STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345410	A. BUILDING _____ B. WING _____	C/R 10/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL CONTINUING CARE	1287 NEWSOME STREET MOUNT AIRY, NC 27030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the Complaint Investigation of 10/01/12 - 10/05/12. Event ID #KOAL11.	F 000	Filing the Plan of Correction does not constitute an admission that the deficiencies alleged, did, in fact, exist. This Plan of Correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality resident care.	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to ensure the medication error rate was 5% or below by not following the physician's orders. There were four errors out of 50 opportunities resulting in an 8% error rate affecting two (Residents # 19 & # 75) of ten residents observed for medication administration. Findings include: 1. Resident # 19 was readmitted on 7/20/12 with diagnoses, dementia with behaviors and gastroesophageal reflux disorder (reflux of stomach acid into the esophagus). Review of the physician's orders dated 10/2/12 indicated an order for Miralax (bulk laxative) 17 Grams (Gms) in 8 ounces water and take by mouth daily. Observation of medication administration on 10/4/12 at 8:30 AM revealed Nurse # 1 mixed 17 Grams of Miralax in water. The nurse stated there	F 332	1) The Director of Nursing will in-service Nurse #1 on following physician orders and facility policy and procedure with an emphasis on medication administration. The Director of Nursing, or her designee, will notify the attending physician for resident #19 and #75 of the medication errors. 2) The Director of Nursing, or the Staff Development Coordinator will conduct individual medication pass observation with the current licensed staff and provide corrective action for non-compliance with facility policies and procedures related to medication administration. 3) The Director of Nursing or Staff Development Coordinator will in-service the licensed staff on following physician orders and the facility policy and procedures for medication administration. The Staff Development Coordinator will include information on following physician orders and the facility policy and procedures for medication administration,	11/2/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Karen Gaylo	ADMINISTRATOR	10/17/2012

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
	345410	A. BUILDING _____ B. WING _____	C 10/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL CONTINUING CARE	1287 NEWSOME STREET MOUNT AIRY, NC 27030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 1 was 6 ounces of water in the cup. 2. Resident # 75 had diagnoses of dementia, diabetes and macular degeneration. 2 a. Review of the physician's orders dated 10/2/12 revealed orders for isosorbide (for control of chest pain) ER (extended release) 60 milligrams (mg) one tablet by mouth once daily (do not crush). At 8:50 AM on 10/4/12 nurse #1 was observed to crush the isosorbide ER and mix it in applesauce with other medications. She entered the resident's room and spooned the medications from the medication cup and started to administer them to the resident. Upon request Nurse # 1 did not administer the medications and stepped into the hallway. An interview with nurse #1 at that time revealed she should not have crushed the isosorbide ER. She discarded the crushed medications and re-poured the medications, leaving the isosorbide ER intact. 2 b. Review of the physician's orders dated 10/2/12 revealed an order for Eldertonic (appetite stimulant) 15 milliliters (ml) before meals. Observation of medication administration on 10/4/12 at 8:55 AM revealed nurse #1 administered Eldertonic to resident # 75. The nurse was asked if the resident had finished breakfast and she stated " yes " . An interview was conducted with nurse # 1 at 1:00 PM on 10/4/12 and she stated "It's hard to	F 332	in the orientation of new licensed staff. The Director of Nursing, or her designee, and/or the Staff Development Coordinator will conduct random medication pass observations with licensed staff members at least weekly for three months then at least monthly and provide in-servicing and/or counseling as indicated as a result of the review process. 4) The Director of Nursing, or her designee, will monitor through observation, Medication Administration Record review and Pharmacy Consultant report review, at least monthly for three months, then at least quarterly, to assure medications are administered according to physician orders and facility policy and procedure. Monitors will be reviewed at scheduled QA Meetings. The Administrator is responsible for overall compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345410	A. BUILDING _____ B. WING _____	C 10/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL CONTINUING CARE	1287 NEWSOME STREET MOUNT AIRY, NC 27030

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F 332	Continued From page 2 get all the Eldertonics to residents before 7:30 AM ". When questioned about the purpose of the Eldertonic she revealed it is given to residents who don't eat well because it stimulates the appetite. 2 c. Review of the physician's orders dated 10/2/12 revealed an order for Cerovite Senior (SR) (multivitamin with minerals) one tablet by mouth daily. Observation of medication administration revealed nurse #1 administered a multivitamin with minerals tablet to resident # 75 at 8:55 AM on 10/4/12. At 3:30 PM the labels on the bottles of multivitamin with minerals and Cerovite senior SR were compared with nurse #1. The labels indicated that Cerovite SR was a different formulation than the multivitamin with minerals. A telephone interview with the pharmacist on 10/5/12 at 10:45 AM revealed if Cerovite is ordered the senior tabs should be given. He stated that Cerovite SR contains vitamins for eyes that are not contained in the multivitamins with minerals.	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff	F 333	1) Nurse #1 gave Resident #75 the correct form of medication on 10/2/2012. The Director of Nursing will in-service Nurse #1 on passing medications in accordance with physician orders with an emphasis on do not crush medications. 2) The Director of Nursing, or her designee, has reviewed current resident Medication Administration Records to assure do not crush medications were	11/2/12

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CENTRAL CONTINUING CARE	1287 NEWSOME STREET MOUNT AIRY, NC 27030

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F 333	Continued From page 3 interview the facility failed to prevent a significant medication error for one (Resident #75) of ten residents observed for medication administration by crushing isosorbide ER not in accordance with the physician's order. Findings include: Resident # 75 had diagnoses of dementia, diabetes and macular degeneration. Review of the physician's orders dated 10/2/12 revealed orders for isosorbide (for control of chest pain) ER (extended release-slowly absorbed over 24 hours) 60 milligrams (mg) one tablet by mouth once daily (do not crush). At 8:50 AM on 10/4/12, during a medication administration observation, nurse #1 crushed isosorbide ER and mixed it in applesauce with other medications. She entered the resident's room, spooned the medications from the medication cup and began to administer them to the resident. Upon request nurse # 1 did not administer the medications and stepped into the hallway. An interview with nurse #1 at that time revealed she should not have crushed the isosorbide ER. She discarded the crushed medications and re-poured the medications, leaving the isosorbide ER intact. On 10/4/12 at 9:45 AM the Medication Administration Record (MAR) was reviewed. The isosorbide ER listing was consistent with the physician's order and included instructions not to crush the medication. In the front of the MAR	F 333	identified. The Director of Nursing, or the Staff Development Coordinator will conduct individual medication pass observation with the current licensed staff and provide corrective action for non-compliance with facility policies and procedures related to medication administration. 3) The Director of Nursing or Staff Development Coordinator will in-service the licensed staff on following physician orders and the facility policy and procedures for medication administration. The Staff Development Coordinator will include information on following physician orders and the facility policy and procedures for medication administration, in the orientation of new licensed staff. The Director of Nursing, or her designee, and/or the Staff Development Coordinator will conduct random medication pass observations with licensed staff members at least weekly for three months then at least monthly and provide in-servicing and/or counseling as indicated as a result of the review process. 4) The Director of Nursing, or her designee, will monitor through observation, Medication Administration Record review and Pharmacy Consultant Report review, at least monthly for three months, then at least quarterly, to assure medications are administered according to physician's orders. Monitors will be reviewed at scheduled QA Meetings. The Administrator is responsible for overall compliance.	

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F 333	Continued From page 4 there was a list of medications not to be crushed and included isosorbide ER. The list further indicated it is a time release formula. An interview with nurse #1 on 10/4/12 at 3:30 PM revealed she could notify the physician for an order change if a resident has difficulty swallowing a medication.	F 333		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345410	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL CONTINUING CARE	1287 NEWSOME STREET MOUNT AIRY, NC 27030

RECEIVED
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CONSTRUCTION SECTION

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III(211) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Filing the Plan of Correction does not constitute an admission that the deficiencies alleged, did, in fact, exist. This Plan of Correction is filed as evidence of the facility's desire to comply with the requirements and to continue to provide high quality resident care.	
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation on Tuesday 10/30/12 between 9:30 AM and 1:30 PM the following was noted: 1) The one hour rated corridor was not maintained. The sheet rock in the attic that is part of the one hour fire rated corridor has holes that were not repaired in order to maintain the required rating of the ceiling. 42 CFR 483.70(a)	K 012	1) The Maintenance Director, or his designee, shall assure the holes in the sheet rock in the attic are repaired. 2) The Maintenance Director, or his designee, will conduct environmental rounds to identify other holes in the sheet rock in the attic and make repairs to areas identified through the inspection process. 3) The Maintenance Director, or his designee, will conduct at least quarterly inspections to assure there are no holes in the sheet rock in the attic. 4) The Maintenance Director, or his designee, will monitor through observation at least quarterly, to assure there are no holes in the sheet rock in the attic. Monitors will be reviewed at scheduled QA meetings. The Administrator is responsible for overall compliance.	12/14/12
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Karen Gaylor — TITLE: ADMINISTRATOR — (X6) DATE: 11/16/12

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345410	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTRAL CONTINUING CARE	1287 NEWSOME STREET MOUNT AIRY, NC 27030

(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 029	Continued From page 1 option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Tuesday 10/30/12 between 9:30 AM and 1:30 PM the following was noted: 1) The dry storage room for the kitchen located next to the exit door did not have positive latching. 42 CFR 483.70(a)	K 029	1) The Maintenance Director repaired the dry storage room door located next to the exit door of the kitchen to assure positive latching 2) The Maintenance Director, or his designee, will conduct environmental rounds to identify other doors for positive latching and make repairs to areas identified through the inspection process. 3) The Maintenance Director, or his designee, will conduct at least monthly inspections to assure doors maintain positive latching. 4) The Maintenance Director, or his designee, will monitor through observation monthly for three months, then at least quarterly, to assure doors maintain positive latching. Monitors will be reviewed at scheduled QA meetings. The Administrator is responsible for overall compliance.	12/14/12
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation on Tuesday 10/30/12 between 9:30 AM and 1:30 PM the following was noted: 1) The smoke duct detectors located in the HVAC units were not maintained clean and in good operating condition. Location - HVAC unit in the telephone room. 42 CFR 483.70(a)	K 054	1) The Maintenance Director cleaned the smoke duct detectors located in the HVAC unit in the telephone room. 2) The Maintenance Director, or his designee, will conduct environmental rounds to identify other smoke duct detectors located in the HVAC units and clean areas identified through the inspection process. 3) The Maintenance Director, or his designee, will conduct at least quarterly inspections of smoke duct detectors located in the HVAC units and clean them as necessary. 4) The Maintenance Director, or his designee, will monitor through observation at least quarterly, to assure smoke duct detectors are clean and in good operating condition. Monitors will be reviewed at scheduled QA meetings. The Administrator is responsible for overall compliance.	12/14/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345410	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/30/2012

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K 076 SS=D	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 Tuesday 10/30/12 between 9:30 AM and 1:30 PM the following was noted: 1) Oxygen cylinders were found gang chained together in the oxygen storage room. 2) Oxygen storage was non-compliant, specific findings include; full and empty oxygen cylinders were stored together. If stored within the same enclosure, empty cylinders shall be segregated and designated (with signage) from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly. [NFPA 99 4-3.5.2.2b(2)] (oxygen storage near the nurses station) 42 CFR 483.70(a)	K 076	1) The Central Supply Clerk separated the full and empty oxygen cylinders and assured each empty cylinder was individually secured on 10/30/2012. 2) No other areas of the facility are used to store oxygen cylinders 3) The Staff Development Coordinator will conduct an in-service with the Licensed Staff on storage of oxygen cylinders according to regulation. The Staff Development Coordinator will include information on the storage of oxygen cylinders according to regulation in the orientation of new Licensed Nurses. The Central Supply Clerk, or her designee, will conduct at least weekly inspection of the Central Supply Room to assure oxygen cylinders are stored according to regulation. 4) The Central Supply Clerk, or her designee, will monitor through observation monthly for three months, then at least quarterly, to assure oxygen cylinders are stored according to regulation. Monitors will be reviewed at scheduled QA meetings. The Administrator is responsible for overall compliance.	12/14/12