an interview with the DON (Director of Nursing) on 6/20/13 at 11:30AM, the DON addressed the normal procedure for storing	F 431	4. Ongoing monitoring of PPD and Advair Discus' will be conducted weekly for 90 days to ensure compliance with this requirement. Findings will be reported to QA&I for review.	7/17/13

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F 431	Continued From page 11 tuberculin PPD injectable solution. The DON indicated all opened (and unopened) tuberculin PPD vials should be kept in the refrigerator until used or up to 30 days after opening in accordance with the manufacturer ' s product labeling. 2) An observation of the 200 Front Hall medication cart on 6/20/13 at 10:15 AM revealed an Advair Diskus 250mcg/50mcg inhaler (a dry powder inhaler used for asthma or chronic obstructive lung disease) was not dated as to when it had been removed from the foil pouch. Supplemental labeling from the dispensing pharmacy noted the Advair Diskus inhaler " Expires 1 month after opening. " Manufacturer product labeling indicated the Diskus device should be discarded 1 month after removal from the foil pouch. During an interview with Nurse #4 on 6/20/13 at 10:15 AM, the nurse indicated the opened Advair Diskus inhaler should have been dated when it was opened and discarded 1 month after removal from the foil pouch. During an interview with the Director of Nursing (DON) on 6/20/13 at 11:30 AM, the DON stated her expectation would be for both the Advair Diskus inhaler and the clear storage bag to be dated when the inhaler is removed from the foil pouch. The DON acknowledged an Advair Diskus inhaler needed to be dated so that an appropriate expiration date could be determined for the inhaler. 3) An observation of the 200 Back Hall medication cart on 6/20/13 at 10:24 AM revealed	F 431		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 12 an Advair Diskus 250mcg/50mcg inhaler (a dry powder inhaler used for asthma or chronic obstructive lung disease) was not dated as to when it had been removed from the foil pouch. Supplemental labeling from the dispensing pharmacy noted the Advair Diskus inhaler " Expires 1 month after opening. " Manufacturer product labeling indicated the Diskus device should be discarded 1 month after removal from the foil pouch. During an interview with Nurse #5 on 6/20/13 at 10:24 AM, the nurse reported an Advair Diskus inhaler needed to be labeled with the date opened after it had been removed from the foil pouch. During an interview with the Director of Nursing (DON) on 6/20/13 at 11:30 AM, the DON stated her expectation would be for both the Advair Diskus inhaler and the clear storage bag to be dated when the inhaler is removed from the foil pouch. The DON acknowledged an Advair Diskus inhaler needed to be dated so that an appropriate expiration date could be determined for the inhaler. 4) An observation of the 100 Back Hall medication cart on 6/20/13 at 10:34 AM revealed an Advair Diskus 250mcg/50mcg inhaler (a dry powder inhaler used for asthma or chronic obstructive lung disease) was not dated as to when it had been removed from the foil pouch. Supplemental labeling from the dispensing pharmacy noted the Advair Diskus inhaler " Expires 1 month after opening. " Manufacturer product labeling indicated the Diskus device should be discarded 1 month after removal from the foil pouch.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 06/20/2013

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F 431	Continued From page 13 During an interview with Nurse #6 on 6/20/13 at 10:34 AM the nurse stated, " Normally we open (the inhaler) and date it. " She also indicated the Advair Diskus inhaler expired 30 days from the date opened. During an interview with the Director of Nursing (DON) on 6/20/13 at 11:30 AM, the DON stated her expectation would be for both the Advair Diskus inhaler and the clear storage bag to be dated when the inhaler is removed from the foil pouch. The DON acknowledged an Advair Diskus inhaler needed to be dated so that an appropriate expiration date could be determined for the inhaler.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	346434	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/17/2013

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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 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. Buildings 01 and 02 are Type II construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	THIS RESPONSE AND PLAN OF CORRECTION IS BEING SUBMITTED PURSUANT TO THE APPLICABLE FEDERAL AND STATE REGULATIONS. NOTHING CONTAINED HEREIN SHALL BE CONSTRUED AS AN ADMISSION THAT THE FACILITY VIOLATED ANY FEDERAL OR STATE REGULATION, OR FAILED TO FOLLOW ANY APPLICABLE STANDARD OF CARE.	
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 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 7/17/13 at approximately noon the fire alarm system was non-compliant, specific findings include, documentation from the fire alarm annual inspection indicated smoke detector at room 210 did not function properly.	K 052		
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no	K 066		8/2/13

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

8/2/13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/17/2013

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K 066	Continued From page 1 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	K52 1. Smoke detector in room 210 is working properly. 2. An audit of all sprinkler heads will be conducted to ensure no other areas were affected. 3. In-service education will be conducted by the Administrator and or designee to plant operations staff regarding smoke detector compliance to ensure compliance with this requirement by August 22nd, 2013. 4. On-going monitoring of smoke detector function will be completed weekly for 90 days to ensure compliance with this requirement. Findings will be reported to the QA&I committee for review monthly.	8/22/13
K 067 SS=D	This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 7/17/13 at approximately noon the following smoking regulations were observed as non-compliant, specific findings include; ashtrays of noncombustible material and safe design per paragraph 3 above were not provided. NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's	K 067		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/17/2013

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K 067	Continued From page 2 specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 7/17/13 at approximately noon the following Heating, Ventilating, and Air Conditioning system (HVAC) was non-compliant; specific findings include A. The HVAC system shut down switch located at nurses station #1 near room 128 did not function properly. B. The ceiling/radiation dampers in the laundry folding area, near room 128, could not be confirmed in the supply and return. C. The HVAC system in the laundry folding area, near room 128, was not equipped with an emergency shut down switch. D. The clean linen room, near room 128, was not supplied with ceiling radiation damper in the supply duct. It appeared that the room was equipped with an exhaust vent only.	K 067	K66 1. Ash trays will be replaced by August 22nd with non combustible material and safe design. 2. A complete review of ash trays will be completed to ensure no other areas are affected by August 22nd, 2013 3. Education will be completed by Plant Operations Director or deignee regarding proper ash tray use will be completed by August 22nd, 2013 to ensure compliance with this requirement. 4. Ongoing monitoring of ash trays will be completed weekly for 90 days to ensure compliance with this requirement. Findings will be reported to QA&I monthly for review.	8/22/13

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

PRINTED: 07/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING 02 - BUILDING 02 B. WING _____	07/17/2013

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K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 . and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 7/17/13 at approximately noon the following hazardous area was observed as non-compliant, specific findings include lack of separation of laundry from the customary access of the exit egress by both the door to laundry wedged open and the old through the wall unit not sealed properly.	K 029	K67 1. HVAC shut down switch will be repaired and functioning properly by August 22nd, 2013. The ceiling/ radiation dampers in the laundry area near room 128 will be corrected by August 22nd, 2013. HVAC system in the laundry folding area near room 128 has been equipped with an emergency shutdown switch. The clean linen room near room 128 will be supplied with ceiling radiation damper in the supply duct by August 22nd.	
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 7/17/13 at approximately noon the cliking facilities was non-compliant, specific findings include, Cooking equipment (deep fat fryer) was not properly protected in accordance to NFPA 96.	K 069	2. A review of HVAC shut down switches, and radiation dampers will be completed by the Plant Operations director to ensure no other areas were affected.	

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

Administrator 6/16/13

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING 02 - BUILDING 02 B. WING	07/17/2013

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K 069	Continued From page 1 Specifiec Reference; NFPA 96 - Ventilation Control and Fire Protection of Commercial Cooking Operations. Chapter 9, "Minimum Safety Requirements for Cooking Equipment" Section - 9-1.2.3 All deep fat fryers shall be installed with at least a 16-in. (406.4-mm) space between the fryer and surface flames from adjacent cooking equipment. Exception: Where a steel or tempered glass baffle plate is installed at a minimum 8 in. 203(mm) in height between the fryer and surface flames of the adjacent appliance.	K 069	3. In-service education will be conducted by the Administrator to the Plant Operations staff regarding HVAC shut down switches, radiation dampers by August 22nd to ensure compliance with this requirement. 4. On-going monitoring of HVAC shut down switches and radiation dampers will be conducted monthly for Continued on attachment A & B	8/22/13

Attachment A

K 029

1. The old through the wall unit has been sealed. The door remains closed.
2. A review of separation between exit egress' and custom access will be completed to ensure no other areas are affected.
3. Education to staff will be completed by Administrator or designee regarding separation between customary access and exit egress' to ensure compliance with this requirement.
4. Ongoing monitoring of customary access and exit egress' will be completed weekly for 90 days to ensure compliance with this requirement. Findings will be reported to QA&I monthly for review.

9/1/13

Attachment B

K 069

1. The deep fat fryer will be protected according to NFPA guidelines by August 22nd, 2013
2. A comprehensive review of cooking equipment will be completed by August 22nd, 2013 to ensure no other areas are affected.
3. Education to staff to be completed by Plant Operations Director and or designee will be conducted regarding protection of cooking equipment to ensure compliance with this requirement.
4. On-going monitoring of protection of cooking equipment will be completed monthly for three months to ensure compliance with this requirement. Findings will be reported to QA&I for review each month.