3/21/13

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

PRINTED: 03/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345177	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SVCS PINEHURST	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

(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 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:	F 156	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. **F156** **It is the practice of this facility to prominently display in the facility written contact information for the NC Dept. of Health and Human Services, depart. of Health Service Regulation.** **Criteria One:** **For the resident found to have been affected by the alleged deficient practice:** No resident was found to have been affected by the alleged deficient practice. **Criteria Two:** **For other residents who may have been affected by the alleged deficient practice:** Each resident has the potential to have been affected by the alleged deficient practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Toni Williams	Administrator	3/21/13

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

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F 156	Continued From page 1 A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's	F 156	**Criteria Three:** **The following systemic changes will be put into place to ensure the alleged deficient practice does not recur.** The sign has been changed to reflect the current name, address, and telephone number of the NC DHHS Division of Health Service Regulation. It has been lowered to 4.3 ft. off the floor (to the top of the page.) A total of five residents, one from each of the four units and the resident council president were asked to read and confirm that the sign is at an appropriate height and font to be easily read. Administrator or designee will ensure correct state contact information is listed annually. **Criteria Four:** **The corrective action will be monitored as follows:** The Administrative Director of Nursing Services (ADNS) or designee will audit weekly times 4 weeks then monthly times 3 months and annually in December that no changes have been made to the contact information as well as the position of the sign. Audits to be taken to QA by ADNS, for review o: the need for continued auditing. 3/21/13	

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F 156	Continued From page 2 policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility failed to post state contact information at or near eye level for residents in wheelchairs and failed to post current state contact information. The findings include: On 2/18/13 at 11:30 AM the state contact information was observed posted on a bulletin board, on a n 8 x 10 piece of paper, approximately 6 feet off the floor (to the top of the page). The contact phone number for the North Carolina Department of Health Services, Division of Health Services Regulation was listed as (919) 833 - 4250. The current contact phone number for the North Carolina Department of Health Services, Division of Health Services Regulation was (919) 855 - 4500. The expiry date on the sign was 12/31/12.	F 156		

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F 156	Continued From page 3 On 2/21/13 at 11:45 AM the state contact information was observed posted on a bulletin board, on a n 8 x 10 piece of paper, approximately 4 feet off the floor (to the top of the page). Interview with the Administrator at this time reveled that she moved it because when she was walking by it the other day she realized it would be difficult for people in wheelchairs to read at the height it had been at. The Administrator was not interviewed about the incorrect state contact information.	F 156		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, record review and facility policy review, the facility failed to trim toenails for 1 of 3 residents (Resident #71) reviewed for activities of daily living care. The findings included: The facility policy entitled "Bathing", dated 12/2009 included, "Clean and trim nails as needed. (Only a licensed nurse can perform nail cutting on a diabetic patient.)" Resident #71 was readmitted to the facility on 11/27/06. Diagnoses included contractures. Diabetes was not a listed diagnosis. The annual Minimum Data Set (MDS) dated 1/5/13 indicated	F 312	**F312** **It is the practice of the facility that when a resident is unable to carry out activities of daily living they receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene** **Criteria One:** **For the resident found to have been affected by the alleged deficient practice:** Resident's toenails were clipped on 2/20/13 by RN at facility. **Criteria Two:** **For other residents who may have been affected by the deficient practice:** Each resident has been assessed on 3/8/13 by the RN's and LPN's on night shift for long nails and groomed appropriately. Resident's needing podiatry services were placed on the podiatry list to be seen on 4/10/13. No immediate needs for podiatry services were identified..	

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F 312	Continued From page 4 the resident required extensive to total assistance with all activities of daily living. Observations on 2/20/13 at 10:40 AM and 4:40 PM revealed the resident's toenails were long. On the great and 2nd toes bilaterally the nails extended approximately 1 centimeter beyond the end of the toes. The nails were thin. During an interview on 2/20/13 at 4:40 PM, Nursing Assistant (NA) #1 indicated that the nurses or podiatrist cut residents' toenails. NA #1 said she thought the resident was on the list to be seen by the podiatrist. During an interview on 2/21/13 at 8:30 AM, the social worker indicated that Resident #71 was not on the podiatrist list. During an interview on 2/21/13 at 10:55 AM, Administrative Staff #3 indicated that NAs were expected to cut toenails if the nails were not thick and the resident was not a diabetic. During an interview on 2/21/13 at 10:59 AM, Nurse #2 stated that the nursing assistants could cut Resident #71's toenails since the resident was not a diabetic and the nails were not too thick. Nurse #2 indicated that if the resident refused to let the NAs cut her toenails, she expected the NAs to let the nurse know. Nurse #2 added that the nurse on duty 2/20/13 did trim the resident's toenails. During an interview on 2/21/13 at 12:45 PM, Administrative Staff #2 said that as a rule, she expected the NAs to let the nurses know if a resident's toenails needed to be cut so the nurse	F 312	**Criteria Three:** **The following systemic changes will be put into place to ensure the deficient practice does not recur:** All nursing staff have been in-serviced by the ADNS to include full time, part time and PRN staff on ADL care regarding proper grooming of resident nails. A new system has been implemented requiring CNA's on day shift to do even numbered rooms and CNA's on evening shift to do odd numbered rooms for nail grooming daily. Diabetic patient nails are to be groomed by the Charge Nurse. Patients needing podiatry services are reported to the charge nurse for assessment and recorded on the 24 hour report book for notification to social services, to place on the podiatry list for next visit. **Criteria Four:** **The corrective action will be monitored as followed:** An audit will be conducted by the Director of Care Delivery (DCD) or designee of 10 residents weekly times 4 weeks to include residents from even and odd numbered rooms then monthly times 3 months. Audit tools to be taken to QA by ADNS for review of the need for continued auditing. 3/21/13	

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F 312	Continued From page 5 could cut them if the resident was not a diabetic and the nails were not too thick. Administrative Staff #2 added that she did not know why Resident #71's toenails were allowed to get so long.	F 312		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356	**F356** **It is the practice of the facility to record accurate information on the daily nurse staff posting form.** **Criteria One:** **For the resident found to have been affected by the alleged deficient practice.** No resident were been found to have been affected by the alleged deficient practice. **Criteria Two:** **For other residents who may have been affected by the alleged deficient practice:** Each resident has the potential to have been affected by the alleged deficient practice. **Criteria Three:** **The following systemic changes will be put into place to ensure the deficient practice does not recur:** Nursing supervisors have been in-serviced by ADNS to perform the task of posting the nurse staffing form during each shift as needed during the week and on weekends.	

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F 356	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to record accurate information on the Daily Nurse Staff Posting Form. The findings included: On 2/18/13 at 2:58 PM., the Daily Staff Posting Sheets for 2/16/13, 2/17/13 and 2/18/13 were observed posted on the bulletin board. The actual hours worked area was blank for all shifts on all three days. Also, the Resident Census was documented as 113 for 2/16/13, 2/17/13 and 2/18/13. The Administrative Assistant reviewed the census for 2/16,13, 2/17,13 and 2/18/13. The actual Resident Census was 111 on 2/16/13, 110 on 2/17/13 and 110 on 2/18/13. On 2/18/13 at 2:58 PM., the Administrative Assistant stated she posted the Daily Nurse Staff Sheets for the weekend and Monday on Friday. She said nobody made the changes on the nursing hours and the Resident Census during the weekend. When she returned on Monday, she would retrieve the forms and complete the actual nursing hours and the Resident Census. On 2/20/13 at 3:47 PM., Administrative staff #2 stated the Administrative Assistant posted the Daily Nurse Staff Posting Form the evening before the next day and posted the weekend forms on Friday. She stated she did not realize that the total number of actual nursing hours and census should be completed on a daily basis.	F 356	**Criteria Four:** **The corrective action will be monitored as followed:** Audits will be completed by the ADNS or designee daily times 1 week, then weekly times 4 weeks and then monthly times 3 months. Audit tool to be taken to QA by the ADNS monthly, for review of the need for continued auditing. **3/21/13**	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 7 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to maintain sanitary condition in the kitchen and ensure proper food storage by not ensuring all packaged food items opened and used were labeled and dated and failed to ensure all food items were closed/sealed. The facility also failed to ensure that clean trays were not stacked wet. The findings included: On 2/18/13 at 10:47 AM, initial tour of the kitchen was conducted. In the walk in refrigerator, there were 2 bags and 1 box of lemons observed. In the bags/box, there were multiple lemons that were observed moldy. There was also a box of cucumber observed and ¼ of the box were moldy and rotten. There was an opened plastic bag with bologna in it and was dated 2/3/13. In the walk in freezer, there were 5 hamburger patties, 14 waffles and french fries that were not labeled/dated. In the dry storage, there was a packet of opened gravy mix which was undated. At 10:55 AM, dietary staff #1 was interviewed. She stated that a dietary staff member should be checking the refrigerator, freezer and dry storage	F 371	**F371** **It is the practice of the facility to procure food from sources approved or considered satisfactory by Federal, State and local authorities and store, prepare, distribute and serve under sanitary conditions.** **Criteria One:** **For the resident found to have been affected by the alleged deficient practice:** No resident has been found to have been affected by the alleged deficient practice. **Criteria Two:** **For other residents who may have been affected by the alleged deficient practice:** Each resident has the potential to have been affected by the alleged deficient practice. On 2/18/13 the following defective items, to include 2 bags and 1 box of lemons, a ¼ box of cucumbers, and an opened plastic bag with bologna dated 2/3/13 from the walk in refrigerator were discarded. From the walk in freezer, 5 hamburger patties, 14 waffles and a large bag of French fries, and an opened pack of gravy mix from dry storage were also discarded.	

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F 371	Continued From page 8 daily for proper storage and labeling/dating of food. She further stated that evidently, this was not happening. On 2/20/13 at 9:00 AM, another tour of the kitchen was conducted. A scoop was observed inside the sugar bin and empty boxes were noted on the floor. In the dry storage, there was a bag of sugar that was not closed/sealed. In the walk in freezer, there was an opened plastic bag of smoked sausage that was not closed/sealed. At 9:30 AM, interview with the dietary staff #2 revealed that the scoop should not be stored inside the bin and the sugar should have been sealed. The dietary staff member also stated that the food in the freezer should have been sealed, labeled and dated after opening. On 2/20/13 at 11:45 AM, observation of the tray line was conducted. All the trays were observed to be stacked together wet and were used to serve the lunch meal. At 11:48 AM, dietary staff #3 was interviewed. She stated that the new trays took a long time to dry. The dietary staff was observed to wipe each tray with paper towel prior to using it after it was brought to her attention. On 2/21/13 at 9:20 AM, administrative staff #4 was interviewed. The staff stated that they were aware that the dietary staff needed a lot of support and education.	F 371	On 2/20/13, all debris from the floor was removed and discarded to include boxes, and a scoop. A bag of sugar was discarded as it was not sealed. An opened bag of smoked sausage from the walk in freezer was also discarded. **Criteria Three:** **The following systemic changes will be put into place to ensure the alleged deficient practice does not recur:** In-service for dietary staff was conducted by the Dietary Manager to include the following topics: 1) Washing and drying of pots and pans 2) Receiving and storage of food items 3) Food Safety Product-Labeling and Dating 4) Food Product Shelf Life Guidelines 5) Preventing Cross-Contamination **Criteria Four:** **The corrective action will be monitored as follows:** Audits for dietary services will be conducted by the Dietary Manager or designee weekly times 4 weeks, then monthly times 3 months. Audits will be taken to QA by the ADNS for review of the need for continued auditing. 3/21/13	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431		

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F 431	Continued From page 9 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review; the facility failed to maintain medication refrigerator temperature within the 36 - 46 degree range, required by medications in the refrigerator, according to the medication manufactures	F 431	**F431** **It is the practice of the facility to maintain medication refrigerator temperatures within the 36-46 degree range, as recommended by drug manufacturer.** **Criteria One:** **For the resident found to have been affected by the alleged deficient practice:** No residents were found to have been affected by the alleged deficient practice. **Criteria Two:** **For other residents who may have been affected by the deficient practice:** Each resident using medication stored in the refrigerator has the potential to have been affected by the alleged deficient practice. All medications to include 3 vials of Engerix-B, 10 vials of Humalog Insulin, 4 vials of Levemir Insulin, 3 vials of Lantas Insulin, 1 vial of Humulin 70/30 Insulin, 1 vial of Humulin R Insulin, 1 vial of Novolog Insulin, and 24 vials of Intramuscular/Intravenous Lorazepam solution were returned to pharmacy unopened. Defective thermometer was disposed of and a new one put in place.	

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F 431	Continued From page 10 recommendations, for 1 of 2 medication refrigerators. Findings included: According to the Prescribing Information for Engerix-B from the manufacturer GlaxoSmithKline, dated 2012, Engerix-B was a vaccination against Hepatitis B that should be stored refrigerated between 36 and 46 degrees F (farenheight). The instructions also indicated " do not freeze, discard if product has been frozen " . According to the Prescribing Information for Humalog from the manufacturer Eli Lilly and Company revised October 14, 2012, Humalog was an insulin medication unused in the treatment of diabetes mellitus. The instructions also indicated that unopened Humalog should be stored refrigerated between 36 and 46 degrees F but not in the freezer. The instructions also indicated " do not use Humalog if it has been frozen " . According to the Prescribing Information for Levemir from the manufacturer Novo Nordisk A/S revised January, 2012, Levemir was an insulin medication unused in the treatment of diabetes mellitus. The instructions also indicated that unopened Levemir should be stored refrigerated between 36 and 46 degrees F but not in the freezer or near the refrigerator cooling element. The instructions also indicated " do not freeze, do not use Levemir if it has been frozen " . According to the Prescribing Information for Lantas from the manufacturer Sanofi-Aventis	F 431	**Criteria Three:** **The following systemic changes will be put into place to ensure the alleged deficient practice does not recur.** All nursing staff were in-serviced by the ADNS regarding correct temperatures for storage of medications per manufactures recommendations. The Nursing Supervisor on night shift will maintain new refrigerator log of 36 to 46 degrees. Any deviation of temperatures, in the medication refrigerators are to be reported immediately to the ADNS, pharmacy and maintenance director for correction to ensure safe medication supply. **Criteria Four:** **The corrective action will be monitored as follows:** Refrigerator audits will be conducted by the ADNS or designee weekly times four weeks then monthly times 3 months. Audits to be taken to QA by the ADNS for review of the need for continued auditing. **3/21/13**	

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	345177	A. BUILDING _____ B. WING _____	C 02/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SVCS PINEHURST	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

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F 431	Continued From page 11 revised March, 2007, Lantas was an insulin medication unused in the treatment of diabetes mellitus. The instructions also indicated that unopened Lantas should be stored refrigerated between 36 and 46 degrees F but not in the freezer. The instructions also indicated if it " has been frozen or overheated, throw it away " . According to the Patient Information for Humulin 70/30 from the manufacturer Eli Lilly and Company revised January 20, 2011, Humulin 70/30 was an insulin medication unused in the treatment of diabetes mellitus. The instructions also indicated that unopened Humulin 70/30 should be stored in the refrigerator and not in the freezer. The instructions also indicated do not use Humulin 70/30 if it has been frozen. According to the Patient Information for Humulin R from the manufacturer Eli Lilly and Company revised March 25, 2011, Humulin R was an insulin medication unused in the treatment of diabetes mellitus. The instructions also indicated that unopened Humulin R should be stored in the refrigerator (36 - 46 degrees F) and not in the freezer. The instructions also indicated do not use Humulin R if it has been frozen. According to the Prescribing Information for NovoLog from the manufacturer Novo Nordisk A/S dated January 2013, NovoLog was an insulin medication unused in the treatment of diabetes mellitus. The instructions also indicated that unopened NovoLog should be stored refrigerated between 36 and 46 degrees F but not in the freezer. The instructions also indicated " do not freeze, do not use Levemir if it has been frozen " .	F 431		

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F 431	Continued From page 12 According to the Prescribing Information for Lorazepam Injection Solution from the manufacturer, Baxter Health Care Corporation, Revised 09/2009 Lorazepam was a medication used in status epileptics (seizures). The instructions also indicated that the solution should be stored in the refrigerator. Review of the Refrigerator Temperature Control Log for 01/01/13 through 02/19/13 revealed that on the following dates the 100 hall medication room refrigerator temperature was recorded as 32 degrees F (freezing temperature): January: 1, 2, 4, 6, 10, 14, 17, 19, 21, 22, 24, 29 February: 4, 6, 10, 16, 17, 18, 19. For the remaining days during this time period the temperature was recorded as 34 degrees F on 24 occasions, 33 degrees on 1 occasion, 35 degrees on I occasions and 36 degrees F on 3 occasions (January 26 and 27 and February 11). There were no temperatures above 36 degrees or below 32 degrees recorded. On January 21, under the comments heading temperature increased was handwritten. A typed note at the top of the log read " 11-7 checks nightly adjusts as needed if temp > (temperature less than) 40 degrees. Then recheck as needed.) On 2/20/13 at 4:40 PM the thermometer inside the medication refrigerator of the 100 hall medication room was observed to read 30 degrees. The medications stored in the refrigerator included the following unopened medications: Engerix B vaccine - quantity: 3 Humalog Insulin - quantity: 10 Levemir Insulin - quantity: 4 Lantas Insulin - quantity: 3	F 431		

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F 431	Continued From page 13 Humulin 70/30 Insulin - quantity: 1 Humulin R Insulin - quantity: 1 Novolog Insulin - quantiry: 1 Lorazepam Intramuscular/Intravenous Solution - quantity 24 Interview with Nurse #2 on 2/20/13 at 4:40 PM revealed that she acknowledged the presence of the above medications in the 100 hall medication refrigerator as well as the thermometer that was inside the refrigerator registering 30 or 31 degrees. Nurse #2 the storage instructions on the medications and acknowledged they indicated: Engerix B - refrigerate Humalog - refrigerate do not freeze Levemir - store between 36 - 46 degrees F Lantas - refrigerate do not freeze Humulin - refrigerate do not freeze Lorazepam - refrigerate Nurse #2 reviewed the temperature logs for the refrigerator for January and February 2013 and indicated the temperatures had registered lower than 36 degrees F for all but 3 days of this time period. She also acknowledged that the temperature had registered as 32 degrees F or freezing on numerous occasions. She stated that nursing staff recording the temperatures should have reported it so that action could be taken. She also indicated that the logs were reviewed at the end of each month my Nursing Management and should have been caught at that time as well. Interview with the Administrative Staff #2 on 2/21/13 at 8:30 AM revealed that a new thermometer was tested in the refrigerator, against the old thermometer, the night before and the old thermometer was found to be defective.	F 431		

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F 431	Continued From page 14 She indicated that nursing staff should have taken action when the temperature was registering below 36 degrees so accurate storage temperatures could have been known and recorded and to ensure the continued safety of medications that needed to be stored in the refrigerator.	F 431		

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	345177	A. BUILDING 01 - MAIN BUILDING B. WING	03/21/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANOR CARE HEALTH SVCS PINEHURST	205 RATTLESNAKE TRAIL PINEHURST, NC 28374

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, one story, with a complete automatic sprinkler system. Facility is using Delayed Egress locking system. The deficiencies determined during the survey are as follows:	K 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federal and state regulations, the facility has taken or will take the actions set forth in this plan of correction. The following plan of correction constitutes the facility's allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
K 027 SS=D	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 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: Surveyor: 27871 Based on observations and staff interview at approximately 11:30 am onward, the following item was noncompliant, specific findings include: cross corridor door left leaf did not close and latch for smoke tight seal(by room 116 going into short hall) on activation of fire test.	K 027	**K027** **Criteria One:** What corrective action(s) will be accomplished by the facility to correct the alleged deficient practice; Close rate was adjusted for cross corridor door left leaf on 3/22/13 to facilitate door closing with tight seal on activation of fire test. When tested on the following dates, 3/22/13, 3/26/13, and 4/2/13, door closed with tight seal on activation of a fire test. **Criteria Two:** How you will identify other life safety issues having the potential to affect residents by the same alleged deficient practice and what corrective action will be taken; Each resident has the potential to have been affected by the alleged deficient practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Toni Williams	Administrator	4/4/13

GW

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	345177	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/21/2013

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K 027	Continued From page 1 42 CFR 483.70(a)	K 027	A fire/smoke door closure test has been conducted by the Maintenance Director on _4/2/13__ and all fire/smoke doors have been inspected to ensure a tight seal has been obtained with activation of a fire test.	
K 067 SS=E	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: Surveyor: 27871 Based on observations and staff interview at approximately 11:30 am onward, the following items were noncompliant, specific findings include: 1. all damper in return vents had excess lent on fusible link(facility wide). 2. fire/smoke dampers in HVAC duct work had excess lent build up on links(unit above ceiling at nurse station on short hall). 3. duct detector tube on HVAC unit by room 115 & 116 had excess lent on tube.	K 067	**Criteria Three:** What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does recur; With each monthly fire drill, a staff member will be assigned to each fire door in the facility to ensure doors release and close with activation of a fire test. Doors will remain closed until the Maintenance Director checks them for proper closure and seal. The results will be obtained by the Maintenance Director prior to the end of each fire test for review and communicated immediately to the Administrator for follow up as needed.	
K 069 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 11:30 am onward, the following	K 069	**Criteria Four:** How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place. The Maintenance Director will immediately make adjustments necessary to correct any findings and bring the results of each fire test and any maintenance completed to the monthly QA meeting, for review and further recommendations if necessary.	5/5/13

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K 069	Continued From page 2 item was noncompliant, specific findings include: the deep fryer was located next to gas stove without the required splash guard in the dietary kitchen. 42 CFR 483.70(a)	K 069	**K069** **Criteria One:** What corrective action(s) will be accomplished by the facility to correct the alleged deficient practice; A new splash guard was obtained and installed per requirements.	
K 072 SS=E	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 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 11:30 am onward, the following items were noncompliant, specific findings include: Med. carts and B/P machine's were stored on corridors(not being used during survey) reducing the path of egress. 42 CFR 483.70(a)	K 072	**Criteria Two:** How you will identify other life safety issues having the potential to affect residents by the same alleged deficient practice and what corrective action will be taken; Each staff member has the potential to have been affected by the alleged deficient practice. An order was placed for one additional splash guard for use as needed. The Dietary Staff will be trained/in-serviced regarding the requirement of the splash guard use prior to 5/5/13. **Criteria Three:** What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does recur; The use of the splash guard has been added to the daily dietary audit sheet to be done by the Dietary Manager. In addition, the Maintenance Director will check the	

use of the splash guard when completing the monthly Quick Check of the Hood Suppression system.

Criteria Four:
How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place.

The audit will be submitted to the Quality Assurance and Assessment Committee (QAPI) monthly for review and further recommendations if necessary. 5/5/13

K067

Criteria One:
What corrective action(s) will be accomplished by the facility to correct the alleged deficient practice;

All dampers in return vents' facility wide, and HVAC duct work to include duct detector tube near room 115 and 116 have been cleared of excess dust and lint as of ___4/4/13_____.

Criteria Two:
How you will identify other life safety issues having the potential to affect residents by the same alleged deficient practice and what corrective action will be taken;

All fire and smoke dampers will be inspected by a licensed contractor for proper function and condition prior to 5/5/13. In addition, all smoke/duct detectors and sample tubes have been inspected by the Maintenance Director, and cleared of dust and debris if found.

Criteria Three:
What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur;

An audit will be conducted by the Administrator /Housekeeping Supervisor and Maintenance Director weekly times 4 weeks then monthly to ensure continued compliance with cleanliness of HVAC units and fire/smoke dampers.

Criteria Four:
How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place.

The Maintenance Director will report results of audits to the QA committee for review and further recommendations if necessary.

5/5/13

K072

Criteria One:
What corrective action(s) will be accomplished by the facility to correct the alleged deficient practice;

Medication carts and B/P machines were removed from the corridors.

Criteria Two:
How you will identify other life safety issues having the potential to affect residents by the same alleged deficient practice and what corrective action will be taken;

An audit of the building was completed on __4/4/13___, by the Administrator and Maintenance Director, to identify any obstacles that may reduce the width of exit egress to exit access. No other areas were identified.

Criteria Three:
What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does recur;

In-service training for all facility staff will be completed prior to May 5, 2013 on importance of keeping corridors free of obstruction to exits.

Monitoring halls for obstacles reducing width of exit egress to exit access will be added to the daily rounds audit sheet done by Administrator or Nursing Supervisor to ensure the alleged deficient practice has resolved.

Criteria Four:
How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place.

The audit sheets will be submitted to the monthly QA committee for review and further recommendations if necessary.

5/5/13