STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 000	INITIAL COMMENTS The identified hospital is a multi-campus provider consisting of a remote campus and satellite campus. A full survey and complaint investigation was conducted November 17, 2008 - November 21, 2008 to evaluate the hospital's compliance with the Medicare Conditions of Participation and to follow-up the outstanding condition level deficiencies cited during the September 25, 2008 complaint investigation. The survey findings resulted in an Immediate Jeopardy (IJ) identification in regards to facility staff 's failure to provide care in a safe environment, failure to prevent patient abuse, and failure to prevent patient neglect November 20, 2008, and November 21, 2008, respectively. Specifically, pursuant to 482.12 Governing Body, 482.13 Patients' Rights, 482.23 Nursing Services and 482.41 Physical Environment the facility staff failed to ensure means of egress lighting were functioning, failed to ensure means of egress were unobstructed, failed to ensure primary exit doors were not blocked and could be unlocked, (eg., the primary exit door was observed to be locked and could not be unlocked from inside the stairwell, therefore preventing exit) failed to ensure normal power visual indicator was functioning on the fire alarm panel, and failed to ensure staff were knowledgeable of an emergency procedure to post a fire watch in the event of a loss of power, staff failed to ensure adequate qualified staffing to prevent staff to patient abuse as evidenced by facility staff inappropriately physically restraining a patient, and failing to monitor the restrained patient in accordance with physician's order. Examples as referenced within the report of	A 000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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A 000	Continued From page 1 survey: Observations on November 18, 2008 at approximately 0930 onward, the primary exit egress discharge door, at ground level of Stairwell #A2- Level 0, was found to be locked and could not be unlocked from inside stairwell with tool, key, etc. therefore not allowing exiting. (CRH- Butner Campus) Observation on November 19, 2008 at approximately 0830 onward, revealed the normal power visual indicator was not functioning on the fire alarm panel serving identified buildings on the remote campus. The Main fire alarm panels for the McBryde and Williams buildings have no capability for battery back-up, (1955 year models). The back-up power supply is the Emergency Generators. In the event of loss of power just to the Fire Alarm Control Panel (FACP) , breaker malfunction, etc, the generators would not crank and supply power for that isolated incident. Therefore the FACP would not function (as tested during survey) until the problem was identified and corrected - power restored. Per documentation review and staff interview there were no emergency procedures in place for posting a fire watch during this event. The audible fire alarm notification devices (horns) on Hall 2 East did not work when testing the Fire Alarm. The facility staff failed to have audible alarms heard on the short corridors near rooms 240 and 343 during the test of the Fire Alarm Control Panel (McBryde Building). There was no machine room smoke detector serving the elevator equipment room - Williams Building. Observations on November 18, 2008 at approximately 1640 revealed no audible and	A 000		

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	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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A 000	Continued From page 2	A 000		

visual signaling device connected to the fire alarm system serving unit #4 - Building 52.(CRH Butner Annex Campus). There was no visual trouble signal with loss of power to fire alarm control panel.(Building 53 - CRH Butner Annex Campus).

Medical record review on November 21, /2008 for patient #68, a 24 year old male revealed that the patient was admitted to the facility on November 13, 2008 under involuntary commitment orders with a diagnosis of "schizophrenia." The review revealed telephone written physician's orders by the facility's registered nurse on November 19, 2008 at 0620 to "Manual hold times 10 minutes for blood draw. Release when complete." A following telephone physician's order by the same registered nurse on November 19, 2008 at 0625 revealed "Place in Restraint with 1:1 (one to one) for combative behavior for up to 4 hours. Release after calm and can contract for safety."

Documentation review of the patient's medical record section titled "Restrictive Intervention Assessment and Monitoring" revealed that the patient was placed in restraints on 11/19/2008 at 0620 until 0725. The review of the documentation revealed the reason for the restraints was "Patient did not want his blood drawn and became aggressive." The following documentation during the time the patient was restraint is as follows for 11/19/2008:

~0620 "Patient fighting at staff.",
~0625 "With 1:1, patient unwilling to contract for safety and reported to on-call MD (physician) that he would not contract not to hit staff if taken out of restraints.",
~0640 "Laying face down in four point restraints and refuse to contract for safety, stating he will hit

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	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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A 000	Continued From page 3	A 000		

staff and physician if let out of restraints.",
~0655 "Patient quiet and resting, asked nurse if he could come out of restraint.",
~0710 "Patient still in restraint. Resting. He asked (**staff) for a bandage on a bleeding finger."
~0725 "Patient was turned over and lay on the back, patient was cooperative and did not show aggression."
~0725 "Patient sitting on bed eating. States he is much calmer. Contracts for safety. Patient removed from restraints."

No documentation was found in the medical record where the patient was assessed for vital signs and/or extremity checks by the facility's staff while in restraints.

Observation on November 21, 2008 at 1410 of the facility's internal video recording of the restraint usage for the patient that occurred on Noember 19, 2008 revealed that at 0610/39 (0610 and 39 seconds) a scuffle was viewed with the staff of the facility and the patient. At 0613/22 the observation revealed the patient face down was carried by staff members holding each patient limb into the restraint room. The patient was placed face down with his head facing the door at the foot of the bed and feet facing the head of the bed. Observation revealed a total of 8 staff members started putting restraints on both arms and both legs. At 0613/45 the staff rotated the patient 360 degrees, placing his head at the head of the bed and his feet at the foot of the bed. At 0614/10, the observation of the video revealed two staff members with knees on top of the patient between the patient's mid and lower back as the restraints were being applied. One staff member was observed putting his arm around the other staff member while on top of the patient.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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A 000	Continued From page 4	A 000		

Further observation revealed that the patient was in restraints face down until 0707 (total of 53 minutes in restraints face down) by the staff. The observation revealed that the patient was released from restraints completely at 0729. Observation further revealed that the patient had his blood drawn by a facility health care technician while he was in restraints laying face down. The observation also revealed a total of 8 staff members in the restraint room at the time of restraining patient. Observation also revealed that all of the staff left the patient after placing the restraints on the patient and the 1:1 (one to one constant observation) did not begin until 0647 on the video (total of 33 minutes without 1:1). Observation also revealed no checks were done by the staff during the 33 minutes of the patient's limbs with restraints on or checks of the patient's vital signs.

Review of the facility's internal investigation of the patient in restraints on November 19, 2008 revealed concerns by the facility's administration of the facility's staff use of restraints. The review of the internal investigation revealed concerns about the patient being placed in mechanical restraints face down by the staff at the facility. Other concerns reviewed in the investigation revealed concerns of "neglect" in the patient's case.

Interview with the facility's administration on November 21, 2008 at 1505 revealed that the patient should not have been in mechanical restraints face down. The interview revealed that the facility's administration was made aware of the situation on the afternoon of 11-19-08 and conducted an internal investigation immediately. The interview also revealed that the video

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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A 000	Continued From page 5 monitoring was also watched by the administrative staff and that they found that the staff did not restrain the patient appropriately and some neglect was determined to have happened. "The patient being restrained face down is unacceptable and should not happen." The interview further revealed that some staff personnel investigations have occurred since the event and was ongoing. As a result of the review, the facility's staff after approaching the patient for a forced blood draw, restrained a patient face down in four (4) point restraints restraining each limb for a total of 53 minutes. The patient while restrained face down had his blood drawn by a health care technician. The review of the video revealed that a facility staff members placed knees on the back of the patient while the patient was being placed in restraints by a total of 8 staff members. Review of the video revealed during the restraining event that no 1:1 observation was observed for a total of 33 minutes while the patient was initally restrained and medical record review revealed documentation during this same time period that the patient was being monitored 1:1. The Immediate Jeopardy was determined to be on-going.	A 000		
A 043	482.12 GOVERNING BODY The hospital must have an effective governing body legally responsible for the conduct of the hospital as an institution. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body.	A 043		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 043	Continued From page 6 This CONDITION is not met as evidenced by: Based on hospital documentation reviews, policy and procedure reviews, medical record reviews, observations, credential file reviews, personnel file reviews, internal video monitoring reviews, staffing worksheet reviews and contract services reviews the hospital failed to have an effective Governing Body ensuring a safe environment, safe patient care, promotion of patients rights and adequate respiratory staff to meet the patient needs. The finding include: 1. The hospital failed to maintain an environment for the safety of patients as referenced in the Life Safety survey completed 11-21-08 . ~cross refer to 482.41 Physical Environment, Condition Tag A0700. 2. The hospital staff failed to promote and protect patient rights. ~cross refer to 482.13 Patients' Rights, Condition Tag A0115. 3. The nursing staff failed to provide safe patient care, assessment of patients and reassessment of patients. ~cross refer to 482.23 Nursing Services, Condition Tag A0385. 4. The leadership staff failed to maintain and ensure safe radiological services were provided to the patients. ~cross refer to 482.26 Radiologic Services,	A 043		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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A 043	Continued From page 7 Condition Tag A0528. 5. The facility's leadership staff failed to maintain an effective, hospital-wide, data-driven quality assessment and performance improvement program. ~cross refer to 482.21 Quality Assessment and Performance Improvement, Condition Tag A0263. 6. The Governing Body failed to have a system or process in place to ensure rehabilitation services were adequately staff to provide hearing, vision and speech-language screenings to children and adolescent. Staff failed to ensure a physician's order for hearing, vision and speech screenings were completed prior to a patient's discharge from the facility for 2 of 4 child and adolescent records reviewed (#30, #68). ~cross refer to CFR 482.56 Organization of Rehabilitation Services, Standard, Tag A1124 7. The Governing Body failed to ensure the facility was adequately and appropriately staffed with trained individuals for the delivery of respiratory services in a safe manner. Staff interview revealed placing CPAP equipment on units other than the medical unit is a new process. Interview confirmed there is no evidence of documentation of CPAP training for nurse #37, nurse #35, nurse #44 and nurse #46. ~cross refer to 482.57 Respiratory Services, Standard, Tag A1152.	A 043		
A 083	482.12(e) CONTRACTED SERVICES The governing body must be responsible for services furnished in the hospital whether or not	A 083		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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A 083	Continued From page 8	A 083		

they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services.

This STANDARD is not met as evidenced by:
Based on review of facility policies and procedures, open and closed medical records and staff interview staff failed to ensure a physician's order for hearing, vision and speech screenings were completed prior to a patient's discharge from the facility for 2 of 4 child and adolescent records reviewed (#30, #68).

The findings included:

Review of facility policy "Scope of Services Department (name of facility) Speech and Hearing Department" (not dated) revealed " Scope of Service...4. ...Speech-language screenings are conducted within two weeks of admission, if possible...5. Availability of necessary staff. the Speech and Hearing Department is staffed by two SLPs (Speech and Language Pathologists) at each campus..." Further review revealed "Ongoing Performance Improvement and quality control data are used to assess effectiveness...Data on amount of time spent with each Division or time serving patients with particular disorders is analyzed to determine trends in order to determine need for increased or decreased staff involvement."

1. Open record review on 11/20/2008 for Patient #30 revealed a 14 year old admitted to the 494 unit on 11/10/2008 for autism and bipolar

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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A 083	Continued From page 9	A 083		

disorder. Review of physician's admission orders revealed "Screenings (routine): (checkmark) Child/Adolescent: Speech-Hearing/Vision". Record review revealed no Speech-Hearing/Vision screening was completed prior to the patient's discharge on 11/20/2008 (10 days from admission).

Interview with the SLP assigned to the main campus of the faculty on 11/20/2008 at 1115 revealed there are two SLPs at the Raleigh campus and currently one SLP at the main campus. Interview revealed there is a current staffing need for one SLP. Interview revealed with the current workload "The screenings on the child and adolescent unit (CAU) do not get priority." Interview revealed the SLP is available on the CAU on Wednesdays and Fridays only for screenings and evaluations. Interview revealed there is a two-week allowance to get the screenings completed. Interview revealed there is no data currently collected to know how many patients on the CAU are not being screened as ordered by the physician when discharged prior to the two week allowance. Interview revealed the first opportunity the SLP had to screen Patient #30 was on 11/19/2008. Interview revealed Patient #30 was too agitated to screen and was discharged the next day. Interview revealed Patient #30 was not screened for speech-hearing/vision, as ordered by the physician, prior to discharge from the hospital.

2. Open record review on 11/20/2008 for Patient #68 revealed a 14 year old admitted 10/14/2008 for conduct disorder. Review of physician's admission orders revealed "Screenings (routine): (checkmark) Child/Adolescent: Speech-Hearing/Vision". Record review revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 083	Continued From page 10 no Speech-Hearing/Vision screening was completed prior to the patient's discharge on 10/24/2008 (10 days from admission). Interview with the SLP assigned to the main campus of the faculty on 11/20/2008 at 1115 revealed there are two SLPs at the Raleigh campus and currently one SLP at the main campus. Interview revealed there is a current staffing need for one SLP. Interview revealed with the current workload "The screenings on the child and adolescent unit (CAU) do not get priority." Interview revealed the SLP is available on the CAU on Wednesdays and Fridays only for screenings and evaluations. Interview revealed there is a two-week allowance to get the screenings completed. Interview revealed there is no data currently collected to know how many patients on the CAU are not being screened as ordered by the physician when discharged prior to the two week allowance. Interview confirmed Patient #68 was not screened for speech-hearing/vision, as ordered by the physician, prior to discharge from the hospital.	A 083		
A 084	482.12(e)(1) CONTRACTED SERVICES The governing body must ensure that the services performed under a contract are provided in a safe and effective manner. This STANDARD is not met as evidenced by: Based on contract reviews, staff interviews and Quality Assurance/Performance Improvement (QAPI) report reviews the Governing Body failed to have a system or process in place to ensure radiology, laboratory and respiratory therapy services provided under contract were evaluated and performed in a safe and effective manner.	A 084		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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A 084	Continued From page 11 The findings include: 1. Review of clinical contract CRH-05 revealed a contract between the facility and a (Name) school of medicine, department of psychiatry to provide outpatient children and adolescent psychiatric services. Interview with the Facility's Clinical Director on 11/19/2008 at 1040 revealed the hospital and the named school of medicine had a children's outpatient clinic operating five days per week on the Raleigh campus. The interview revealed the clinic was open to any patient in the surrounding communities and not just for patients affiliated with the hospital. The interview revealed there had not been any oversight of the services provided in the outpatient children's clinic. The interview revealed the clinic did not participate in the hospital's Quality Improvement program. The interview revealed there were plans to pull the clinic under the hospital in the future for oversight. 2. Review of clinical contract CRH-2309 revealed a contract between the facility and an agency to provide supplemental pharmacy services effective 9-12-08. Interview with the Facility's Pharmacy Director and Quality Director on 11-19-08 at 1325 revealed one pharmacist was contracted to work part time. The interview revealed there had not been any evaluation of the individuals work performance since 2003. The interview did not reveal any documentation of oversight by the Governing Body of the service provided by the contract pharmacy service.	A 084		

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	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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A 084	Continued From page 12	A 084		

3. Review of clinical contract CRH-3909 revealed an agreement effective July 01,2008 through June 30, 2009 between the facility and a Radiologist group to provide diagnostic radiology services onsite as well as via teleradiology service. Review of Attachment B "Scope of Work" revealed "Project Evaluation - 1. Records shall be maintained comparing patient referral dates with dates of examinations to determine promptness of delivery of service. 2. Patients' medical records are audited periodically in accordance with (name of accrediting body) standards."

Interview with the Radiology Director on 11/21/2008 at 1245 revealed there was no clinical data as outlined in the contract collected, aggregated or reported to the facility's leadership for the contracted group. Interview revealed "I know they have an internal peer review process, but I have never received any information back from them."

Interview with the Facility's Clinical Director on 11/21/2008 at 1400 revealed there has been no clinical data as outlined in the clinical contract collected, aggregated or reported to the Governing Body in regards to the quality of care being provided by the contract service.
4. Review of contract #CRH4309 dated 07/01/2008 revealed a contractual agreement with Hospital B for laboratory (lab) services. Contract review revealed Hospital B's lab would provide microbiology testing, stat (immediate) after-hours testing, equipment down-time

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 084	Continued From page 13	A 084		

coverage and hepatitis/HIV testing for the Raleigh Campus. Contract review revealed, "Project Evaluation: 1. Tracking will be done to show that all laboratory testing is completed in a timely fashion. 2. Records shall be maintained with dates and times of pick up and delivery of specimens to determine promptness of delivery of service. 3. Patients' medical records are audited periodically in accordance with JCAHO standards."

Interview on 11/18/2008 at 1100 with the laboratory supervisor revealed after-hours stat lab services were provided at the Butner Campus by Hospital A's lab. Interview revealed there was no contractual agreement with Hospital A to ensure after-hours stat lab services were available.

Review of 2007 and 2008 QAPI reports provided by laboratory administrative staff on 11/21/2008 revealed no documentation that the dates and times of pick up and delivery of specimens to Hospital A or B was tracked to evaluate the promptness of the delivery of service. Review also revealed no documentation that the promptness of lab testing completion at Hospital A or B was tracked.

Interview on 11/21/2008 at 1315 with the laboratory supervisor revealed dates and times of pick up and delivery of specimens to Hospital A and Hospital B's lab and lab result times from Hospital A and Hospital B's lab were not monitored and evaluated to ensure the lab tests were done in a safe and effective manner.

An interview with the laboratory medical director was requested on 11/21/2008 at 1230. The laboratory medical director was on vacation and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 084	Continued From page 14 was thus unavailable for interview per hospital administrative staff. 5. Review of the hospital's list of direct patient services contracts revealed a respiratory contracted service providing/performing direct patient services to the hospital patients. Review of the contract revealed services provided and/or performed under contract were delivery of CPAP (continuous positive airway pressure) equipment including training of patients and staff members. Interview with management staff on 11-21-08 at 1500 revealed there was no defined process or system in place for the review of direct patient services provided by contract. The interview revealed there was no documentation available for the evaluation of direct patient services provided by contract. Interview revealed that "if the monitoring/evaluation of contracted services is not addressed in the contract, it is probably not done." Interview with administrative staff on 11-21-08 at 1530 revealed there was no documentation available for the evaluation of contracted services. The interview revealed contracted services were not included in the hospital wide quality assurance performance improvement program. The interview revealed the staff was not aware of a system or process in place that evaluated services provided/performed by contracted services.	A 084		
A 115	482.13 PATIENT RIGHTS A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on review of policy and procedure,	A 115		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 115	Continued From page 15	A 115		

medical record review, Advocacy Log of Grievances review, Adverse Event/Sentinel Event Investigation Summary Reports review, investigative reports, personnel files, occurrence report review, observation, observation of facility's internal video monitoring, and staff interviews the hospital failed to promote and protect patients' rights.

The findings include:

A. The hospital failed to prevent staff to patient abuse for 1 of 10 sampled restrained patients (#68).

~cross refer to 482.13(e)(5) Patients' Rights: Restraint or Seclusion Tag A0168

B. The hospital failed to ensure a safe environment in a courtyard to prevent patient elopement for 2 of 2 sampled patients that eloped (#17 and #7).

~cross refer to 482.13(c)(2) Patients' Rights: Care In A Safe Setting Tag A0144

C. The hospital failed to ensure internal patient advocates did not disclose confidential patient information to unauthorized family members prior to patient consent.

~cross refer to 482.13(c)(1) Patients' Rights: Personal Privacy Tag A0143

D. The hospital failed to document a physician order for a restraint per hospital policy for 1 of 10 sampled patients with restraints (#36).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 115	Continued From page 16 ~cross refer to 482.13(e)(5) Patients' Rights: Restraint or Seclusion Tag A0168 E. The hospital failed to ensure a time limited restraint order was obtained for 1 of 10 patients restrained (#35) and failed to ensure an age appropriate time limited restraint and/or seclusion order was obtained for 1 of 10 patients restrained and secluded (#32). ~cross refer to 482.13(e)(8) Patients' Rights: Restraint or Seclusion Tag A0171	A 115		
A 143	482.13(c)(1) PATIENT RIGHTS: PERSONAL PRIVACY The patient has the right to personal privacy. This STANDARD is not met as evidenced by: Based on hospital policy review, medical record review, Advocacy Log of Grievances review, Adverse Event/Sentinel Event Investigation Summary Reports review, patient advocate interview and staff interview, the hospital failed to ensure internal patient advocates did not disclose confidential patient information to unauthorized family members prior to patient consent. The findings include: Review of hospital policy Standards of Clinical Practice-Confidentiality, SCPM-C-6 (11/1/07), revealed an Authorization To Disclose Health Information form that lists individuals authorized by the patient to receive confidential patient information is required to be completed prior to the release of information. Policy review also revealed the internal Patient Advocate may disclose patient information with a written consent	A 143		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 143	Continued From page 17	A 143		

of the patient or his legal responsible person.

Closed medical record review for patient #2 (Raleigh campus) revealed this 21 year old male had a history of Bipolar Disorder with manic psychotic features. Record review revealed patient #2 had been involuntarily committed to the hospital on 8/28/08-9/8/08 as directed by court order for "Pre-Trial evaluation". Review also revealed a subsequent involuntary commitment admission on 10/2/08-10/24/08 as a law enforcement detainee for an acute psychotic episode.

Review of the hospitals Advocacy Log of Grievances revealed patient #2 alleged staff grabbed him by the neck and dragged him down the hall on 9/4/08 (first admission), and alleged that he also had been threatened and choked by staff on 10/6/08 (second admission).

Review of the 9/8/08 and 10/17/08 Adverse Event/Sentinel Event Investigation Summary Reports completed by the internal Patient Advocates revealed the patient's father had been verbally informed of the pending investigations regarding the allegations of abuse by staff on 9/4/08 and on 10/7/08.

Record review revealed no documentation could be located that gave any legal jurisdiction of patient #2 to his father. Medical record review revealed no documented evidence that patient #2 had given his consent for information to be disclosed to his father at the time it was shared.

Medical record review revealed no documented evidence of an Authorization To Disclose Health Information form that allowed the internal Patient

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 143	Continued From page 18	A 143		

Advocate to release the information regarding the alleged abuse by staff to the patient's father on 9/4/08 for the 8/28/08 admission.

Record review revealed two Authorization To Disclose Health Information forms for the 10/2/08 hospital admission that had been completed by hospital staff that listed the patient's father as an individual authorized to receive patient health information. However, review of these forms revealed the patient had refused to sign the form completed upon admission on 10/2/08. Record review also revealed the other Authorization To Disclose Health Information form had been signed by the patient on 10/8/08 (the day after the internal patient advocate had shared the alleged staff abuse episode to patient's father).

Interview on 11/19/08 at 1210 with the internal Patient Advocate that investigated the 9/4/08 allegation of abuse by staff revealed he was not aware that a consent form was required.

Interview on 11/19/08 at 1130 with the internal Patient Advocate that investigated the 10/6/08 allegation of abuse by staff revealed that although she had not documented it, she had obtained the patient's "verbal consent" prior to the release of the confidential patient information to the patient's father on 10/7/08.

Interview with the Director of Nursing on 11/20/08 at 0830 revealed the these internal Patient Advocates were under the same auspice as hospital employees and were required to have an Authorization To Disclose Health Information form that had been signed by the patient that listed the individual(s) that were authorized to receive confidential patient information. She stated that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 143	Continued From page 19 the internal Patient Advocates had not followed hospital protocol regarding release of confidential patient information.	A 143		
A 144	482.13(c)(2) PATIENT RIGHTS: CARE IN SAFE SETTING The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on closed record review, occurrence report review, observation and staff interview, the hospital staff failed to ensure a safe environment in a courtyard to prevent patient elopement for 2 of 2 sampled patients that eloped (#17 and #7). The findings include: Closed record review on 11/19/2008 of Patient #17 revealed a 36 year-old male admitted to the Raleigh campus under petition for involuntary commitment on 06/23/2008 with paranoid schizophrenia and discharged on 07/21/2008. Review of the record revealed the patient attempted escape and was placed on one to one precautions on 07/14/2008 following the elopement attempt. Review of an occurrence report dated 07/14/2008 at 1843 revealed Patient #17 attempted elopement during a fresh air break by climbing over a gate in the courtyard. Closed record review on 11/18/2008 of Patient #7 revealed a 28 year-old male admitted to the Raleigh campus under petition for involuntary commitment on 09/25/2008 with bipolar disorder and discharged on 10/14/2008. Review of the record revealed the patient eloped on 10/01/2008	A 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 144	Continued From page 20	A 144		

at 1845 and was returned to the facility by campus police at 1925. Review further revealed the patient was placed on one to one precautions on the unit and two to one precautions off the unit after the elopement.

Review of an occurrence report dated 10/01/2008 revealed Patient #7 eloped during a fresh air break by climbing over a gate in the courtyard. The report revealed the patient sustained a skin tear to the left hand and a bruise on the foot.

Observation on 11/19/2008 at 1450 of a courtyard revealed an area enclosed by a brick wall with one locked door that exited the facility and entered the courtyard. The courtyard had two separate exits to the hospital campus (unsecured areas). These exits were enclosed with metal gates that were surrounded by the brick courtyard walls. Observation of one of the metal gates revealed two heavy gage wire gates that closed in the center with a chain and lock. The top of the metal gates were approximately eight foot from the ground. Observation revealed a brick archway approximately two feet above the top of the metal gate with an opening between the top of the gate and the brick archway. Observation revealed the chain loop was located in the center of the gate approximately three feet from the ground. Observation revealed a metal pole in the center of the gate with the top of the pole about five feet from the ground.

Interview during tour of the courtyard on 11/19/2008 at 1450 with staff involved with Patient #7's elopement revealed "This gate is a target. Patients go right to it and look at it to try to figure out how to get out." The staff stated that there had been 3 or 4 patients that have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 144	Continued From page 21	A 144		

attempted or succeeded at elopement through the opening at the top of this gate. The staff identified Patient #17 and stated that he had escaped through the gate the same way as Patient #7 by stepping into the chain with one foot, then on the top of the pole with the other foot and over the gap at the top of the gate. The staff stated that they had told administrative staff that the gate was a problem and that patients tried to elope from this area. The staff stated that since Patient #7 eloped, the staff had positioned one staff member by the gate whenever patients were in the courtyard. Interview revealed Patient #7 had just entered the courtyard with staff members and other patients. The interview revealed Patient #7 was bouncing a basketball walking down the sidewalk when he dropped the ball and "bolted over the gate." The interview revealed no staff was positioned by the gate when the patient "bolted" because the staff and patient had just entered the courtyard and there wasn't enough time to position a staff member at the gate. The staff stated the patients and staff would be safer if the gap at the top of the gate were fixed to prevent elopement.

Interview on 11/20/2008 at 1330 with an administrative staff member revealed patients from 1 North and 2 North (male adult admission units) at the Raleigh campus go to the observed courtyard for outside breaks. The staff member stated "We have identified the gate as a potential problem for elopement." The staff member stated "We (administrative staff members) went out there and we discussed that we could get over that gate." The interview revealed administration had responded to the concern of elopement by locating a staff member by the gate while patients are in the courtyard. The interview

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 144	Continued From page 22 revealed no structural changes were evaluated to enclose the opening because of the cost and planned relocation of patients. The staff member stated "I seriously doubt that anything will be done structurally to that gate. We've discussed this at patient safety committee. The expense will probably not be spent because of the move." The interview revealed no work order had been requested to evaluate the gate. Further interview revealed no time frame has been identified for the relocation of patients and that the courtyard will continue to be utilized until patients are moved.	A 144		
A 145	482.13(c)(3) PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on facility policy review, medical record review, observation of facility's internal video monitoring, investigative report review and staff interview the hospital failed to prevent staff to patient abuse for 1 of 10 sampled restrained patients (#68). The findings include: Review of the facility policy "Restrictive Interventions-Behavioral Hospital and Psychiatric Residential Treatment Facility #CPM-R.0020" (effective 11/10/2008) revealed that restrictive interventions are not used as a coercion, punishment or retaliation; or for the convenience of staff; or to be used in a manner that causes harm or pain to the patient. The review of the policy further revealed that "Patients are never restrained or carried in a face down position." The review also revealed that when implementing a	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 145	Continued From page 23	A 145		

restrictive intervention, the registered nurses responsibilities include an assessment of checking restraint cuffs at the first 15-minute interval and a visual observation of the patient's physical condition (labored breathing, swollen extremities, etc). Review of the policy revealed for monitoring that "whenever restrictive interventions are used, the patient is observed by a staff member assigned to observe that individual patient only."

Medical record review on 11/21/2008 for patient #68, a 24 year old male revealed that the patient was admitted to the facility on 11/13/2008 under involuntary commitment orders with a diagnosis of "schizophrenia." The review revealed telephone written physician's orders by the facility's registered nurse on 11/19/2008 at 0620 to "Manual hold times 10 minutes for blood draw. Release when complete." A following telephone physician's order by the same registered nurse on 11/19/2008 at 0625 revealed "Place in Restraint with 1:1 (one to one) for combative behavior for up to 4 hours. Release after calm and can contract for safety."

Documentation review of the patient's medical record section titled "Restrictive Intervention Assessment and Monitoring" revealed that the patient was placed in restraints on 11/19/2008 at 0620 until 0725. The review of the documentation revealed the reason for the restraints was "Patient did not want his blood drawn and became aggressive." The following documentation during the time the patient was restraint is as follows for 11/19/2008:

~0620 "Patient fighting at staff.",
~0625 "With 1:1, patient unwilling to contract for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 145	Continued From page 24	A 145		

safety and reported to on-call MD (physician) that he would not contract not to hit staff if taken out of restraints.",
~0640 "Laying face down in four point restraints and refuse to contract for safety, stating he will hit staff and physician if let out of restraints.",
~0655 "Patient quiet and resting, asked nurse if he could come out of restraint.",
~0710 "Patient still in restraint. Resting. He asked (**staff) for a bandage on a bleeding finger."
~0725 "Patient was turned over and lay on the back, patient was cooperative and did not show aggression."
~0725 "Patient sitting on bed eating. States he is much calmer. Contracts for safety. Patient removed from restraints."

No documentation was found in the medical record where the patient was assessed for vital signs and/or extremity checks by the facility's staff while in restraints.

Observation on 11/21/2008 at 1410 of the facility's internal video monitoring for patient #68 being restrained revealed that the facility had documented video of the restraining of the patient on 11/19/2008. Interview with information managment staff during the viewing revealed the time had not been changed on the video for day light savings time. The interview revealed the time shown on the tape was at 0708 but the factual time was 0608. The observation of the facility's internal video revealed that the video had multiple camera shots for video that included inside, outside of the restraint room where the patient was placed in restraints. There was also a camera shot from the nursing station. The observation of the video monitoring also revealed that the events in the restraining of the patient

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 145	Continued From page 25 had exact times on the video recording. Observation viewing of the video recording of the restraint usage for the patient that occurred on 11/19/2008 revealed that at 0610/39 (0610 and 39 seconds) a scuffle was viewed with the staff of the facility and the patient. At 0613/22 the observation revealed that the patient face down was carried by staff members holding each patient limb into the restraint room and placed face down with his head facing the door (foot of the bed) and feet facing the head of the bed. Observation revealed a total of 8 staff members started putting restraints on both arms and both legs. At 0613/45 the staff rotated the patient 360 degrees, placing his head at the head of the bed and his feet at the foot of the bed. At 0614/10, the observation of the video revealed two staff members with knees on top of the patient between the patient's mid and lower back as the restraints were being applied. One staff member was observed putting his arm around the other staff member while on top of the patient. Further observation revealed that the patient was in restraints face down until 0707 (total of 53 minutes in restraints face down) by the staff. The observation revealed that the patient was released from restraints completely at 0729. Observation further revealed that the patient had his blood drawn by a facility health care technician while he was in restraints laying face down. The observation also revealed a total of 8 staff members in the restraint room at the time of restraining patient. Observation also revealed that all of the staff left the patient after placing the restraints on the patient and the 1:1 (one to one constant observation) did not begin until 0647 on the video (total of 33 minutes without 1:1). Observation also revealed no checks were done	A 145		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 145	Continued From page 26	A 145		

by the staff during the 33 minutes of the patient's limbs with restraints on or checks of the patient's vital signs.

Review of the facility's internal investigation of the patient in restraints on 11/19/2008 revealed concerns by the facility's administration of the facility's staff use of restraints. The review of the internal investigation revealed concerns about the patient being placed in mechanical restraints face down by the staff at the facility. Other concerns reviewed in the investigation revealed concerns of "neglect" in the patient's case.

Interview with the facility's administration on 11/21/2008 at 1505 revealed that the patient should not have been in mechanical restraints face down. The interview revealed that the facility's administration was made aware of the situation on the afternoon of 11-19-08 and conducted an internal investigation immediately. The interview also revealed that the video monitoring was also watched by the administrative staff and that they found that the staff did not restrain the patient appropriately and some neglect was determined to have happened. "The patient being restrained face down is unacceptable and should not happen." The interview further revealed that some staff personnel investigations have occurred since the event and was ongoing. Other staff members involved in the restraining of the patient were not available.

As a result of the review, the facility's staff after approaching the patient for a forced blood draw, restrained a patient face down in four (4) point restraints on each limb for a total of 53 minutes. The patient while restrained face down for the 53

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 145	Continued From page 27 minutes had his blood drawn by a health care technician. The review of the video revealed that a facility staff members placed knees on the back of the patient while the patient was being placed in restraints by a total of 8 staff members. Review of the video revealed during the restraining event that no 1:1 observation was observed for a total of 33 minutes while the patient was initally restrained and medical record review revealed documentation during this same time period that the patient was being monitored 1:1.	A 145		
A 168	482.13(e)(5) PATIENT RIGHTS: RESTRAINT OR SECLUSION The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under §482.12(c) and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on review of hospital policy and procedure, medical record review and staff interview, the hospital staff failed to document a physician order for a restraint per hospital policy for 1 of 10 sampled patients with restraints (#36). The findings include: Review of hospital policy "Restrictive Interventions - Behavioral, Hospital and..." Policy Number: CPM-R.0020, Effective Date: November 10, 2008, revealed "5. Implementing a Restrictive Intervention: ...c. ...(1) Physician Orders (a) A physician's order must be written on a Physician's Order form and must specify: the type of	A 168		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 168	Continued From page 28 restrictive intervention to be used; (1) the reason for the restrictive intervention; (2) the amount of time authorized (not to exceed four [4] hours for adults, two [2] hours for children and adolescents ages 9-17, or one [1] hour for children under the age of 9); and (3) the behavioral criteria for release..." Open record review of Patient #36 revealed a 9 year old male admitted to the hospital on 10/02/2008 for treatment of Attention Deficit Hyperactivity Disorder and Oppositional Defiant Disorder. Review of a "Restrictive Intervention Assessment and Monitoring sheet dated 11/04/2008 at 0845, revealed a manual restraint was applied at 0845 and released at 0847 (2 minutes). Further record review failed to reveal any available documentation of a physician's order for the manual restraint. Interview on 11/20/2008 at 1525 with administrative staff revealed a physician's order is required for the application of restraints. Interview confirmed there was no available documentation of a physician's order for the manual restraint applied on 11/04/2008 at 0845. Interview confirmed the hospital staff failed to follow the hospital policy for Restrictive Interventions.	A 168		
A 171	482.13(e)(8) PATIENT RIGHTS: RESTRAINT OR SECLUSION Unless superseded by State law that is more restrictive-- (i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours:	A 171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 171	Continued From page 29 (A) 4 hours for adults 18 years of age or older; (B) 2 hours for children and adolescents 9 to 17 years of age; or (C) 1-hour for children under 9 years of age; This STANDARD is not met as evidenced by: Based on review of hospital policy and procedure, medical record review and staff interview, the hospital staff failed to ensure a time limited restraint order was obtained for 1 of 10 patients restrained (#35) and failed to ensure an age appropriate time limited restraint and/or seclusion order was obtained for 1 of 10 patients restrained and secluded (#32). The findings include: Review of hospital policy "Restrictive Interventions - Behavioral, Hospital and..." Policy Number: CPM-R.0020, Effective Date: November 10, 2008, revealed "5. Implementing a Restrictive Intervention: ...c. ...(1) Physician Orders (a) A physician's order must be written on a Physician's Order form and must specify: the type of restrictive intervention to be used; (1) the reason for the restrictive intervention; (2) the amount of time authorized (not to exceed four [4] hours for adults, two [2] hours for children and adolescents ages 9-17, or one [1] hour for children under the age of 9); and (3) the behavioral criteria for release..." 1. Open record review of Patient #35 revealed a 59 year old female admitted to the hospital on 10/13/2008 for treatment of a psychiatric disorder. Record review revealed on 10/25/2008 at 1306 the patient was placed in a manual restraint for documented "...throwing food @ (at) staff...pt (patient) assaulted staff member..." Further	A 171		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 171	Continued From page 30	A 171		

review revealed a physician's order was obtained and documented for the patient's manual restraint. The review revealed no documentation of any time limit for the patient to be manually restrained. The order was dated for 10/25/2008 at 1306 without any time limit noted. Further record review revealed on 10/25/2008 at 2142 the patient was placed in a manual restraint for documented "patient refused schedule po (by mouth) meds (medications). Forced meds given by IM (intramuscular) method." Further review revealed a physician's order was obtained and documented for the patient's manual restraint. The review revealed no documentation of any time limit for the patient to be manually restrained. The order was dated for 10/25/2008 at 2145 without any time limit noted. Further record review revealed on 10/26/2008 at 2010 the patient was placed in a manual restraint for documented "patient refused schedule po meds. Forced meds given." Further review revealed a physician's order was obtained and documented for the patient's manual restraint. The review revealed no documentation of any time limit for the patient to be manually restrained. The order was dated for 10/26/2008 at 2010 without any time limit noted. Further record review revealed on 10/30/2008 at 1615 the patient was placed in a manual restraint for documented "patient is schedule for po meds. If refused, is to receive forced meds." Further review revealed a physician's order was obtained and documented for the patient's manual restraint. The review revealed no documentation of any time limit for the patient to be manually restrained. The order was dated for 10/30/2008 at 1615 without any time limit noted.

Interview on 11/20/2008 at 1525 with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 171	Continued From page 31	A 171		

administrative management staff revealed all orders for restraints are to have a time limit. Interview confirmed no available documentation of a time limited order for the manual restraints applied on 10/25/2008 at 1306 and 2145, 10/26/2008 at 2010, and 10/30/2008 at 1615. Interview confirmed the hospital staff failed to follow the Restrictive Intervention policy.

2. Open record review of Patient #32 revealed a 8 year old male admitted to the hospital on 11/15/2008 for treatment of Attention-Deficit Hyperactivity Disorder, Oppositional Defiant Disorder, and rule out Bipolar Disorder. Record review revealed on 10/31/2008 at 2008 the patient was placed in a manual restraint for escort to the seclusion room and at 2010 placed in four point soft restraints for documented physical aggression against others, property destruction, physical aggression against self, and injury to self. Further review revealed a physician's order was obtained and documented for the patient's manual and mechanical restraints. The review revealed a documented time limit for the patient to be mechanically restrained in four point soft restraints for up to 2 hours. The order was dated for 10/31/2008 at 2040. Further record review revealed on 11/02/2008 at 0800 the patient was placed in seclusion for documented physical aggression against others and injury to others "patient hitting staff." Further review revealed a physician's order was obtained and documented for the patient's seclusion. The review revealed a documented time limit for the patient to be secluded for up to 2 hours. The order was dated for 10/31/2008 at 0800. Further record review revealed on 11/02/2008 at 0900 the patient was placed in seclusion for documented physical aggression against others and injury to others

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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A 171	Continued From page 32 "patient hitting staff." Further review revealed a physician's order was obtained and documented for the patient's seclusion. The review revealed a documented time limit for the patient to be secluded for up to 2 hours. The order was dated for 10/31/2008 at 0900. Interview on 11/19/2008 at 1045 with administrative staff confirmed that a time limited order for up to two (2) hours was written for the patient's restraint order dated 10/31/2008 at 2040. Further interview confirmed that a time limited order for up to two (2) hours was written for the patient's seclusion orders dated 11/02/2008 at 0800 and 0900 respectively. The interview revealed that the patient was a child under 9 years old and should have had a written physicians order with a time limit documented for no longer than one (1) hour for restraint or seclusion. Interview confirmed the hospital staff failed to follow the Restrictive Intervention policy.	A 171		
A 263	482.21 QAPI The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.	A 263		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 263	Continued From page 33 This CONDITION is not met as evidenced by: Based on review of facility policies and procedures, Quality Oversight Committee minutes, quality assessment and performance improvement data, medical records, list of contracted services and staff interviews, the facility's leadership staff failed to maintain an effective, hospital-wide, data-driven quality assessment and performance improvement program. The findings include: 1. The Governing Body failed to have a system or process in place to ensure radiology, laboratory and respiratory therapy services provided under contract were evaluated and performed in a safe and effective manner. ~cross refer to CFR 482.21(a)(2) Standard, Tag A0267 2. The Governing Body failed to have a hospital wide system or process in place to monitor and maintain a safe environment for the delivery of patient care. ~cross refer to CFR 482.41 Physical Environment Condition, Tag A0700	A 263		
A 267	482.21(a)(2) QAPI QUALITY INDICATORS The hospital must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that assess processes of care, hospital services and operations. This STANDARD is not met as evidenced by:	A 267		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 267	Continued From page 34 Based on contract reviews, staff interviews and Quality Assurance/Performance Improvement (QAPI) report reviews the Governing Body failed to have a system or process in place to ensure radiology, laboratory and respiratory therapy services provided under contract were evaluated and performed in a safe and effective manner. The findings included: 1. Review of clinical contract CRH-3909 revealed an agreement effective July 01,2008 through June 30, 2009 between the facility and a Radiologist group to provide diagnostic radiology services onsite as well as via teleradiology service. Review of Attachment B "Scope of Work" revealed "Project Evaluation - 1. Records shall be maintained comparing patient referral dates with dates of examinations to determine promptness of delivery of service. 2. Patients' medical records are audited periodically in accordance with (name of accrediting body) standards." Interview with the Radiology Director on 11/21/2008 at 1245 revealed there was no clinical data as outlined in the contract collected, aggregated or reported to the facility's leadership for the contracted group. Interview revealed "I know they have an internal peer review process, but I have never received any information back from them." Interview with the Facility's Clinical Director on 11/21/2008 at revealed there has been no clinical data as outlined in the clinical contract collected, aggregated or reported to the Governing Body in regards to the quality of care being provided by the contract service.	A 267		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 267	Continued From page 35 2. Review of contract #CRH4309 dated 07/01/2008 revealed a contractual agreement with Hospital B for laboratory (lab) services. Contract review revealed Hospital B's lab would provide microbiology testing, stat (immediate) after-hours testing, equipment down-time coverage and hepatitis/HIV testing for the Raleigh Campus. Contract review revealed, "Project Evaluation: 1. Tracking will be done to show that all laboratory testing is completed in a timely fashion. 2. Records shall be maintained with dates and times of pick up and delivery of specimens to determine promptness of delivery of service. 3. Patients' medical records are audited periodically in accordance with JCAHO standards." Interview on 11/18/2008 at 1100 with the laboratory supervisor revealed after-hours stat lab services were provided at the Butner Campus by Hospital A's lab. Interview revealed there was no contractual agreement with Hospital A to ensure after-hours stat lab services were available. Review of 2007 and 2008 QAPI reports provided by laboratory administrative staff on 11/21/2008 revealed no documentation that the dates and times of pick up and delivery of specimens to Hospital A or B was tracked to evaluate the promptness of the delivery of service. Review also revealed no documentation that the promptness of lab testing completion at Hospital A or B was tracked. Interview on 11/21/2008 at 1315 with the laboratory supervisor revealed dates and times of pick up and delivery of specimens to Hospital A and Hospital B's lab and lab result times from	A 267		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 267	Continued From page 36	A 267		

Hospital A and Hospital B's lab were not monitored and evaluated to ensure the lab tests were done in a safe and effective manner.

An interview with the laboratory medical director was requested on 11/21/2008 at 1230. The laboratory medical director was on vacation and was thus unavailable for interview per hospital administrative staff.

3. Review of the hospital's list of direct patient services contracts revealed a respiratory contracted service providing/performing direct patient services to the hospital patients. Review of the contract revealed services provided and/or performed under contract were delivery of CPAP (continuous positive airway pressure) equipment including training of patients and staff members.

Interview with management staff on 11-21-08 at 1500 revealed there was no defined process or system in place for the review of direct patient services provided by contract. The interview revealed there was no documentation available for the evaluation of direct patient services provided by contract. Interview revealed that "if the monitoring/evaluation of contracted services is not addressed in the contract, it is probably not done."

Interview with administrative staff on 11-21-08 at 1530 revealed there was no documentation available for the evaluation of contracted services. The interview revealed contracted services were not included in the hospital wide quality assurance performance improvement program. The interview revealed the staff was not aware of a system or process in place that evaluated services provided/performed by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 267	Continued From page 37 contracted services.	A 267		
A 275	482.21(b)(2)(i) QAPI QUALITY OF CARE The hospital must use the data collected to-- (i) Monitor the effectiveness and safety of service and quality of care. This STANDARD is not met as evidenced by: Based on observations during tours, fire drill log reviews, policy and procedure reviews and staff interviews as referenced in the Life Safety survey completed 11-21-08 the hospital failed to monitor and maintain an environment for the safety of patients. The finding include: Observations on November 18, 2008 at approximately 0930 onward, the primary exit egress discharge door, at ground level of Stairwell #A2- Level 0, was found to be locked and could not be unlocked from inside stairwell with tool, key, etc. therefore not allowing exiting. (CRH- Butner Campus) Observation on November 19, 2008 at approximately 0830 onward, revealed the normal power visual indicator was not functioning on the fire alarm panel serving identified buildings on the remote campus. The Main fire alarm panels for the McBryde and Williams buildings have no capability for battery back-up, (1955 year models). The back-up power supply is the Emergency Generators. In the event of loss of power just to the Fire Alarm Control Panel (FACP) , breaker malfunction, etc, the generators would not crank and supply power for that isolated incident. Therefore the FACP would not	A 275		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 275	Continued From page 38 function (as tested during survey) until the problem was identified and corrected - power restored. Per documentation review and staff interview there were no emergency procedures in place for posting a fire watch during this event. The audible fire alarm notification devices (horns) on Hall 2 East did not work when testing the Fire Alarm. The facility staff failed to have audible alarms heard on the short corridors near rooms 240 and 343 during the test of the Fire Alarm Control Panel (McBryde Building). There was no machine room smoke detector serving the elevator equipment room - Williams Building. Observations on November 18, 2008 at approximately 1640 revealed no audible and visual signaling device connected to the fire alarm system serving unit #4 - Building 52.(CRH Butner Annex Campus). There was no visual trouble signal with loss of power to fire alarm control panel.(Building 53 - CRH Butner Annex Campus).	A 275		
A 385	482.23 NURSING SERVICES The hospital must have an organized nursing service that provides 24-hour nursing services. The nursing services must be furnished or supervised by a registered nurse. This CONDITION is not met as evidenced by: Based on policy and procedure reviews, medical record reviews, internal video monitoring review, observations and staff interviews the nursing staff failed to provide safe patient care, assessment of patients and reassessment of patients. The findings include: 1. The hospital's nursing staff failed to provide care to ensure that patient needs were met by	A 385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 385	Continued From page 39 failing to adequately monitor and supervise a patient placed in restraints to prevent patient abuse and neglect in 1 of 10 patients restrained (#68). ~ cross refer to 482.23(b) Staffing, Standard Tag A0392. 2.. The nursing staff failed to ensure: monitoring of a patient on CPAP (Continuous Positive Airway Pressure) per hospital policy for 2 of 2 CPAP records reviewed (#66, #65) and monitoring of a patient's vital signs as ordered by the physician for 4 of 7 child and adolescent patient records reviewed (#30, #54, #56, #55) ~ cross refer to 482.23(b)(3) RN Supervison of Nursing Care, Standard Tag A0395.	A 385		
A 392	482.23(b) STAFFING AND DELIVERY OF CARE The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient. This STANDARD is not met as evidenced by: Based on review of policy and procedure, medical record review, Advocacy Log of Grievances review, Adverse Event/Sentinel Event Investigation Summary Reports review, investigative reports, personnel files, occurrence report review, observation, observation of facility's internal video monitoring the hospital's nursing staff failed to provide care to ensure that patient needs were met by failing to adequately monitor	A 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 392	Continued From page 40	A 392		

and supervise a patient placed in restraints to prevent patient abuse and neglect in 1 of 10 patients restrained (#68).

The findings include:

Review of the facility policy "Restrictive Interventions-Behavioral Hospital and Psychiatric Residential Treatment Facility #CPM-R.0020" (effective 11/10/2008) revealed that restrictive interventions are not used as a coercion, punishment or retaliation; or for the convenience of staff; or to be used in a manner that causes harm or pain to the patient. The review of the policy further revealed that "Patients are never restrained or carried in a face down position." The review also revealed that when implementing a restrictive intervention, the registered nurses responsibilities include an assessment of checking restraint cuffs at the first 15-minute interval and a visual observation of the patient's physical condition (labored breathing, swollen extremities, etc). Review of the policy revealed for monitoring that "whenever restrictive interventions are used, the patient is observed by a staff member assigned to observe that individual patient only."

Open medical record review on 11/21/2008 for patient #68, a 24 year old male revealed that the patient was admitted to the facility on 11/13/2008 under involuntary commitment orders with a diagnosis of "schizophrenia." The review revealed telephone written physician's orders by the facility's registered nurse on 11/19/2008 at 0620 to "Manual hold times 10 minutes for blood draw. Release when complete." A following telephone physician's order by the same registered nurse on 11/19/2008 at 0625 revealed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 392	Continued From page 41	A 392		

"Place in Restraint with 1:1 (one to one) for combative behavior for up to 4 hours. Release after calm and can contract for safety."

Documentation review of the patient's medical record section titled "Restrictive Intervention Assessment and Monitoring" revealed that the patient was placed in restraints on 11/19/2008 at 0620 until 0725. The review of the documentation revealed the reason for the restraints was "Patient did not want his blood drawn and became aggressive." The following documentation during the time the patient was restraint is as follows for 11/19/2008:

~0620 "Patient fighting at staff.",
~0625 "With 1:1, patient unwilling to contract for safety and reported to on-call MD (physician) that he would not contract not to hit staff if taken out of restraints.",
~0640 "Laying face down in four point restraints and refuse to contract for safety, stating he will hit staff and physician if let out of restraints.",
~0655 "Patient quiet and resting, asked nurse if he could come out of restraint.",
~0710 "Patient still in restraint. Resting. He asked (**staff) for a bandage on a bleeding finger."
~0725 "Patient was turned over and lay on the back, patient was cooperative and did not show aggression."
~0725 "Patient sitting on bed eating. States he is much calmer. Contracts for safety. Patient removed from restraints."

No documentation was found in the medical record where the patient was assessed for vital signs and/or extremity checks by the facility's staff while in restraints.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 392	Continued From page 42	A 392		

Observation on 11/21/2008 at 1410 of the facility's internal video monitoring for patient #68 being restrained revealed that the facility had documented video of the restraining of the patient on 11/19/2008. Interview with information management staff during the viewing revealed the time had not been changed on the video for day light savings time. The interview revealed the time shown on the tape was at 0708 but the actual time was 0608.

Observation of the video recording of the restraint usage for the patient that occurred on 11/19/2008 revealed that at 0610/39 (0610 and 39 seconds) a scuffle was viewed with the staff and the patient occurring near anuses's station. At 0613/22 observation revealed that the patient face down was carried by staff members holding each patient limb into the restraint room. The staff placed the patient face down with his head facing the door at the foot of the bed and feet facing the head of the bed. Observation revealed a total of 8 staff members started putting restraints on both arms and both legs. At 0613/45 the staff rotated the patient 360 degrees, placing his head at the head of the bed and his feet at the foot of the bed. At 0614/10, the observation of the video revealed two staff members with knees on top of the patient between the patient's mid and lower back as the restraints were being applied. One staff member was observed putting his arm around the other staff member while on top of the patient. Further observation revealed that the patient was in restraints face down until 0707 (total of 53 minutes in restraints face down) by the staff. The observation revealed that the patient was released from restraints completely at 0729. Observation further revealed that the patient had his blood drawn by a facility health care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 392	Continued From page 43	A 392		

technician while he was in restraints laying face down. The observation also revealed a total of 8 staff members in the restraint room at the time of restraining patient. Observation also revealed that all of the staff left the patient after placing the restraints on the patient and the 1:1 (one to one constant observation) did not begin until 0647 on the video (total of 33 minutes without 1:1). Observation also revealed no checks were done by the staff during the 33 minutes of the patient's limbs with restraints on or checks of the patient's vital signs.

Review of the facility's internal investigation of the patient in restraints on 11/19/2008 revealed concerns by the facility's administration of the facility's staff use of restraints. The review of the internal investigation revealed concerns about the patient being placed in mechanical restraints face down by the staff at the facility. Other concerns reviewed in the investigation revealed concerns of "neglect" in the patient's case.

Interview with the facility's administration on 11/21/2008 at 1505 revealed that the patient should not have been in mechanical restraints face down. The interview revealed that the facility's administration was made aware of the situation on the afternoon of 11-19-08 and conducted an internal investigation immediately. The interview also revealed that the video monitoring was also watched by the administrative staff and that they found that the staff did not restrain the patient appropriately and some neglect was determined to have happened. "The patient being restrained face down is unacceptable and should not happen." The interview further revealed that some staff personnel investigations have occurred since the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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A 392	Continued From page 44 event and was ongoing. As a result of the review, the facility's staff after approaching the patient for a forced blood draw, restrained a patient face down in four (4) point restraints restraining each limb for a total of 53 minutes. The patient while restrained face down had his blood drawn by a health care technician. The review of the video revealed that a facility staff members placed knees on the back of the patient while the patient was being placed in restraints by a total of 8 staff members. Review of the video revealed during the restraining event that no 1:1 observation was observed for a total of 33 minutes while the patient was initially restrained and medical record review revealed documentation during this same time period that the patient was being monitored 1:1.	A 392		
A 395	482.23(b)(3) RN SUPERVISION OF NURSING CARE A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on review of facility policies and procedures, open and closed medical records,internal video monitoring reviews, observations and staff interviews nursing staff failed to ensure: monitoring of a patient on CPAP (Constant Positive Airway Pressure) per hospital policy for 2 of 2 CPAP records reviewed (#66, #65) and monitoring of a patient's vital signs as ordered by the physician for 4 of 7 child and adolescent patient records reviewed (#30, #54, #56, #55) The findings include:	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 395	Continued From page 45 Nursing staff failed to ensure monitoring of a patient on CPAP (Constant Positive Airway Pressure) per hospital policy for 2 of 2 CPAP records reviewed. (pt #66, #65) Review of policy "Respiratory Support-CPAP and BIPAP effective June 1, 2008 revealed "Policy: C. CPAP machines have no clinical alarms and may be used in all settings at (name) facility. Procedures: B. Set Up Equipment: 1. Collect and assemble equipment at bedside... 3. Verify that you have the machine that was pre-set for that patient....7. After the mask is applied assess the patient for adequate respiratory effort and breathing comfort throughout night. 8. The assigned nursing staff will document when the patient was placed on device, the time device was removed and their response/reactions to the treatment...." Review of CPAP protocol dated 11/14/08 (8 days post CPAP initiation for Pt #66 and 7 day post CPAP for Pt #65) revealed "5. The RN in charge of the ward where the CPAP is in use is responsible for: ....Making sure that the CPAP and equipment is used each night per instruction (document on treatment sheet when put on and taken off).... Making sure that documentation reflects use, cleaning and weekly disinfection of equipment. Any adverse responses must also be indicated. (The treatment record may be used and / or the progress notes." 1. Open medical record review on 11/19/08 for Pt #65 revealed a 55 year-old patient admitted on 11/08/08 for psychosis and untreated irritable bowel syndrome. Review of physician's orders dated 11/8/08 at 1300 revealed an order for CPAP (constant positive airway pressure), large	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 395	Continued From page 46	A 395		

mask, humidified, room air, FIO2 (oxygen concentration) = 21%, pressure 10 cm (centimeters) water. Review of medical record reveals no evidence of the CPAP/BiPAP (Bi-Level Positive Airway Pressure) Treatment and Care Worksheet being completed by nursing. Review of progress notes revealed a summary documentation by nursing staff on 11/9/08 at 0400 "C-PAP in place. Further review of progress notes revealed documentation by nursing staff on 11/12/08 at 2300 "complained air from CPAP was 'too cold'" (67 hours since last CPAP documentation). Further review revealed documentation by nursing staff on 11/14/08 at 2120 "Pt (patient) has been stating that he was not taught how to operate CPAP. When machine was delivered on Saturday 11/8, pt was sitting next to the named vendor rep (representative) & return demonstrated use of machine - wear of mask & location of power button." (22 hours since last CPAP documentation) Further review of medical record revealed no evidence of any further documentation of care of the CPAP for pt #65(108 hours since last CPAP documentation).

Interview with Nurse #37 on 11/21/08 at 1120 revealed staff member had not received education on CPAP machines. Further interview revealed "I'm an experienced nurse." Further interview revealed Pt #65 is capable of applying CPAP, but sometimes he doesn't always do it and the nurse helps him.

Interview with Nurse #46 on 11/21/08 at 1545 revealed "I worked the 3p-11p shift on 11/8/08. I was present when (name) contract service came in with CPAP machine around 1830 - 1900." Further interview revealed nurse #46, 2 HCT (healthcare technicians), the nursing coordinator,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 395	Continued From page 47	A 395		

nurse #35 and the patient #65 were present in the conference room when the contract services representative instructed the patient how to apply and use the CPAP machine. Further interview revealed no educational packet was left on the unit by the house coordinator or vendor representative. Interview revealed the CPAP protocol was placed on the bulletin board in the report room on 11/14/08 (7 days after pt #65's CPAP initiation) for review by staff. Interview revealed she (nurse #46) received education on the CPAP treatment and care worksheet on Wednesday 11/19/08. Interview confirmed there were no education/competency documents completed by the respiratory vendor contracted services staff.

Interview with nurse #47 on 11/20/08 at 1530 revealed she received education on the CPAP treatment and documentation flowsheet on Thursday 11/20/08. Interview revealed nurse #47 was not familiar with the CPAP treatment and worksheet prior to 11/20/08.

Nurse #35 was unavailable for phone interview on 11/21/08 at 1130. Nurse #35 called back to the facility at 1545 and transfer was attempted to the administrative offices without success. Nurse #35 did not call back.

Nurse #44 was on investigatory leave and phone contact was attempted at 11/21/08 at 1200. Nurse #44 was unavailable for phone interview.

Interview with nursing management staff on 11/21/08 at 1330 revealed the house coordinator contacts the vendor and gives an educational packet to nurses on the ward after CPAP equipment has been delivered and inserviced.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 395	Continued From page 48 Further interview revealed no copy of education/inservice training is completed by the vendor and left on the unit for staff files. Interview confirmed nurse #37, nurse #35, nurse #44 and nurse #46 were staffing on 11/8/08 and responsible for the care of Pt #65. Further interview confirmed there is no evidence of documentation of CPAP training documented on the ward after initiation of CPAP. Further interview confirmed there was no evidence of documentation of CPAP training for nurse #37, nurse #35, nurse #44 and nurse #46. Further interview confirmed nursing staff working on Ward D2 and E2 were educated/in-serviced on the CPAP treatment and care worksheet on 11/19/08 and 11/20/08. Interview confirmed the nursing staff did not follow hospital policy regarding documentation of CPAP monitoring. Interview confirmed leadership failed to ensure nursing staff were competent in use of the CPAP/BiPAP equipment. Interview with administrative nursing staff on 11/19/08 at 1220 revealed some nurses on nursing units (not including medical unit) have been CPAP trained and some have not. Interview revealed placing CPAP equipment on units other than the medical unit is a new process. Interview confirmed there is no evidence of documentation of CPAP training for nurse #37, nurse #35, nurse #44 and nurse #46. Interview confirmed nursing staff working on D2 and E2 were educated/trained on the availability and use of the CPAP treatment and care worksheet on 11/19/08 and 11/20/08. Interview revealed a housewide inservice will be held in an effort to train all nursing staff on the use of CPAP machines and the use of the CPAP treatment and care worksheet for documentation on the patient	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 395	Continued From page 49	A 395		

with CPAP/BiPAP. Interview confirmed the nursing staff did not follow hospital policy regarding documentation of CPAP monitoring.

2. Open medical record review on 11/20/08 for pt #66 revealed a 52 year-old patient admitted on 11/7/08 for paranoid schizophrenia - chronic and pseudoseizures. Review of physician's order dated 11/7/08 at 1605 revealed "1. CPAP Machine. Please have Respiratory provide machine. 2. Use CPAP qhs (at bedtime)." Further review of physician's orders dated 11/7/08 at 1630 revealed clarification of CPAP order. "Auto-CPAP c (with) heated humidity." Review of medical record reveals no evidence of the CPAP/BiPAP Treatment and Care Worksheet being completed by nursing. Review of progress notes revealed documentation by nursing staff on 11/7/08 at 2100 "CPAP obtained & inservice given. CPAP in med (medication) room....". Further review of progress notes revealed documentation by nursing staff on 11/08/08 at 0556 "...Sleeps with CPAP machine due to sleep apnea." Further review revealed documentation by nursing staff on 11/15/08 at 0440 "...Pt (patient) using CPAP s (without) problems (143 hours since last CPAP documentation). Further review revealed documentation by nursing staff on 11/19/08 at 2200 revealed "...CPAP to bed..." (89 hours since last CPAP documentation). Further review of medical record revealed no evidence of any further documentation of care of the CPAP for pt #66.

Interview with nurse #30 11/20/08 at 1500 revealed she received education on the CPAP treatment and care worksheet on Wednesday 11/19/08. Interview confirmed there was no evidence of a CPAP treatment and worksheet in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 395	Continued From page 50	A 395		

Pt #66's medical record or in the flowsheet record maintained at the nurse's station.

Interview with nurse #29 on 11/20/08 at 1530 revealed he received education on the CPAP treatment and care worksheet on Wednesday 11/19/08. Interview confirmed there was no evidence of a CPAP treatment and worksheet in Pt #66's medical record or in the flowsheet record maintained at the nurse's station.

Interview with nurse #36 on 11/20/08 at 1500 revealed she received education on the CPAP treatment and care worksheet on Wednesday 11/19/08. Interview confirmed there was no evidence of a CPAP treatment and worksheet in Pt #66's medical record or in the flowsheet record maintained at the nurse's station.

Interview with nursing management staff on 11/21/08 at 1330 revealed house coordinator contacts vendor and gives educational packet to nurses on the ward after CPAP equipment has been delivered and inserviced. Further interview revealed no copy of education/inservice training is completed by the vendor and left on the unit for staff files. Further interview confirmed there is no evidence of documentation of CPAP training documented on the ward after initiation of CPAP. Further interview confirmed there was no evidence of documentation of CPAP training for nurse #36, nurse #29 and nurse #30. Further interview confirmed nursing staff working on Ward D2 and E2 were educated/in-serviced on the CPAP treatment and care worksheet on 11/19/08 and 11/20/08. Interview confirmed the nursing staff did not follow hospital policy regarding documentation of CPAP monitoring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 395	Continued From page 51 Interview with administrative nursing staff on 11/19/08 at 1220 revealed some nurses on nursing units (not including medical unit) have been CPAP trained and some have not. Interview revealed placing CPAP equipment on units other than the medical unit is a new process. Interview confirmed there is no evidence of documentation of CPAP training for nurse #36, nurse #29 and nurse #30. Interview confirmed nursing staff working on D2 and E2 were educated/trained on the availability and use of the CPAP treatment and care worksheet on 11/19/08 and 11/20/08. Interview revealed a housewide inservice will be held in an effort to train all nursing staff on the use of CPAP machines and the use of the CPAP treatment and care worksheet for documentation on the patient with CPAP/BiPAP. Interview confirmed the nursing staff did not follow hospital policy regarding documentation of CPAP monitoring. Nursing staff failed to ensure monitoring of a patient's vital signs as ordered by the physician for 4 of 7 child and adolescent patient records reviewed (#30, #54, #56, #55) Review of policy "Vital Signs - Documentation and Reporting" dated October 2008 revealed "Policy: Vital Signs will be obtained as ordered, documented, and reported to the medical physician or PA (physician's assistant) when out of range. Definition: Out of Range Vital Signs: BP (blood pressure) (symbol for less than or equal to) or (symbol for greater than or equal to) 180 Systolic (upper BP number) or (symbol for greater than or equal to) 110 Diastolic (lower BP number), Pulse (symbol for less than or equal to) 48 or (symbol for greater than or equal to) 110." Further review revealed "Procedure:...2.	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 395	Continued From page 52 Technicians are responsible for the following:...Repeating any out of range vital signs, Notifying the nurse immediately of all out of range vital signs..." 1. Open record review for Patient #30 revealed a 14 year old admitted to the 494 unit on 11/10/2008 for autism and bipolar disorder. Review of admission orders written by a physician on 11/10/2008 revealed "Vital Signs: BID x3 (twice daily for three days), then q day (every day)...Call the medical officer for: ...BP < 90 systolic or > 180 systolic or > 110 diastolic...Heart Rate < 48 or > 110." Review of the Vital Signs Flow Sheet revealed vital signs were not monitored on 11/13/2008 for the day shift (ordered twice daily). Further review revealed on 11/17/2008 at 0810 the patient's pulse was recorded as 53 and the BP as 85/73 by a Health Care Technician (HCT). Review of the Vital Signs flow sheet and progress notes revealed the next set of vial signs were recorded on 11/18/2008 at 1428 (30 hours and 18 minutes later). Review revealed no documentation the nurse was notified of the out of range BP. Further review revealed no documentation that the nurse reviewed the vital signs flowsheet on 11/13/2008 or 11/17/2008. Interview with the Adolescent Ward Director on 11/18/2008 at 1135 confirmed staff failed to monitor the patient's vital signs as ordered by the physician on 11/13/2008. Interview failed to reveal a reason why the vital signs were not monitored. Further interview confirmed the HCT failed to notify the nurse of the out of range BP on 11/17/2008. Interview confirmed staff failed to follow facility policy on monitoring and reporting of vital signs.	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 395	Continued From page 53 Interview with a HCT on the 494 ward on 11/18/2008 at 1415 revealed the staff member utilizes a policy posted in the nurses' station to determine out of range vital signs. Review of the posted "Addendum to Vital Signs Procedure" dated 3/2008 during the interview revealed the "Within Normal Limits" BP for a child aged 11-16 years would be a range of 60/50 to 110/75 and pulse for a child 12 and older 60-100. Interview with administrative staff on 11/18/2008 at 1520 revealed the policy dated October 2008 is the current policy which also matches the admission orders sheet for out of range vital signs. Interview revealed the staff was unaware the former out of range vital signs policy (dated 3/2008) was still in use in the 494 clinical area. 2. Open record review for Patient #54 revealed an 8 year old admitted 10/25/2008 for Oppositional Defiant Disorder. Review of admission orders written by a physician on 10/25/2008 revealed "Vital Signs: BID x3 (twice daily for three days), then q day (every day)..." Review of the Vital Signs Flow Sheet revealed vital signs were not monitored on 10/26/2008 evening shift, 10/27/2008 day and evening shift, 10/31/2008, 11/04/2008, 11/10/2008 and 11/11/2008. Interview with the Adolescent Ward Director on 11/18/2008 at 1135 confirmed staff failed to monitor the patient's vital signs as ordered by the physician. Interview failed to reveal a reason why the vital signs were not monitored. Interview confirmed staff failed to follow facility policy on monitoring and reporting of vital signs.	A 395		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 395	Continued From page 54 3. Open record review for Patient #56 on 11/20/2008 revealed a 15 year old admitted 11/14/2008 for Conduct Disorder. Review of admission orders written by a physician on 11/14/2008 revealed "Vital Signs: BID x3 (twice daily for three days), then q day (every day)..." Review of the Vital Signs Flow Sheet revealed vital signs were not monitored on 11/16/2008 evening shift and 11/19/2008. Interview with the Adolescent Ward Director on 11/20/2008 at 1440 confirmed staff failed to monitor the patient's vital signs as ordered by the physician. Interview failed to reveal a reason why the vital signs were not monitored. Interview confirmed staff failed to follow facility policy on monitoring and reporting of vital signs. 4. Open record review for Patient #55 on 11/20/2008 revealed a 14 year old admitted 11/15/2008 for Post-traumatic Stress Disorder. Review of admission orders written by a physician on 11/15/2008 revealed "Vital Signs: BID x3 (twice daily for three days), then q day (every day)..." Review of the Vital Signs Flow Sheet revealed vital signs were not monitored on 11/16/2008 day shift. Interview with the Adolescent Ward Director on 11/20/2008 at 1440 confirmed staff failed to monitor the patient's vital signs as ordered by the physician. Interview failed to reveal a reason why the vital signs were not monitored. Interview confirmed staff failed to follow facility policy on monitoring and reporting of vital signs.	A 395		
A 528	482.26 RADIOLOGIC SERVICES The hospital must maintain, or have available, diagnostic radiological services. If therapeutic	A 528		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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A 528	Continued From page 55 services are also provided, they, as well as the diagnostic services, must meet professionally approved standards for safety and personnel qualifications. This CONDITION is not met as evidenced by: Based on review of Medical Staff Bylaws, Rules and Regulations, Radiologist privileging information, facility policies, contract reviews, radiographic (xray) physicist reports, dental xray equipment operator's manuals and staff interviews the leadership staff failed to maintain and ensure safe radiological services were provided to the patients. The findings included: 1. The leadership staff failed to ensure teleradiologists were credentialed and privileged to interpret radiological diagnostic tests ~ cross refer to 482.26(c)(1) Radiologist responsibilities, Standard Tag A0546 2. The leadership staff failed to ensure the dental xray equipment had the required preventative maintenance (PM) performed annually ~ cross refer to 482.26(b)(2) Periodic Equipment Maintenance, Standard Tag A0537 3. The leadership staff failed to have a system or process in place to ensure radiology services provided under contract were evaluated and performed in a safe and effective manner. ~ cross refer to 482.26(a) Scope of Services, Standard Tag A0529	A 528		
A 529	482.26(a) SCOPE OF RADIOLOGIC SERVICES	A 529		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

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A 529	Continued From page 56 The hospital must maintain, or have available, radiologic services according to the needs of the patients. This STANDARD is not met as evidenced by: Based on clinical contract reviews and staff interviews the leadership staff failed to have a system or process in place to ensure radiology services provided under contract were evaluated and performed in a safe and effective manner. The findings include: Review of clinical contract CRH-3909 revealed an agreement effective July 01,2008 through June 30, 2009 between the facility and a Radiologist group to provide diagnostic radiology services onsite as well as via teleradiology service. Review of Attachment B "Scope of Work" revealed "Project Evaluation - 1. Records shall be maintained comparing patient referral dates with dates of examinations to determine promptness of delivery of service. 2. Patients' medical records are audited periodically in accordance with (name of accrediting body) standards." Interview with the Radiology Director on 11/21/2008 at 1245 revealed there was no clinical data as outlined in the contract collected, aggregated or reported to the facility's leadership for the contracted group. Interview revealed "I know they have an internal peer review process, but I have never received any information back from them." Interview with the Facility's Clinical Director on 11/21/2008 at 1400 revealed there has been no clinical data as outlined in the clinical contract	A 529		

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	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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A 529	Continued From page 57 collected, aggregated or reported to the Governing Body in regards to the quality of care being provided by the contract service.	A 529		
A 537	482.26(b)(2) PERIODIC EQUIPMENT MAINTENANCE Periodic inspection of equipment must be made and hazards identified must be promptly corrected. This STANDARD is not met as evidenced by: Based on review of facility policies, radiographic (xray) physicist reports, dental xray equipment operator's manuals and staff interviews staff failed to ensure the dental xray equipment had the required preventative maintenance (PM) performed annually. Findings included: Review of Radiology Department policy "Radiation Safety Program" dated 10/2008 revealed "Equipment: All equipment shall be kept in good working order and inspected as required..." Review of a xray physicist report dated 3/27/2008 revealed "The table summarizes the results of the annual radiographic surveys...Unit: Gendex I/O (R), Comments/Findings: Recommend kVp reviewed at PM, Unit: Gendex I/O 2 (R), Comments/Findings: Recommend kVp reviewed at PM..." Interview with the physicist who completed the report on 11/21/2008 at 1241 revealed the physicist did not perform PMs on the xray equipment during the visit in March 2008 and does not perform PMs on xray equipment.	A 537		

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	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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A 537	Continued From page 58 Interview with the Radiology Director on 11/21/2008 at 1245 revealed there are three pieces of xray equipment on the main campus' dental clinic: two intraoral and one extraoral (panoramic). Interview revealed there was no record of PMs performed on the three dental xray machines. Interview with the dental clinic's dentist on 11/21/2008 at 1300 revealed the dentist had been running the clinic for more than five years. Interview revealed the three pieces of xray equipment in the dental clinic are not on a PM schedule. Interview revealed "I make my own adjustments as necessary." Interview revealed the dentist was unsure if there were any routine PMs required for the three pieces of xray equipment. Review of the operator's manual for the Gendex (intraoral) xray machines (not dated) revealed "Section 4 - System Function Checks: The following must be performed to complete the installation of the GX-770. These are also to be performed as part of the Periodic Maintenance, at 12 month intervals. Failure to perform these checks may result in an installation that does not comply with the U.S. Radiation Performance Standards 21 CFR Subchapter J. Further review revealed 14 individual steps of periodic maintenance required at 12 month intervals. Review of the operator's manual for the Planmeca PM 2002 CC Panoramic x-ray Unit (not dated) revealed "Service - To guarantee user and patient safety and to ensure image quality the unit must be checked and recalibrated by a qualified Planmeca service technician once a year or after	A 537		

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	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

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A 537	Continued From page 59 10,000 exposures if this is sooner." Interview with the facility's Biomedical Technician on 11/21/2008 at 1420 revealed there was no record of PMs performed on the three pieces of dental xray equipment. Interview revealed "I cannot perform PMs on xray equipment". Further interview revealed there was an outside contract obtained to perform PMs on xray equipment. Interview revealed "For some reason, the dental (xray) equipment never made it on the master inventory." Interview revealed the Biomed staff was unsure if the dental xray equipment had ever had a PM performed since installation.	A 537		
A 546	482.26(c)(1) RADIOLOGIST RESPONSIBIITIES A qualified full-time, part-time, or consulting radiologist must supervise the ionizing radiology services and must interpret only those radiological tests that are determined by the medical staff to require a radiologist's specialized knowledge. For purposes of this section, a radiologist is a doctor of medicine or osteopathy who is qualified by education and experience in radiology. This STANDARD is not met as evidenced by: Based on review of Medical Staff Bylaws, Rules and Regulations, Radiologist privileging information and staff interviews leadership staff failed to ensure teleradiologists were credentialed and privileged to interpret radiological diagnostic tests. Findings included: Review of a privileging manual for the facility's contracted teleradiologist service revealed 53 teleradiologists who interpret radiological	A 546		

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	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

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A 546	Continued From page 60 diagnostic tests for the facility. Review of the Medical Staff Bylaws, Rules and Regulations dated 11/2008 revealed no medical staff category for teleradiology. Further review revealed "Section 2 - Professional Criteria for Medical Staff Membership and Clinical Privileges - A. Appointment to the Medical Staff shall be made on the basis of professional criteria: (1) verification of current licensure, (2) relevant training or experience, (3) current competence and (4) the ability to perform the privileges requested." Further review revealed "I. Minimum Criteria for Radiology: 1. General Criteria: Licensed to practice in NC as an independent practitioner. 2. Completion of an approved residency in radiology." Interview with administrative staff on 11/21/2008 at 1400 revealed the radiology service for the facility is provided by contract teleradiology (digital images are read by an off-site radiologist). Interview revealed "(Name of contracted agency) does all of the credentialing for us." Interview revealed there has been no verification by the facility's medical staff of current licensure, verification of training, experience or completion of a residency in radiology. Further interview revealed there has been no approval by the facility's medical staff of any of the 53 teleradiologists privileges to interpret radiological diagnostic tests via teleradiology service. Interview revealed the contract service provided a list of the services each radiologist could provide to the facility. Interview revealed there has been no credential review or privileging of the teleradiologists by the facility's medical staff or governing body since the contract went into effect July 01, 2008.	A 546		

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	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

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A 582	482.27(a) ADEQUACY OF LABORATORY SERVICES The hospital must have laboratory services available, either directly or through a contractual agreement with a certified laboratory that meets the requirements of part 493 of this chapter. This STANDARD is not met as evidenced by: Based on staff interview and contract review the hospital failed to have a contractual agreement with the laboratory (lab) that provided after-hours lab services. The findings include: Interview on 11/18/2008 at 1100 with the laboratory supervisor revealed the lab at the Butner Campus was open on Monday - Friday from 0600 to midnight and on weekends and holidays from 0600 - 1800. Interview revealed emergency lab services, including arterial blood gases, troponin levels and basic blood chemistries (Chem - 8), were available onsite at the Butner Campus at all times. Interview revealed all other after-hours stat (immediate) lab services were provided by Hospital A's lab. Interview revealed after-hours stat lab specimens were obtained at the Butner Campus and sent to Hospital A's lab for analysis. Interview revealed Hospital A's lab provided after-hours lab services on a "fee for service" basis (a fee is charged for each service when the service is performed). Interview revealed there was no contractual agreement with Hospital A to ensure after-hours stat lab services were available. Review of hospital contracts revealed no documentation of a laboratory services agreement with Hospital A.	A 582		

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	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

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A 582	Continued From page 62 Interview on 11/18/2008 at 1215 with administrative staff revealed, "(Hospital A) does labs after hours as a fee for service. We do not have a written agreement with (Hospital A). They bill us for each test as it's done." Interview confirmed there was no contractual agreement with Hospital A to ensure after-hours lab services were available.	A 582		
A 700	482.41 PHYSICAL ENVIRONMENT The hospital must be constructed, arranged, and maintained to ensure the safety of the patient, and to provide facilities for diagnosis and treatment and for special hospital services appropriate to the needs of the community. This CONDITION is not met as evidenced by: Based on observations during tours, fire drill log reviews, policy and procedure reviews and staff interviews as referenced in the Life Safety survey completed 11-21-08 the hospital failed to maintain an environment for the safety of patients. The Findings include: 1. The hospital failed to develop and maintain a safe physical plant and overall safe environment assuring the safety and well being of patients. ~cross refer to 482.41(a) Physical Environment, Standard Tag A0701 2. The hospital failed to have functioning emergency lighting within all stairwells. ~cross refer to 482.41(a)(1) Physical Environment, Standard Tag A0702	A 700		

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	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

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A 700	Continued From page 63 3. The hospital failed to discontinue usage of roller latches. ~cross refer to 482.41(b)(5) Physical Environment, Standard Tag A0712 4. The hospital failed to have: emergency procedures in place for posting a fire watch during a power outage event, audible fire alarms and a smoke detector in an elevator room . ~cross refer to 482.41(b)(7) Physical Environment, Standard Tag A0714 5. The staff failed to perform the required number of fire drills. ~cross refer to 482.41(b)(8) Physical Environment, Standard Tag A0715 6. The hospital failed to ensure supplies, equipment and the physical plant were maintained in a safe level. ~cross refer to 482.41(c)(2) Physical Environment, Standard Tag A0724.	A 700		
A 701	482.41(a) MAINTENANCE OF PHYSICAL PLANT The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observations, tours and staff interviews as referenced in the Life Safety survey completed 11-21-08 the hospital failed to develop and maintain a safe physical plant and overall safe	A 701		

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A 701	Continued From page 64 environment assuring the safety and well being of patients. The Findings include: 1. During tour on November 18, 2008 at approximately 0930 onward, the primary exit egress discharge door, at ground level of Stairwell #A2- Level 0, was found to be locked and could not be unlocked from inside stairwell with tool, key, etc. therefore not allowing exiting. (CRH- Butner Campus) Observations on November 19, 2008 at approximately 0830 onward revealed the exit discharge is not complete to the publicway with surface other than soil and grass.(Wright Building - northeast exit) ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 032. 2. Observation, on November 18, 2008 at approximately 1000 revealed there were penetrations thru 2 hr fire rated wall above the ceiling @ door D0003 that had not been sealed to maintain the required fire-rating of the wall. (CRH - Butner Campus) Observations on November 18, 2008 at approximately 1555 onward revealed Areas of Buildings 54, and 53 are used as Business Occupancies without a minimum two hour fire barrier between Health Care Occupancy - areas do allow customary access by patients. The bathroom vanity was missing in the restroom on the second floor along with holes in the floor (Building 51)	A 701		

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	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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A 701	Continued From page 65 ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 011. 3. Observation on November 19, 2008 at approximately 0830 onward revealed generator and mechanical equipment room is not equipped with a self-closing and latching fire door - Edgerton Building - door is equipped with a louver at area adjacent to lower level exit. The storage room greater than one hundred square feet - beside room 229 - is not equipped with one hour enclosure or sprinkler.(Edgerton Building). The mechanical room door #52 is not self-closing and latching - McBryde facility. The corridor doors (w/closures) to Mech rooms # 151 and 136 would not self close/latch/seal (dragging floor) (McBryde - South) There were pipe penetrations thru ceiling that were not sealed to maintain the required fire rating of the ceiling - Mech room 144-1 (McBryde-South). The damper was wedged open preventing shutter from closing at central supply room. The door 159 the mechanical room did not have self closing device. The door to the central supply room did not have a self closing device installed. The door to the mechanical room 137 did not close and latch The electrical equipment room across from room 229 had a penetration in the ceiling at the abandoned conduit (McBryde Building North). Observation on November 18, 2008 at approximately 1030 revealed no fire door and listed door frame for supply storage room N3060(CRH -Butner Campus). There were electrical penetrations thru the corridor wall that had not been sealed to maintain the required one-hour fire rating of the wall. Storage room # M1011 (CRH - Butner Campus). There was a	A 701		

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	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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A 701	Continued From page 66 penetration in the wall at the bottom of the right side of the room in the corner of the electrical room (N2001) (CRH - Butner Campus). There was a penetration in the rated wall at the top of the wall on the right hand side as you enter the room (K2001) (CRH - Butner Campus) Observation on November 18, 2008 at approximately 1642 revealed the mechanical room on the second floor had unsealed penetrations in the rated ceiling (Building 51) and the mechanical room on ward 513 had penetrations in the rated ceiling (Building 51). ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 029. 4. Observations on November 19, 2008 at approximately 0830 onward revealed in the Mc Bryde Building Basement area the corridor wall is not smoke tight due to a grill being installed between room 60A and the corridor. There were holes in the corridor walls above ceiling in rooms 62A and 63. Unsealed penetrations above the corridor door at room 45. ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 017. 5. Observations on November 19, 2008 at approximately 0830 onward revealed the smoke wall above door G-1 had penetrations and was not smoke tight. (McBryde Basement) The smoke wall above smoke door 11 had penetrations and was not smoke tight. (McBryde Basement) The smoke wall above smoke door 137 had penetrations and was not smoke tight. (1East McBryde)	A 701		

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A 701	Continued From page 67 ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 025. 6. Observations on November 18, 2008 at approximately 1642 revealed the smoke barrier doors did not close during activation of the facility fire alarm system in unit #50 - ward 502. (CRH-Butner Annex Campus) Observations on November 19, 2008 at approximately 0830 onward revealed the smoke doors one, two and three did not close smoke tight. (McBryde Building basement). The double doors at (2006) did not close smoke tight. (McBryde Building North). The double doors (240) which had door closures were wedged open to prevent one side from closing. (McBryde Building North). The left side of the double doors (1014) did not release with activation of the fire alarm system (McBryde Building). ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 027. 7. Observations on November 18, 2008 at approximately 1642 revealed the mechanical room on the second floor had unsealed penetrations in the rated ceiling (Building 51). The mechanical room on ward 513 had penetrations in the rated ceiling (Building 51) ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 029. 8. Observations on November 19, 2008 at approximately 0830 onward revealed the exit door (660) was dragging at the bottom of the threshold (McBryde Building).	A 701		

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	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 701	Continued From page 68 ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 038. 9. Observations on November 19, 2008 at approximately 0830 onward revealed the means of egress lighting serving the exit discharges are single bulb light fixtures at each exit discharge. (McBryde, Edgerton Building, Wright, Williams, and Hargrove facilities) The stairway florescent lights were switched and able to be turned off. (McBryde Building North). The emergency exit discharge lighting was wired to a switched circuit at ambulance entrance - McBryde facility. ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 045. 10. Observations on November 18, 2008 at approximately 0930 onward revealed the exit sign was not lit in the following locations: 1 North - #21 & #22 (McBryde facility). Observations on November 19, 2008 at approximately 0830 onward revealed the exit signs at stairwells #21 and C018 were found not illuminated . (McBryde- South) ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 045. 11. Observations on November 19, 2008 at approximately 0830 onward revealed the soiled linen chute doors are noncompliant in the following areas: the upper chute access door is not self-closing in all positions in soiled linen anteroom across from room 229 - Edgerton Building and the soiled linen chute door was not self closing (2nd floor near room 218) (McBryde Building).	A 701		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 701	Continued From page 69 ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 071. 12. Observations on November 19, 2008 at approximately 0830 onward revealed the essential electrical system components were lacking generator annunciator panels for generators and emergency systems serving McBryde, McBryde North, and Hargrove buildings at CRH-Raleigh campus. The existing generator annunciator panel located in electrical switchgear room, beside ambulance entrance, did not function during loss of normal power to the ATS serving the Life Safety Branch of the essential electrical system. The essential electrical system required approximately fifteen seconds to restore power, upon loss of normal power, to the automatic transfer switch serving the McBryde facility. There was a lack of task light and unitary light at generator set locations serving the McBryde, McBryde North, and Hargrove facilities. (generators #1, #2, #3 - McBryde facility, and generator for McBryde North) There was a lack of automatic start for generator #2 during loss of normal power to the automatic transfer switch. (Hargrove facility) ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 145.	A 701		
A 702	482.41(a)(1) EMERGENCY POWER AND LIGHTING There must be emergency power and lighting in at least the operating, recovery, intensive care, and emergency rooms, and stairwells. In all other areas not serviced by the emergency supply source, battery lamps and flashlights must be available.	A 702		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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A 702	Continued From page 70 This STANDARD is not met as evidenced by: Based on observations during tours the hospital failed to have functioning emergency lighting within all stairwells. The Findings include: Observations during tours on November 19, 2008 at approximately 0830 onward, the means of egress lighting was observed not functioning in the following areas: a. exit discharge near employee lounge.(McBryde facility) b. stairway vestibule near room #625.(McBryde facility) c. stair #2 - sixth and fifth floor levels.(McBryde facility) d. stairway vestibule 4018-4-east-A.(McBryde facility) e. stairway vestibule 4025-4-east-A.(McBryde facility) f. stairway vestibule 3005-3-east-B.(McBryde facility) g. stairway vestibule 3019-3-east-A.(McBryde facility) h. stairway vestibule 1025-1-east-A.(McBryde facility) i. stairway landing at exit #1 - Edgerton Building j. exit #5 - stairway in Edgerton Building	A 702		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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A 702	Continued From page 71 ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 046.	A 702		
A 712	482.41(b)(5) ROLLER LATCHES PROHIBITED Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to hospitals. This STANDARD is not met as evidenced by: Based on observations during tours the hospital failed to discontinue usage of roller latches. The Findings include: 1. Observations on November 18, 2008 at approximately 0930 onward revealed the lack of positive latching hardware on doors in the corridor serving as a means of egress: 9, 12, 17, 19, & 21. (Hargrove- Basement). The dutch door to pharmacy did not meet NFPA 101 19.3.6.3.6 (Hargrove - 3rd floor) ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 018. 2. Observations on November 18, 2008 at approximately 1555 onward revealed roller latches on exit access doors in ward 544 - Building 54 and lack of positive latching hardware on doors in ward 542 - Building 54, and Building 53. Exit access doors require manual latching by key activated deadbolt locks - latches are not equipped with spring activated latch. Further observation revealed a magnetic hold open device wedged open - 1st floor entrance to unit 533. The following toilet areas did not have positive latching and the listed closure had been removed on unit 532 room 12, unit 493 room 11, unit 494 room 11 and unit 492 room 12. There	A 712		

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	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 712	Continued From page 72 was a lack of positive latching hardware on bedroom door #2 - unit 531 (Building 53). The main entrance door did not close and latch tightly in it's frame - unit 492 (Building 49). The main entrance door did not close and latch properly, door scrubbed in it's frame - unit 501 (Building 50). The stairwell door between unit 523 and connecting corridor did not close and latch in it's frame. (Building 52). ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 018. 3. Observations on November 19, 2008 at approximately 0830 onward revealed a wedge under exit access door to room 516.(McBryde Building). Dutch doors that did not have positive latching on the upper leaf at room 128 and room 160.(McBryde Building). The Dutch doors at the cashiers office on the first floor did not have positive latching (McBryde Building). There were three doors that opened into the corridor without door closures and not opening 180 degrees (214, 215, 216) Typical (McBryde Building North). ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 018.	A 712		
A 714	482.41(b)(7) FIRE CONTROL PLANS The hospital must have written fire control plans that contain provisions for prompt reporting of fires; extinguishing fires; protection of patients, personnel and guests; evacuation; and cooperation with fire fighting authorities. This STANDARD is not met as evidenced by: Based on documentation review, observations and staff interviews the hospital failed to have: emergency procedures in place for posting a fire	A 714		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 714	Continued From page 73	A 714		

watch during a power outage event, audible fire alarms and a smoke detector in an elevator room .

The Findings include:

1. Observation during tours on November 19, 2008 at approximately 0830 onward, the normal power visual indicator was not functioning on fire alarm panel serving the Williams Building.

The Main fire alarm panels for the McBryde and Williams buildings have no capability for battery back-up, (1955 year models). Their back-up power supply are the Emergency Generators. In the event of loss of power just to the Fire Alarm Control Panel (FACP) , breaker malfunction, etc, the generators would not crank and supply power for that isolated incident. Therefore the FACP would not function (as tested during survey) until the problem was identified and corrected - power restored.. Per documentation review and staff interview there were no emergency procedures in place for posting a fire watch during this event. The audible fire alarm notification devices (horns) on Hall 2 East did not work when testing the Fire Alarm. There were no audible alarms heard on the short corridors near rooms 240 and 343 during the test of the Fire Alarm Control Panel (McBryde Building). There was no machine room smoke detector serving the elevator equipment room - Williams Building.

~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 051.

2. Observations on November 18, 2008 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 714	Continued From page 74 approximately 1640 revealed no audible and visual signaling device connected to the fire alarm system serving unit #4 - Building 52.(CRH Butner Annex Campus). There was no visual trouble signal with loss of power to fire alarm control panel.(Building 53 - CRH Butner Annex Campus). ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 051.	A 714		
A 715	482.41(b)(8) REGULAR FIRE AND SAFETY INSPECTIONS The hospital must maintain written evidence of regular inspection and approval by State or local fire control agencies. This STANDARD is not met as evidenced by: Based on fire drill documentation review the staff failed to perform the required number of fire drills. The Findings include: Documentation review, on November 20, 2008 at approximately 1000 onward revealed the following was noncompliant: Documentation indicated less than the required number of fire drills were held on 2nd and 3rd shifts of third quarter 2008 (Wright building). Documentation indicated less than the required number of fire drills were held on 2nd shift of third quarter 2008 (Williams building). Documentation indicated 17 drills were missed over the past year. Third quarter documentation indicated that all shifts in buildings 49 - 54 were missed. (Umstead Campus) ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 050.	A 715		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 724	482.41(c)(2) FACILITIES, SUPPLIES, EQUIPMENT MAINTENANCE Facilities, supplies, and equipment must be maintained to ensure an acceptable level of safety and quality. This STANDARD is not met as evidenced by: Based on observations during tours the hospital failed to ensure supplies, equipment and the physical plant were maintained in a safe level. The Findings include: 1. Observation on November 18, 2008 at approximately 1030 revealed the converted storage room (F2043) had oxygen cylinders without proper signage for that space. CRH -Butner Campus) Observations on November 19, 2008 at approximately 0830 onward revealed the medical gas systems the oxygen manifold system is not protected from inclement weather - cylinders are exposed to the rain, sleet, snow, and other adverse weather conditions.(area near ambulance entrance at McBryde facility) The oxygen cylinders are not secured individually at oxygen manifold system beside ambulance entrance.(McBryde facility) The oxygen tanks were found unsupported in Oxygen storage Room 159 (McBryde South) There were unsecured oxygen bottles in room (218) (McBryde Building). ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 076. 2. Document review and staff interview on 11/20/2008 revealed the generator logs for	A 724		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 724	Continued From page 76	A 724		

building 49-54 did not show that the generator servicing these buildings was load tested during the month of July 2008 and the generator logs for the buildings did not show a weekly inspection of the generators.

Observations on November 18, 2008 at approximately 1115 revealed the essential electrical system required approximately fourteen seconds to restore power during loss of normal power to ATSC-W1.(CRH- Butner Campus)

~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 144.

3. Observations on November 18, 2008 at approximately 0930 onward revealed the light was not functioning properly in patient bedroom 144. (McBryde facility - 1 North) The following medical room refrigerators were fed from normal power McBryde facility - 3 South, room 369 and Wright Building. The mechanical room near room 245 there was an opened junction box above the HVAC trunk just as you enter the room (McBryde Building North). The med room refrigerator at nurses station #271 was not on an emergency circuit. (McBryde Building North). The wet location at the ice machine in room (265) was not plugged into a Ground Fault interrupter circuit (McBryde Building North).

Observations on November 18, 2008 at approximately 1044 revealed the generator annunciator audible and visual signaling devices did not function at time of survey.(Central Plant generator annunciator located in Security room M2007 - CRH Butner Campus).

Observations on November 18, 2008 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 724	Continued From page 77 approximately 0930 onward revealed there were exposed light bulbs with out a cover in the following areas: H0007, H0008. (CRH- Butner Campus) ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 147. 4. Observations on November 19, 2008 at approximately 0830 onward revealed the stairwell rear stairs ward 517 had holes in walls that were not sealed. (Building 51) The fire doors in the following stair enclosures were not self-closing and latching: the fire door 3006 in stair #5-3-east-B.(McBryde facility), the fire door 1011-stair #4-1-east-B.(McBryde facility), the fire door to stairway #6 - ground floor near male wing - McBryde North, the fire door 3010 did not close and latch properly. 3 South (McBryde facility) and the stairwell door 1005 with door closure would not close latch and seal (McBryde 1 East) ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 033. 5. Observations on November 18, 2008 at approximately 0930 onward revealed the sprinkler certification indicated that four (4) gages were outdated and need replacement: Ground floor, 1st floor, north wing, 2nd floor north wing and main riser south wing (McBryde facility) Observations on November 19, 2008 at approximately 1125 revealed the sprinkler system gauges serving the sprinkler fire pump are not listed for fire protection service.(McBryde North)	A 724		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 724	Continued From page 78 ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 062. 6. Observation on November 18, 2008 at approximately 1555 onward revealed there were no emergency shutdown switches for air handling units serving Buildings 49,50,51,52,53,54, and 55. (CRH -Butner Annex Campus) Observations on November 19, 2008 at approximately 0830 onward revealed the mechanical system components in the following areas were observed as incomplete: AHU #13 is not equipped with an outside air duct detector, lack of duct detectors to cover all supply and return ducts for AHU #13 - North McBryde facility, lack of emergency shutdown switches to cover all air handling units serving McBryde and Hargrove facilities - staff could not confirm switch locations in the vicinity of supervised stations served by air handling units.(McBryde, Hargrove, Williams, Edgerton, and Wright facilities), lack of duct detectors for AHU#2 - McBryde North, lack of service access openings for duct detectors serving AHU#4, and AHU#8 in McBryde North and lack of emergency shutdown switch(es) for air handling units serving Edgerton Building. ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 067. 7. Observation on November 19, 2008 at approximately 0830 onward revealed the means of egress was obstructed with an unattended chair in stair #2-5-east-A.(McBryde facility) ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 072.	A 724		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 724	Continued From page 79 8. Observation on November 19, 2008 at approximately 1440 revealed the smoke damper did not close completely at corridor smoke barrier beside room 119 - Edgerton Building. ~ Cross refer to Life Safety Code Standard - NFPA 101, Tag K 104.	A 724		
A 749	482.42(a)(1) INFECTION CONTROL OFFICER RESPONSIBILITIES The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel. This STANDARD is not met as evidenced by: Based on review of Infection Control (IC) policies and procedures, open and closed medical records and interviews, Infection Control staff failed to ensure patients with positive multi-drug resistant organisms (MDRO) cultures were placed on a facility-defined isolation precaution for 3 of 3 records reviewed of patients with positive MDRO cultures (#29, #30, #28). The findings included: Review of IC policy "Infection Control Program Description" dated 02/2008 revealed "Purpose:...The Infection Control Program/Plan is to ensure that every effort is made to: A. Prevent infections among patients and staff...Policy: (Name of facility) fulfills its responsibility to its patients, staff and community by insuring that proper safeguards are instituted for surveillance, prevention and control of infections." Further review revealed "Procedures:...4. General Infection Control Program/Plan	A 749		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 749	Continued From page 80	A 749		

Strategies:...Surveillance, Early Detection, Reporting - Conducts a structured surveillance program and maintains an effective system in tracking, monitoring and analysis for HAI (Healthcare Acquired Infections), community acquired infections, communicable diseases and treatment throughout the hospital."

Review of IC policy "Drug Resistant Organisms" dated 02/2008 revealed "Staphylococcus aureus - Definition of Resistant - Resistant to oxycillin, or Resistant to vancomycin..."

Review of IC policy "Isolation Precautions" dated 02/2008 revealed "D. Types of precautions:...3. Transmission-Based Precautions: Are designed for patients documented or suspected to be infected with highly transmittable or epidemiologically important pathogens for which additional precautions beyond standard precautions are needed to interrupt transmission in hospitals...c. Contact Precautions: Used for patients known or suspected to have serious illnesses easily transmitted by direct patient contact or by contact with items in the patient's environment (e.g....MRSA {Methicillin or Oxycillin Resistant Staphylococcus aureus})."

1. Open record review for Patient #29 revealed a 58 year old admitted to the facility 11/10/2008 for schizoaffective disorder. Review revealed a right hip wound culture was collected 11/11/2008 and was reported back from the laboratory on 11/13/2008 as positive for MRSA. Review of physician orders on 11/10/2008 at 2215 revealed "10. Contact Isolation for questionable h/o (history of) MRSA and current r (right) hp wound - open." Review of nursing documentation on 11/11/2008 at 0930 revealed "Rt (right) hip wound draining

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 749	Continued From page 81	A 749		

moderate amount of yellowish drainage." Review of physician orders on 11/11/2008 at 2000 (two days prior to the culture result) revealed "2. D/C (discontinue) contact isolation - continue to use good hand-washing & keep area covered."

Interview with the facility's IC Registered Nurse (ICRN) on 11/21/2008 at 0925 revealed the current facility policy is for positive MRSA cultures to be on contact precautions. Interview confirmed the patient was removed from contact precautions prior to the culture result being reported. Interview confirmed the culture result was reported as positive for MRSA. Interview confirmed the patient's level of isolation precautions was not in accordance with current facility policy.

2. Open record review for Patient #30 revealed a 14 year old admitted to the 494 unit on 11/10/2008 for autism and bipolar disorder. Review revealed an umbilical wound culture was obtained 11/14/2008 and was reported back from the laboratory on 11/16/2008 as positive for MRSA. Review of a physician's telephone order written 11/16/2008 at 1237 revealed "...Modified MRSA precaution."

Interview with Health Care Technician staff monitoring Patient #30 on 11/19/2008 at 1400 on the 494 unit revealed the staff could not verbalize what "modified MRSA precautions" would involve in the care of Patient #30. Interview revealed the staff understood Patient #30 to be on standard precautions for the wound on the stomach.

Interview with the facility's ICRN on 11/21/2008 at 0925 revealed the current facility policy is for positive MRSA cultures to be on contact

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 749	Continued From page 82	A 749		

precautions. Interview revealed there is no facility policy outlining a modified MRSA precaution. Interview confirmed the culture result was reported as positive for MRSA. Interview confirmed the patient's ordered level of isolation precautions was not in accordance with current facility policy.

3. Closed record review for Patient #28 revealed a 49 year old admitted to the facility 7/13/2008 for depression. Review revealed an abdominal wound culture was obtained 9/06/2008 and was reported back from the laboratory on 9/08/2008 as positive for MRSA. Review of documentation by the physician on 9/09/2008 on the culture report revealed "Awaiting surgical consult. Antibx (antibiotics) could be used when the surgeon lays the tunnel open for healing..." Review of the Medical Treatment Plan dated 9/11/2008 revealed "Problem - Draining sinus left lower abdomen." Review of the Discharge Summary dictated on the day of discharge, 10/22/2008, revealed "Disposition:...(Patient) has an appointment with the (Name of Surgeon group) on Wednesday 10/22/2008 at 1:00pm. She was going to be taken to this appointment by the (name of assisted living facility) staff." Record review revealed no isolation precautions were ordered for the positive MRSA culture. Record review revealed no documentation of isolation precautions taken by staff. Record review revealed the patient was in the general milieu with other patients for the duration of the hospital stay.

Interview with the facility's ICRN on 11/21/2008 at 0925 revealed the current facility policy is for positive MRSA cultures to be on contact precautions. Interview confirmed the culture result was reported as positive for MRSA. Interview

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 749	Continued From page 83 confirmed isolation precautions were not addressed in the patient's Plan of Care from the time the culture was reported on 9/08/2008 through discharge on 10/22/2008 (44 days). Interview confirmed the patient's level of isolation precautions was not in accordance with current facility policy.	A 749		
A 750	482.42(a)(2) INFECTION CONTROL LOG The infection control officer or officers must maintain a log of incidents related to infections and communicable diseases. This STANDARD is not met as evidenced by: Based on review of Infection Control (IC) policies and procedures, laboratory culture reports, medical records, the facility's Infection Control Log, and interview, Infection Control staff failed to record a complete log of incidences of identified multi-drug resistant organisms (MDRO) for 1 of 3 records reviewed of patients with positive MDRO cultures (#28). The findings included: Review of IC policy "Infection Control Program Description" dated 02/2008 revealed "Purpose:...The Infection Control Program/Plan is to ensure that every effort is made to: A. Prevent infections among patients and staff...Policy: (Name of facility) fulfills its responsibility to its patients, staff and community by insuring that proper safeguards are instituted for surveillance, prevention and control of infections." Further review revealed "Procedures:...4. General Infection Control Program/Plan Strategies:...Surveillance, Early Detection, Reporting - Conducts a structured surveillance program and maintains an effective system in	A 750		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 750	Continued From page 84	A 750		

tracking, monitoring and analysis for HAI (Healthcare Acquired Infections), community acquired infections, communicable diseases and treatment throughout the hospital."

Review of IC policy "Drug Resistant Organisms" dated 02/2008 revealed "Staphylococcus aureus - Definition of Resistant - Resistant to oxycillin, or Resistant to vancomycin..."

Review of a "Query Summary Report" from the Microbiology Laboratory of the facility revealed on 9/06/2008 Patient #28 had a positive culture for Methicillin (or Oxycillin) Resistant Staphylococcus aureus (MRSA).

Closed record review for Patient #28 revealed a 49 year old admitted to the facility 7/13/2008 for depression. Review revealed an abdominal wound culture was obtained 9/06/2008 and was reported back from the laboratory on 9/08/2008 as positive for MRSA. Review of documentation by the physician on 9/09/2008 on the culture report revealed "Awaiting surgical consult. Antibx (antibiotics) could be used when the surgeon lays the tunnel open for healing..." Review of the Medical Treatment Plan dated 9/11/2008 revealed "Problem - Draining sinus left lower abdomen." Review of the Discharge Summary dictated on the day of discharge, 10/22/2008, revealed "Disposition:...(Patient) has an appointment with the (Name of Surgeon group) on Wednesday 10/22/2008 at 1:00pm. She was going to be taken to this appointment by the (name of assisted living facility) staff." Record review revealed no isolation precautions were ordered for the positive culture. Record review revealed no documentation of isolation precautions taken by staff. Record review

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 750	Continued From page 85 revealed the patient was in the general milieu with other patients for the duration of the hospital stay. Review of the facility's IC Log revealed no documentation that Patient #28's positive MRSA culture was entered onto the IC Log. Interview with the facility's IC Registered Nurse (ICRN) on 11/21/2008 at 0925 revealed positive cultures are only entered onto the log if there is treatment ordered. Interview confirmed the wound was draining by record review. Interview confirmed the physician had ordered a consultation by record review. Interview confirmed the wound culture was positive for MRSA. Further interview confirmed the patient was in the general milieu with other patients for the duration of the hospital stay. Interview confirmed the ICRN failed to enter the positive MRSA culture onto the IC Log.	A 750		
A 827	482.43(c)(6)(iii) DISCHARGE PLANNING DOCUMENT The hospital must document in the patient's medical record that the list was presented to the patient or to the individual acting on the patient's behalf. This STANDARD is not met as evidenced by: Based on closed medical record reviews and staff interviews the discharge planning staff failed to have a process and system in place to document in the medical record a list of available facilities (Home Health Agencies and/or Skilled Nursing Facilities) given to the patient for 2 of 2 discharged patients reviewed (#63,#43). Findings Include:	A 827		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 827	Continued From page 86	A 827		

1. Review revealed patient #63 a 62 year old admitted on 10/18/2008 with a diagnosis of Schizophrenia affective disorder - bipolar type. Review revealed history of admission to the facility for 46 years that ended with placement in an unsecured group home in 2002. The patient required readmission to the facility on 06/21/2008 related to behaviors in the group home environment. Reveiw revealed the paitent required a secured facility and could not return to the group home. Record review revealed on 10/20/2008 the patient was pending discharge to a secured nursing home facility. Record review revealed no documented evidence of a list of available facilities given to the patient or his guardian.

Interview with discharge planning administrative social worker #1 on 11/18/2008 at 1025 revealed "each social worker develops their own list they work with." Further interview revealed "we do not have a specific list that becomes part of the chart we have a list we work from and discuss with the patient or guardians what is available to them."

Interview with discharge planning social worker #3 on 11/21/2008 at 1130 revealed "we(social workers) keep an individual list of facilities we work with. I can tell you in this case the guardian was not presented a list. I have talked to his guardian and she wants him to remain at Central Regional. The LME (local management entity) recommended where this patient should go and the decision was made for him to go there."

2. Open medical record review of patient #43 revealed a 61 year old admitted on 08/09/2008 with a diagnosis of Schizophrenia Chronic undifferentiated type and a history of sexual

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A 827	Continued From page 87 assault 2nd degree rape. Record review revealed on 10/19/2008 the patient was pending discharge. Record review revealed no documented evidence in the medical record of a list of available facilities given to the patient or his guardian. Interview with discharge planning social worker #2 on 11/19/2008 at 1130 revealed "we keep a list of facilities we work with (we all have our own list)." The facility does not have a specific system that is used by all. "The guardian in this case was part of the discussion for placement of the patient, but she was not presented a list. The LME was who recommended the facility where this patient should go and the decision to discharge plan for him to go there was made."	A 827		
A1124	482.56(a) ORGANIZATION OF REHABILITATION SERVICES The organization of the service must be appropriate to the scope of the services offered. This STANDARD is not met as evidenced by: Based on review of facility policies and procedures, open and closed medical records and staff interview staff failed to ensure a physician's order for hearing, vision and speech screenings were completed prior to a patient's discharge from the facility for 2 of 4 child and adolescent records reviewed (#30, #68). The findings included: Review of facility policy "Scope of Services Department (name of facility) Speech and Hearing Department" (not dated) revealed " Scope of Service...4. ...Speech-language screenings are conducted within two weeks of admission, if possible...5. Availability of necessary	A1124		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A1124	Continued From page 88	A1124		

staff. the Speech and Hearing Department is staffed by two SLPs (Speech and Language Pathologists) at each campus..." Further review revealed "Ongoing Performance Improvement and quality control data are used to assess effectiveness...Data on amount of time spent with each Division or time serving patients with particular disorders is analyzed to determine trends in order to determine need for increased or decreased staff involvement."

1. Open record review on 11/20/2008 for Patient #30 revealed a 14 year old admitted to the 494 unit on 11/10/2008 for autism and bipolar disorder. Review of physician's admission orders revealed "Screenings (routine): (checkmark) Child/Adolescent: Speech-Hearing/Vision". Record review revealed no Speech-Hearing/Vision screening was completed prior to the patient's discharge on 11/20/2008 (10 days from admission).

Interview with the SLP assigned to the main campus of the facility on 11/20/2008 at 1115 revealed there are two SLPs at the Raleigh campus and currently one SLP at the main campus. Interview revealed there is a current staffing need for one SLP. Interview revealed with the current workload "The screenings on the child and adolescent unit (CAU) do not get priority." Interview revealed the SLP is available on the CAU on Wednesdays and Fridays only for screenings and evaluations. Interview revealed there is a two-week allowance to get the screenings completed. Interview revealed there is no data currently collected to know how many patients on the CAU are not being screened as ordered by the physician when discharged prior to the two week allowance. Interview revealed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A1124	Continued From page 89 first opportunity the SLP had to screen Patient #30 was on 11/19/2008. Interview revealed Patient #30 was too agitated to screen and was discharged the next day. Interview revealed Patient #30 was not screened for speech-hearing/vision, as ordered by the physician, prior to discharge from the hospital. 2. Open record review on 11/20/2008 for Patient #68 revealed a 14 year old admitted 10/14/2008 for conduct disorder. Review of physician's admission orders revealed "Screenings (routine): (checkmark) Child/Adolescent: Speech-Hearing/Vision". Record review revealed no Speech-Hearing/Vision screening was completed prior to the patient's discharge on 10/24/2008 (10 days from admission). Interview with the SLP assigned to the main campus of the facility on 11/20/2008 at 1115 revealed there are two SLPs at the Raleigh campus and currently one SLP at the main campus. Interview revealed there is a current staffing need for one SLP. Interview revealed with the current workload "The screenings on the child and adolescent unit (CAU) do not get priority." Interview revealed the SLP is available on the CAU on Wednesdays and Fridays only for screenings and evaluations. Interview revealed there is a two-week allowance to get the screenings completed. Interview revealed there is no data currently collected to know how many patients on the CAU are not being screened as ordered by the physician when discharged prior to the two week allowance. Interview confirmed Patient #68 was not screened for speech-hearing/vision, as ordered by the physician, prior to discharge from the hospital.	A1124		
A1152	482.57(a) ORGANIZATION OF RESPIRATORY	A1152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A1152	Continued From page 90 CARE SERVICES The organization of the respiratory care services must be appropriate to the scope and complexity of the services offered. This STANDARD is not met as evidenced by: Based on review of policies and procedures, medical record reviews, personnel file reviews, staffing worksheet reviews, contract services reviews and staff interviews, the facility failed to ensure evidence of documentation of training for 4 of 4 nurses that cared for a patient on a Constant Positive Airway Pressure Mask (CPAP). The findings include: Review of policy "Respiratory support-CPAP and BIPAP" effective June 1, 2008 revealed "C. CPAP machines have no clinical alarms and may be used in all settings at named facility." Review of respiratory care contacted services contract dated April 7, 2005 revealed "3. Delivery, Training and Pick-Up 3.1 Named contracted services shall deliver the Equipment requested by name facility to the homes of patients of named facility or, if requested such other sites within named contacted services service area.... 3.2 Named contracted services shall train, educate, and demonstrate to, the patients of named facility to whom named contracted services delivers such Equipment regarding the use and administration of such Equipment. Named contracted services also shall provide any necessary follow-up training, education and demonstration to the patients of named facility."	A1152		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A1152	Continued From page 91	A1152		

Review of education packet given to staff upon CPAP initiation includes a copy of the CPAP protocol, CPAP equipment information sheet, CPAP/BiPAP (Bi-Level Positive Airway Pressure) treatment and care worksheet and a CPAP/BiPAP competency validation form/check-off sheet for staff.

Review of CPAP/BiPAP competency validation/check-off sheet for staff revealed "Competency Statement: To provide essential steps to set up and maintain the CPAP/BiPAP machine...."

Review of staffing worksheets for 11-08-2008 revealed nurse #37 was responsible for Pt #65 on 11/8/08 from 7A-7P. Further review revealed nurse #35 and nurse #45 were responsible for patient # 65 on 11/8/08 from 3P-11P. Further review revealed nurse #44 was responsible for patient #65 on 11/8/08 from 11P- 7A.

Review of Nurse #37's personnel file revealed no evidence of documentation of CPAP training.

Review of Nurse #35's personnel file revealed no evidence of documentation of CPAP training.

Review of Nurse #46's personnel file revealed no evidence of documentation of CPAP training

Review of Nurse #44's personnel file revealed no evidence of documentation of CPAP training

Interview with Nurse #37 on 11/21/08 at 1120 revealed staff member had not received education on CPAP machines. Further interview revealed "I'm an experienced nurse." Further interview revealed Pt #65 is capable of applying

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A1152	Continued From page 92	A1152		

CPAP, but sometimes he doesn't always do it and the nurse helps him.

Interview with Nurse #46 on 11/21/08 at 1545 revealed "I worked the 3p-11p shift on 11/8/08. I was present when name contract service came in with CPAP machine around 1830 - 1900." Further interview revealed nurse #46, 2 HCT (healthcare technicians), the nursing coordinator, nurse #35 and the patient #65 were present in the conference room when the contract services representative instructed the patient how to apply and use the CPAP machine. Further interview revealed no educational packet was left on the unit by the house coordinator or vendor representative. Interview revealed the CPAP protocol was placed on the bulletin board in the report room on 11/14/08 (7 days after pt #65's CPAP initiation) for review by staff. Interview revealed she (nurse #46) received education on the CPAP treatment and documentation flowsheet on Wednesday 11/19/08. Interview confirmed there were no education/competency documents completed by the contracted services staff.

Nurse #35 was unavailable for phone interview on 11/21/08 at 1130. Nurse #35 called back to the facility at 1545 and transfer was attempted to the administrative offices without success. Nurse #35 did not call back.

Nurse #44 is on investigatory leave and phone contact was attempted at 11/21/08 at 1200. Nurse #44 was unavailable for phone interview.

Interview with nursing management staff on 11/21/08 at 1330 revealed house coordinator contacts vendor and gives educational packet to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A1152	Continued From page 93 nurses on the ward after CPAP equipment has been delivered and inserviced. Further interview revealed no copy of education/inservice training is completed by the vendor and left on the unit for staff files. Interview confirmed nurse #37, nurse #35, nurse #44 and nurse #46 were staffing on 11/8/08 and responsible for the care of Pt #65. Further interview confirmed there is no evidence of documentation of CPAP training documented on the ward after initiation of CPAP. Further interview confirmed there was no evidence of documentation of CPAP training for nurse #37, nurse #35, nurse #44 and nurse #46. Interview with administrative nursing staff on 11/21/08 at 1030 revealed some nurses on nursing units (not including medical unit) have been CPAP trained and some have not. Interview revealed placing CPAP equipment on units other than the medical unit is a new process. Interview confirmed there is no evidence of documentation of CPAP training for nurse #37, nurse #35, nurse #44 and nurse #46.	A1152		
A1161	482.57(b)(1) RESPIRATORY CARE PERSONNEL POLICIES Personnel qualified to perform specific procedures and the amount of supervision required for personnel to carry out specific procedures must be designated in writing. This STANDARD is not met as evidenced by: Based on policy review and staff interview the hospital failed to ensure personnel qualified to perform specific respiratory therapy procedures was designated in writing. The findings include:	A1161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
A1161	Continued From page 94 Review of hospital policies revealed no written policies that specified required qualifications or types of personnel authorized to administer continuous positive airway pressure (CPAP) or nebulizer treatments. Interview on 11/20/2008 at 1000 with a registered respiratory therapist (RRT) revealed the therapist was the only RRT on staff at the hospital, including both the Raleigh and Butner Campuses. Interview revealed the role of the RRT was to provide respiratory care services and write respiratory care policies. Interview revealed nurses at both campuses can assist patients with CPAP and provide nebulizer treatments. Interview revealed nurses are trained to CPAP machines "when they (the machines) are set up". Interview revealed the RRT was unsure what type of training or qualifications of the nursing staff were required before they administered nebulizer treatments. Interview revealed, "I don't deliver medications (via nebulizer) at either campus. The nurses do it. I think nebulizer treatments are within my scope of services, I just don't do it. I can't imagine doing q (every) 4 hour nebs (nebulizer treatments) between 2 campuses." Interview on 11/21/2008 at 1030 with administrative staff confirmed there was no hospital policy available that specified required qualifications or types of personnel authorized to administer continuous positive airway pressure (CPAP) or nebulizer treatments.	A1161		
B 106	482.61(a)(2) DEVELOPMENT OF ASSESSMENT/DIAGNOSTIC DATA A provisional or admitting diagnosis must be made on every patient at the time of admission, and must include the diagnosis of intercurrent	B 106		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
B 106	Continued From page 95 diseases as well as the psychiatric diagnosis. This STANDARD is not met as evidenced by: Based on review of Medical Staff Bylaws, Rules and Regulations, open and closed medical records and staff interviews, medical staff failed to ensure the medical history and physical was completed within 24 hours of patient admission for 4 of 7 adolescent admissions reviewed (#30, #69, #56, #55). The findings included: Review of the Medical Staff Bylaws, Rules and Regulations dated 11/2008 revealed "Article III. Appointment to the Medical Staff - Section 1 - Authority and Accountability...B. ...All patients admitted to the hospital will have a complete mental status and physical examination, as well as a thorough review of mental health and physical history, performed within 24 hours of admission by a member of the Medical Staff..." Review of facility policy "Physical Examination and Medical History" dated 7/2008 revealed "Procedures: A. Physical Exams and Review of Medical History on Admission: 1. The Medical History and Physical Exam is completed and findings documented by the admitting physician, responsible physician, or physician extender as soon as possible but no later than 24 hours following admission...5....The physical exam is attempted daily until the exam has been completed...9....For children, and evaluation of the developmental age is part of the routine physical exam." 1. Open record review for Patient #30 revealed a 14 year old admitted to the 494 unit on	B 106		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
B 106	Continued From page 96	B 106		

11/10/2008 for autism and bipolar disorder. Review of the document "Medical History and Physical Assessment" dated 11/10/2008 at 2300 revealed "Unable to assess (page 1 of 4)...Patient will need physical exam when calmer (page 3 of 4)." Further review of the document revealed a physical assessment was performed 11/14/2008 (four days after admission). Review of the physical assessment of the abdomen revealed "Umbilical excoriation, erythematous, wet with serosanguinous fluid." Record review revealed no daily attempts to obtain the medical history and physical from 11/10/2008 until the assessment was completed 11/14/2008. Further record review revealed a culture was taken of the umbilical wound on 11/14/2008 with the culture result reported on 11/16/2008 as positive for Methicillin-resistant S. aureus (MRSA). Review revealed the patient had a wound positive for MRSA since admission on 11/10/2008 and was not diagnosed until 11/16/2008 with the delay in the medical history and physical performed on 11/14/2008.

Interview on 11/18/2008 at 1100 with the physician who performed the medical history and physical on 11/14/2008 revealed the physician is assigned to the Child and Adolescent Unit (CAU) of the facility as the medical physician. Interview revealed the medical history and physicals (H&P) are partially completed by a psychiatry physician in the admissions intake area and completed by the medical physician once the patient is admitted to the CAU. Interview revealed "The physicians in the admission area are not comfortable with completing the developmental assessments, so those are usually left for me to complete". Interview revealed the developmental assessment is on page 3 of 4 of the Medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
B 106	Continued From page 97 History and Physical Assessment and labeled "Tanner Staging of Puberty". Interview revealed in the case of Patient #30, there was an issue that the patient was not calm enough for an assessment in the admissions intake area. Interview revealed there was no documentation of a daily attempt to complete the medical history and physical. Interview revealed "I realized the H&P was not complete when I went to complete the Initial Medical Treatment Plan". Interview revealed the Initial Medical Treatment Plan must be initiated within 72 hours of admission. Interview revealed there was a delay in diagnosing the wound infected with MRSA. Interview revealed the wound was draining a serous fluid. Interview with administrative medical staff on 11/18/2008 at 1520 revealed if H&Ps are not completed in the admissions intake area, this is communicated from physician to physician so there can be daily attempts to complete the H&P. Interview confirmed there was no documented evidence of a daily attempt to complete the medical H&P for Patient #30 from 11/10/2008 through 11/14/2008. Interview confirmed medical staff failed to follow medical staff bylaws, rules and regulations as well as facility policy by not attempting to complete the medical H&P on a daily basis. 2. Open record review for Patient #69 on 11/20/2008 revealed a 17 year old admitted 10/14/2008 for Post-traumatic Stress Disorder. Review of the document "Medical History and Physical Assessment" dated 11/14/2008 revealed the developmental assessment had not been completed (37 days after admission).	B 106		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
B 106	Continued From page 98	B 106		

Interview on 11/18/2008 at 1100 with the physician assigned to the Child and Adolescent Unit (CAU) of the facility as the medical physician revealed the medical history and physicals (H&P) are partially completed by a psychiatry physician in the admissions intake area and completed by the medical physician once the patient is admitted to the CAU. Interview revealed "The physicians in the admission area are not comfortable with completing the developmental assessments, so those are usually left for me to complete".

Interview with administrative medical staff on 11/18/2008 at 1520 revealed if H&Ps are not completed in the admissions intake area, this is communicated from physician to physician so there can be daily attempts to complete the H&P. Interview confirmed medical staff failed to follow medical staff bylaws, rules and regulations as well as facility policy by not attempting to complete the medical H&P to include developmental assessment.

3. Open record review for Patient #56 on 11/20/2008 revealed a 15 year old admitted 11/14/2008 for Conduct Disorder. Review of the document "Medical History and Physical Assessment" dated 11/14/2008 revealed the developmental assessment had not been completed (six days after admission).

Interview on 11/18/2008 at 1100 with the physician assigned to the Child and Adolescent Unit (CAU) of the facility as the medical physician revealed the medical history and physicals (H&P) are partially completed by a psychiatry physician in the admissions intake area and completed by the medical physician once the patient is admitted to the CAU. Interview revealed "The physicians in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
B 106	Continued From page 99	B 106		

the admission area are not comfortable with completing the developmental assessments, so those are usually left for me to complete".

Interview with administrative medical staff on 11/18/2008 at 1520 revealed if H&Ps are not completed in the admissions intake area, this is communicated from physician to physician so there can be daily attempts to complete the H&P. Interview confirmed medical staff failed to follow medical staff bylaws, rules and regulations as well as facility policy by not attempting to complete the medical H&P to include developmental assessment.

4. Open record review for Patient #55 on 11/20/2008 revealed a 14 year old admitted 11/15/2008 for Post-traumatic Stress Disorder. Review of the document "Medical History and Physical Assessment" dated 11/15/2008 revealed the developmental assessment had not been completed (five days after admission).

Interview on 11/18/2008 at 1100 with the physician assigned to the Child and Adolescent Unit (CAU) of the facility as the medical physician revealed the medical history and physicals (H&P) are partially completed by a psychiatry physician in the admissions intake area and completed by the medical physician once the patient is admitted to the CAU. Interview revealed "The physicians in the admission area are not comfortable with completing the developmental assessments, so those are usually left for me to complete".

Interview with administrative medical staff on 11/18/2008 at 1520 revealed if H&Ps are not completed in the admissions intake area, this is communicated from physician to physician so

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
B 106	Continued From page 100 there can be daily attempts to complete the H&P. Interview confirmed medical staff failed to follow medical staff bylaws, rules and regulations as well as facility policy by not attempting to complete the medical H&P to include developmental assessment.	B 106		
B 125	482.61(c)(2) TREATMENT PLAN The treatment received by the patient must be documented in such a way to assure that all active therapeutic efforts are included. This STANDARD is not met as evidenced by: Based on policy review, physician interview, medical record review and staff interview the hospital failed to ensure electroconvulsive therapy (ECT) treatments were documented by ECT staff or anesthesiologist for 2 of 6 sampled patients that received ECT treatments (#24 and #26). The findings include: Review of current hospital policy number CPM-E.0015 entitled "Electroconvulsive Therapy" dated 02/01/2008 revealed, "Chart documentation must be provided at each treatment regarding pre- and post-treatment vital signs, stimulus parameters, seizure duration, and complications....The attending anesthesiologist will...monitor and record vital signs....On the day of ECT, prior to the administration of anesthesia, the attending anesthesiologist will conduct and document a pre-anesthetic assessment....Following recovery, the attending anesthesiologist will review the completed recovery vital signs and orientation record, including pain assessment, evaluate the patient and determine that he/she meets criteria for	B 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
B 125	Continued From page 101	B 125		

discharge from the PACU (Post Anesthesia Care Unit)....The attending anesthesiologist will also document any complications, and any follow-up care or other observations...."

Interview on 11/18/2008 at 1515 with the ECT physician revealed the anesthesiologist performs a pre-treatment evaluation and monitors the patient during treatment for all ECT treatments. Interview revealed the anesthesiologist documents the pre-treatment evaluation and the patient's vital signs during treatment on an Anesthesia Record. Interview revealed all Anesthesia Records are kept in a notebook in the ECT room so that the anesthesiologist can review prior treatments as part of the pre-anesthesia evaluation. Interview revealed all Anesthesia Records remain in the notebook in the ECT room until the patient stops receiving ECT treatments or is discharged, at which time they are placed in the patient's medical record. Interview revealed the ECT physician and nurse document each ECT treatment on an ECT Flow Sheet. Interview revealed the ECT Flow Sheet documentation includes pre-, intra- and post-treatment assessments of the patient. Interview revealed the anesthesiologist performs a post-treatment assessment and signs the ECT Flow Sheet before the patient is discharged from the PACU.

1. Open medical record review on 11/19/2008 of Patient #24 revealed a 28 year-old female that was admitted on 07/23/2008 with schizophrenia. Record review revealed the patient had ECT treatments on 09/22/2008, 09/24/2008 and 09/26/2008. Record review revealed no documentation of an Anesthesia Record for the treatments on 09/22/2008 and 09/26/2008. Record review revealed no documentation of a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
B 125	Continued From page 102	B 125		

pre-anesthesia evaluation by the anesthesiologist or documented evidence that the anesthesiologist monitored the patient's vital signs during the treatments on 09/22/2008 and 09/26/2008.

Interview on 11/19/2008 at 1600 with the ECT physician revealed the Anesthesia Records for the treatments on 09/22/2008 and 09/26/2008 were not in the notebook in the ECT room or the patient's medical record. Interview confirmed there was no available documentation of a pre-anesthesia evaluation by the anesthesiologist or documented evidence that the anesthesiologist monitored the patient's vital signs during the treatments on 09/22/2008 and 09/26/2008.

2. Open medical record review on 11/18/2008 of Patient #26 revealed a 47 year-old female that was admitted on 10/02/2008 with bipolar disorder. Record review revealed the patient had an initial ECT treatment on 10/24/2008. Record review revealed no documentation of an ECT Flow Sheet for the treatment on 10/24/2008. Record review revealed no documentation of pre- and post-treatment vital signs, stimulus parameters, seizure duration, or complications. Record review revealed no documentation of a post-anesthesia assessment by the anesthesiologist, including assessment of recovery vital signs and level of orientation to ensure the patient met the criteria for discharge from the PACU.

Interview on 11/19/2008 at 1500 with administrative nursing staff confirmed there was no available documentation of pre- and post-treatment vital signs, stimulus parameters, seizure duration, or complications for the ECT treatment on 10/24/2008. Further interview confirmed there was no available documentation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING _____ B. WING _____	C 11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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
B 125	Continued From page 103 of a post-anesthesia assessment by the anesthesiologist.	B 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING 05 , 02 , 03 B. WING _____	11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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 011	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation, on November 18, 2008 at approximately 3:55pm onward, a. Areas of Buildings 54, and 53 are used as Business Occupancies without a minimum two hour fire barrier between Health Care Occupancy - areas do allow customary access by patients. b. The bathroom vanity was missing in the restroom on the second floor along with holes in the floor (Building 51)	K 011		
K 017	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.)	K 017		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING 05 , 02 , 03 B. WING _____	11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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 017	Continued From page 1 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation, on November 19, 2008 at approximately 8:30am onward, the following areas were observed as noncompliant: (Mc Bryde Building Basement area) a. Corridor wall is not smoke tight due to a grill being installed between room 60A and the corridor. b. There were holes in the corridor walls above ceiling in rooms 62A and 63 c. Unsealed penetrations above the corridor door at room 45.	K 017		
K 018	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 1¾ 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.	K 018		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING 05 , 02 , 03 B. WING _____	11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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 2	K 018		

This STANDARD is not met as evidenced by:
Based on observation, on November 18, 2008 at approximately 3:55pm onward, door hardware to the following rooms were noncompliant:

a. roller latches on exit access doors in ward 544 - Building 54.

b. lack of positive latching hardware on doors in ward 542 - Building 54, and Building 53. Exit access doors require manual latching by key activated deadbolt locks - latches are not equipped with spring activated latch.
c. magnetic hold open device wedged open - 1st floor entrance to unit 533.

d. the following toilet areas did not have positive latching and the listed closure had been removed:
unit 532, room 12
unit 493, room 11
unit 494, room 11
unit 492, room 12

e. lack of positive latching hardware on bedroom door #2 - unit 531. (Building 53)

f. the main entrance door did not close and latch tightly in it's frame - unit 492. (Building 49)

g. the main entrance door did not close and latch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING 05 , 02 , 03 B. WING _____	11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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 3 properly, door scrubbed in it's frame - unit 501. (Building 50) h. The stairwell door between unit 523 and connecting corridor did not close and latch in it's frame. (Building 52) Based on observation, on November 19, 2008 at approximately 8:30am onward, doors to the following areas are noncompliant: a. there is a wedge under exit access door to room 516.(McBryde Building). b. dutch doors do not have positive latching on the upper leaf at room 128 and room 160. (McBryde Building). c. the Dutch doors at the cashiers office on the first floor did not have positive latching (McBryde Building). d. there were three doors that opened into the corridor without door closures and not opening 180 degrees (214, 215, 216) Typical (McBryde Building North). Based on observation, on November 18, 2008 at approximately 9:30 AM onward, the following door hardware was observed as noncompliant: a. lack of positive latching hardware on doors in the corridor serving as a means of egress: 9, 12, 17, 19, & 21. (Hargrove- Basement) b. dutch door to pharmacy did not meet NFPA 101 19.3.6.3.6 (Hargrove - 3rd floor)	K 018		
K 025	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING 05 , 02 , 03 B. WING _____	11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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 025	Continued From page 4 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 This STANDARD is not met as evidenced by: Based on observation, on November 19, 2008 at approximately 8:30am onward, a. The smoke wall above door G-1 had penatrations and was not smoke tight. (McBryde Basement) b. The smoke wall above smoke door 11 had penatrations and was not smoke tight (McBryde Basement) c. The smoke wall above smoke door 137 had penatrations and was not smoke tight (1East McBryde)	K 025		
K 027	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in	K 027		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING 05 , 02 , 03 B. WING _____	11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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 027	Continued From page 5 accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation, on November 18, 2008 at approximately 4:42pm, the smoke barrier doors did not close during activation of the facility fire alarm system in unit #50 - ward 502.(CRH-Butner Annex Campus) Based on observation, on November 19, 2008 at approximately 8:30am onward, 1. the smoke doors one, two and three did not close smoke tight) (McBryde Building basement). 2. the double doors at (2006) did not close smoke tight. (McBryde Building North). 3. the double doors (240) which had door closures were wedged open to prevent one side from closing. (McBryde Building North). 4. the left side of the double doors (1014) did not release with activation of the fire alarm system (McBryde Building).	K 027		
K 029	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed	K 029		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING 05 , 02 , 03 B. WING _____	11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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K 029	Continued From page 6 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, on November 18, 2008 at approximately 4:42pm, 1. the mechanical room on the second floor had unsealed penetrations in the rated ceiling (Building 51) 2. the mechanical room on ward 513 had penetrations in the rated ceiling (Building 51) Based on observation, on November 19, 2008 at approximately 8:30am onward, the following hazardous areas were observed as noncompliant: a. generator and mechanical equipment room is not equipped with a self-closing and latching fire door - Edgerton Building - door is equipped with a louver at area adjacent to lower level exit. b. storage room greater than one hundred square feet - beside room 229 - is not equipped with one hour enclosure or sprinkler.(Edgerton Building) c. mechanical room door #52 is not self-closing and latching - McBryde facility. d. Corridor doors (w/closures) to Mech rooms # 151 and 136 would not self close/latch/seal (dragging floor) (McBryde - South) e. There were pipe penetrations thru ceiling that were not sealed to maintain the required fire rating of the ceiling - Mech room 144-1 (McBryde-	K 029		

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	344001	A. BUILDING 05 , 02 , 03 B. WING _____	11/21/2008

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K 029	Continued From page 7 South). f. Fire damper was wedged open preventing shutter from closing at central supply room. g. Door 159 the mechanical room did not have self closing device h. The door to the central supply room did not have a self closing device installed. i. The door to the mechanical room 137 did not close and latch j. the electrical equipment room across from room 229 had a penetration in the ceiling at the abandoned conduit (McBryde Building North).	K 029		
K 032	NFPA 101 LIFE SAFETY CODE STANDARD Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 19.2.4.1, 19.2.4.2 This STANDARD is not met as evidenced by: Based on observation, on November 18, 2008 at approximately 9:30 AM onward, 1. The exit discharge is not complete to the public way with surface other than soil and grass. (Umstead building 53, exit from unit 531) 2. The loading dock leading to " I " street did not have a handrail in place to prevent persons falling	K 032		

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	344001	A. BUILDING 05 , 02 , 03 B. WING _____	11/21/2008

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CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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K 032	Continued From page 8 off the edge of the loading dock during exiting. (Building 52) 3. The exit door leading to " I " street was dragging on its frame (Building 50) 4. Exit stairwell door in ward 513 was draggin on ite frame. (Building 51) Based on observation, on November 19, 2008 at approximately 8:30am onward, the exit discharge is not complete to the publicway with surface other than soil and grass.(Wright Building - northeast exit)	K 032		
K 033	NFPA 101 LIFE SAFETY CODE STANDARD Exit components (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 8.2.5.2, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation, on November 19, 2008 at approximately 8:30am onward, the following areas were observed as noncompliant: the stairwell rear stairs ward 517 had holes in walls that were not sealed. (Building 51) Based on observation, on November 19, 2008 at approximately 8:30am onward, the fire doors in the following stair enclosures were not self-closing and latching: a. fire door 3006 in stair #5-3-east-B.(McBryde facility)	K 033		

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	344001	A. BUILDING 05 , 02 , 03 B. WING	11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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K 033	Continued From page 9 b. fire door 1011-stair #4-1-east-B.(McBryde facility) c. fire door to stairway #6 - ground floor near male wing - McBryde North d. Fire door 3010 did not close and latch properly. 3 South (McBryde facility) e. the stairwell door 1005 with door closure would not close latch and seal (McBryde 1 East)	K 033		
K 038	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, on November 19, 2008 at approximately 8:30am onward, the exit door (660) was dragging at the bottom of the threshold (McBryde Building).	K 038		
K 045	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 darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8	K 045		

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	344001	A. BUILDING 05 , 02 , 03 B. WING _____	11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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K 045	Continued From page 10 This STANDARD is not met as evidenced by: Based on observation, on November 19, 2008 at approximately 8:30am onward, a. the means of egress lighting serving the exit discharges are single bulb light fixtures at each exit discharge.(McBryde, Edgerton Building, Wright, Williams, and Hargrove facilities) b. the stairway florescent lights were switched and able to be turned off. (McBryde Building North). c. emergency exit discharge lighting is wired to a switched circuit at ambulance entrance - McBryde facility.	K 045		
K 046	NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1. This STANDARD is not met as evidenced by: Based on observation, on November 19, 2008 at approximately 8:30am onward, the means of egress lighting is not functioning in the following areas: a. exit discharge near employee lounge.(McBryde facility) b. stairway vestibule near room #625.(McBryde facility) c. stair #2 - sixth and fifth floor levels.(McBryde facility) d. stairway vestibule 4018-4-east-A.(McBryde	K 046		

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K 046	Continued From page 11 facility) e. stairway vestibule 4025-4-east-A.(McBryde facility) f. stairway vestibule 3005-3-east-B.(McBryde facility) g. stairway vestibule 3019-3-east-A.(McBryde facility) h. stairway vestibule 1025-1-east-A.(McBryde facility) i. stairway landing at exit #1 - Edgerton Building j. exit #5 - stairway in Edgerton Building	K 046		
K 047	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation, on November 18, 2008 at approximately 9:30 AM onward, the following was observed as noncompliant: The exit sign was not lit in the following locations: 1 North - #21 & #22 (McBryde facility) Based on observation, on November 19, 2008 at approximately 8:30am onward, The exit signs at stairwells #21 and C018 were	K 047		

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	344001	A. BUILDING 05 , 02 , 03 B. WING _____	11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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K 047	Continued From page 12 found not illuminated . (McBryde- South)	K 047		
K 050	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation, on November 20, 2008 at approximately 10:00 AM onward, the following was observed as noncompliant: documentation indicated 17 drills were missed over the past year. Third quarter documentation indicated that all shifts in buildings 49 - 54 were missed. (Umstead Campus) Based on documentation, on November 20, 2008 at approximately 10:00 AM onward, the following was observed as noncompliant: a. documentation indicated less than the required number of fire drills were held on 2nd and 3rd shifts of third quarter 2008 (Wright building) b. documentation indicated less than the required number of fire drills were held on 2nd shift of third quarter 2008 (Williams building)	K 050		
K 051	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components,	K 051		

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	344001	A. BUILDING 05 , 02 , 03 B. WING _____	11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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K 051	Continued From page 13 devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation, on November 18, 2008 at approximately 4:40pm, the following fire alarm system components are noncompliant: a. there is no audible and visual signaling device connected to the fire alarm system serving unit #4 - Building 52.(CRH Butner Annex Campus) b. there is no visual trouble signal with loss of power to fire alarm control panel.(Building 53 - CRH Butner Annex Campus) Based on observation, on November 19, 2008 at	K 051		

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	344001	A. BUILDING 05 , 02 , 03 B. WING _____	11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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K 051	Continued From page 14 approximately 8:30am onward, a. The normal power visual indicator is not functioning on fire alarm panel serving the Williams Building. b. The Main fire alarm panels for the McBryde and Williams Bldgs have no capability for battery back-up, (1955 year models). Their back-up power supply are the Emergency Generators. In the event of loss of power just to the Fire Alarm Control Panel (FACP) , breaker malfunction, etc, the generators would not crank and supply power for that isolated incident. Therefore the FACP would not function (as tested during survey) until the problem was identified and corrected - power restored.. Per documentation review and staff interview there were no emergency procedures in place for posting a fire watch during this event. c. The audible fire alarm notification devices (horns) on Hall 2 East did not work when testing the Fire Alarm. d. There was no audible alarms heard on the short corridors near rooms 240 and 343 during the test of the Fire Alarm Control Panel (McBryde Building). e. Based on observation, on November 19, 2008 at approximately 8:30am onward, there is no machine room smoke detector serving the elevator equipment room - Williams Building.	K 051		
K 062	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA	K 062		

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	344001	A. BUILDING 05 , 02 , 03 B. WING	11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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K 062	Continued From page 15 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation, on November 19, 2008 at approximately 11:25am, the sprinkler system gauges serving the sprinkler fire pump are not listed for fire protection service.(McBryde North) Based on observation, on November 18, 2008 at approximately 9:30 AM onward, the following was observed as noncompliant: sprinkler certification indicated that four (4) gages were outdated and need replacement: Ground floor 1st floor, north wing 2nd floor, north wing main riser, south wing (McBryde facility)	K 062		
K 067	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 specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observation, on November 18, 2008 at approximately 3:55pm onward, there are no emergency shutdown switches for air handling units serving Buildings 49,50,51,52,53,54, and 55. (CRH -Butner Annex Campus) Based on observation, on November 19, 2008 at	K 067		

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	344001	A. BUILDING 05 , 02 , 03 B. WING _____	11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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K 067	Continued From page 16 approximately 8:30am onward, the mechanical system components in the following areas were observed as incomplete: a. AHU #13 is not equipped with an outside air duct detector b. lack of duct detectors to cover all supply and return ducts for AHU #13 - North McBryde facility c. lack of emergency shutdown switches to cover all air handling units serving McBryde and Hargrove facilities - staff could not confirm switch locations in the vicinity of supervised stations served by air handling units.(McBryde, Hargrove, Williams, Edgerton, and Wright facilities) d. lack of duct detectors for AHU#2 - McBryde North e. lack of service access openings for duct detectors serving AHU#4, and AHU#8 in McBryde North. f. lack of emergency shutdown switch(es) for air handling units serving Edgerton Building.	K 067		
K 071	NFPA 101 LIFE SAFETY CODE STANDARD Rubbish Chutes, Incinerators and Laundry Chutes: (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor is sealed by fire resistive construction to prevent further use or is provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes comply with section 9.5.	K 071		

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	344001	A. BUILDING 05 , 02 , 03 B. WING _____	11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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K 071	Continued From page 17 (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, is provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute discharges into a trash collection room used for no other purpose and protected in accordance with 8.4. (4) Existing flue-fed incinerators are sealed by fire resistive construction to prevent further use. 19.5.4, 9.5, 8.4, NFPA 82 This STANDARD is not met as evidenced by: Based on observation, on November 19, 2008 at approximately 8:30am onward, the soiled linen chute doors are noncompliant in the following areas: a. upper chute access door is not self-closing in all positions in soiled linen anteroom across from room 229 - Edgerton Building. b. the soiled linen chute door was not self closing (2nd floor near room 218) (McBryde Building).	K 071		
K 072	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072		

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	344001	A. BUILDING 05 , 02 , 03 B. WING _____	11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

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K 072	Continued From page 18 This STANDARD is not met as evidenced by: Based on observation, on November 19, 2008 at approximately 8:30am onward, the means of egress is obstructed in the following areas: a. unattended chair in stair #2-5-east-A.(McBryde facility)	K 072		
K 076	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. (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: Based on observation, on November 19, 2008 at approximately 8:30am onward, the medical gas systems were observed as noncompliant due to the following: a. oxygen manifold system is not protected from inclement weather - cylinders are exposed to the rain, sleet, snow, and other adverse weather conditions.(area near ambulance entrance at McBryde facility) b. oxygen cylinders are not secured individually at oxygen manifold system beside ambulance	K 076		

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	344001	A. BUILDING 05 , 02 , 03 B. WING _____	11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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 19 entrance.(McBryde facility) c. Oxygen tanks were found unsupported in Oxygen storage Room 159 (McBryde South) d. there were unsecured oxygen bottles in room (218) (McBryde Building).	K 076		
K 104	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on observation, on November 19, 2008 at approximately 2:40pm, the smoke damper did not close completely at corridor smoke barrier beside room 119 - Edgerton Building.	K 104		
K 144	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on the observations during document review and staff interview on 11/20/2008:	K 144		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	344001	A. BUILDING 05 , 02 , 03 B. WING _____	11/21/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL REGIONAL HOSPITAL	300 VEAZEY ROAD BUTNER, NC 27509

(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 144	Continued From page 20 1. the generator logs for building 49-54 did not show that the generator servicing these buildings was load tested during the month of July 2008. 2. the generator logs for the buildings did not show a weekly inspection of the generators.	K 144		
K 145	NFPA 101 LIFE SAFETY CODE STANDARD The Type I EES is divided into the critical branch, life safety branch and the emergency system in accordance with NFPA 99. 3.4.2.2.2. This STANDARD is not met as evidenced by: Based on observation, on November 19, 2008 at approximately 8:30am onward, the following essential electrical system components were observed as noncompliant: a. lack of generator annunciator panels for generators and emergency systems serving McBryde, McBryde North, and Hargrove buildings at CRH-Raleigh campus. b. existing generator annunciator panel located in electrical switchgear room, beside ambulance entrance, did not function during loss of normal power to the ATS serving the Life Safety Branch of the essential electrical system. c. the essential electrical system required approximately fifteen seconds to restore power, upon loss of normal power, to the automatic transfer switch serving the McBryde facility. d. lack of task light and unitary light at generator set locations serving the McBryde, McBryde North, and Hargrove facilities.(generators #1, #2,	K 145		

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K 145	Continued From page 21 #3 - McBryde facility, and generator for McBryde North) e. lack of automatic start for generator #2 during loss of normal power to the automatic transfer switch.(Hargrove facility)	K 145		
K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, on November 18, 2008 at approximately 9:30 AM onward, the following was observed as noncompliant: a. the light was not functioning properly in patient bedroom 144 (McBryde facility - 1 North) b. the following medical room refrigerators were fed from normal power: McBryde facility - 3 South, room 369 Wright Building c. the mechanical room near room 245 there was an opened junction box above the HVAC trunk just as you enter the room (McBryde Building North). d. the med room refrigerator at nurses station #271 was not on an emergency circuit. (McBryde Building North). e. the wet location at the ice machine in room (265) was not plugged into a Ground Fault interrupter circuit (McBryde Building North).	K 147		
K 011	NFPA 101 LIFE SAFETY CODE STANDARD	K 011		

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K 011	Continued From page 22 If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2 This STANDARD is not met as evidenced by: Based on observation, on November 18, 2008 at approximately 10:30am, There were penetrations thru 2 hr fire rated wall above the ceiling @ door D0003 that had not been sealed to maintain the required fire-rating of the wall. (CRH - Butner Campus)	K 011		
K 029	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: Based on observation, on November 18, 2008 at approximately 10:30am, 1. there is no fire door and listed door frame for supply storage room N3060.(CRH -Butner Campus) 2. There were electrical penetrations thru the	K 029		

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K 029	Continued From page 23 corridor wall that had not been sealed to maintain the required one-hour fire rating of the wall. Storage room # M1011 (CRH - Butner Campus) 3. There was a penetration in the wall at the bottom of the right side of the room in the corner of the electrical room (N2001). (CRH - Butner Campus) 4. There was a penetration in the rated wall at the top of the wall on the right hand side as you enter the room (K2001) (CRH - Butner Campus)	K 029		
K 032	NFPA 101 LIFE SAFETY CODE STANDARD No less than two exits, remote from each other, are provided for each floor or fire section of the building. Only one of these two exits may be a horizontal exit. 18.2.4.1, 18.2.4.2 This STANDARD is not met as evidenced by: Based on observation, on November 18, 2008 at approximately 9:30 AM onward, the following exit egress was observed as noncompliant: The primary exit discharge door, at ground level of Stairwell #A2- Level 0, was found to be locked and could not be unlocked from inside stairwell with tool, key, etc. therefore not allowing exiting. (CRH- Butner Campus)	K 032		
K 051	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the	K 051		

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K 051	Continued From page 24 complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observation, on November 18, 2008 at approximately 9:30 AM onward, the following was observed as noncompliant: There was a compartmentalized area without a smoke detector. (Corridor next to room C0062) (CRH- Butner Campus)	K 051		
K 076	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. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 18.3.2.4	K 076		

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K 076	Continued From page 25 This STANDARD is not met as evidenced by: Based on observation, on November 18, 2008 at approximately 10:30am, the converted storage room (F2043) had oxygen cylinders without proper signage for that space. CRH -Butner Campus)	K 076		
K 144	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation, on November 18, 2008 at approximately 11:15am, the essential electrical system required approximately fourteen seconds to restore power during loss of normal power to ATSC-W1.(CRH- Butner Campus)	K 144		
K 147	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, on November 18, 2008 at approximately 10:44 AM 1. the generator annunciator audible and visual signaling devices did not function at time of survey.(Central Plant generator annunciator located in Security room M2007 - CRH Butner Campus)	K 147		

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K 147	Continued From page 26 Based on observation, on November 18, 2008 at approximately 9:30 AM onward, the following was observed as noncompliant: 2. There were exposed light bulbs with out a cover in the following areas: H0007, H0008 (CRH- Butner Campus)	K 147		