EDICAID SERVICES PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER: 345166 TOF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION)	A. BUILD B. WING	TIPLE CONSTRUCTION NG STREET ADDRESS, CITY, STATE, ZIP CODE 1570 NC 8 AND 89 HIGHWAY	(X3) DATE COMF	0938-0391 E SURVEY PLETED
345166 345166	A. BUILD B. WING	NG STREET ADDRESS, CITY, STATE, ZIP CODE 1570 NC 8 AND 89 HIGHWAY	COM	PLETED
IT OF DEFICIENCIES	ID	STREET ADDRESS, CITY, STATE, ZIP CODE 1570 NC 8 AND 89 HIGHWAY	09/0	04/2014
NT OF DEFICIENCIES BE PRECEDED BY FULL		1570 NC 8 AND 89 HIGHWAY		
NT OF DEFICIENCIES BE PRECEDED BY FULL				
NT OF DEFICIENCIES BE PRECEDED BY FULL		DANDUDY NO 27046		
BE PRECEDED BY FULL		DANBURY, NC 27016		
	PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
OND - SECURITY OF se a surety bond, or ance satisfactory to the security of all personal ited with the facility.	F 1	61		9/23/14
not met as evidenced iew and staff interview, nate the residents as the d. Findings included. Ind revealed the Patient gust 1, 2014 was for ne was North Carolina d Human Services and Division of Medical ervice Center, Raleigh, of the surety bond was ater than the total ds, \$4666.90, on the Chief Executive t the State of North e obligee because the actions on behalf of the oss. Later on 9/3/14, the rider dated 9/3/14 that he and address to "The otokes County Nursing Hwy N, Danbury, NC		 the resident found to be affected by deficient practice: The surety bond was changed on S to meet current guidelines for the residents of the facility to be named obligee. Corrective actions to be accomplish residents having potential to be affe by the same deficient practice: The surety bond was changed on S to meet current guidelines for the residents of the facility to be named obligee. The surety bond was changed on S to meet current guidelines for the residents of the facility to be named obligee. The surety bond will be remannually to reflect current guideline Measures to be put in place or syst changes made to ensure that the d practice will not occur: The Administrator and DON will rev communications from CMS, North Carolina DHHS, Myers and Stauffe 	/ the //3/14 d as the ned for ected //3/14 d as the newed s. emic eficient /iew r, and	
an second and a se	ace satisfactory to the ecurity of all personal ed with the facility. Not met as evidenced ew and staff interview, ate the residents as the . Findings included. revealed the Patient ust 1, 2014 was for e was North Carolina Human Services and Division of Medical vice Center, Raleigh, f the surety bond was er than the total s, \$4666.90, on e Chief Executive the State of North obligee because the ctions on behalf of the ss. Later on 9/3/14, the der dated 9/3/14 that e and address to "The okes County Nursing	ace satisfactory to the ecurity of all personal ed with the facility. not met as evidenced ew and staff interview, ate the residents as the . Findings included. revealed the Patient ust 1, 2014 was for e was North Carolina Human Services and Division of Medical vice Center, Raleigh, f the surety bond was er than the total s, \$4666.90, on e Chief Executive the State of North obligee because the ctions on behalf of the ss. Later on 9/3/14, the der dated 9/3/14 that e and address to "The okes County Nursing	 accessatisfactory to the ecurity of all personal ed with the facility. bot met as evidenced corrective action to be accomplish the resident found to be affected by deficient practice: revealed the Patient sas the Human Services and Division of Medical vice Center, Raleigh, f the surety bond was er than the total s, \$4666.90, on e Chief Executive the State of North obligee because the ctions on behalf of the ss. Later on 9/3/14, the der dated 9/3/14 that e and address to "The okes County Nursing wy N, Danbury, NC Corrective action to be accomplish the resident found to be affected by deficient practice: The surety bond was changed on 9 to meet current guidelines for the residents naving potential to be affected by the same deficient practice: The surety bond was changed on 9 to meet current guidelines for the residents of the facility to be named obligee. The surety bond will be rerannually to reflect current guideline for the facility to be named obligee. The surety bond will be rerannually to reflect current guideline for the residents of the facility to be named obligee. The surety bond will be rerannually to reflect current guideline for the residents of the facility to be named obligee. The surety bond will be rerannually to reflect current guideline for the residents of the facility to be named obligee. The surety bond will be rerannually to reflect current guideline for the residents of the facility to be named oblige. The surety bond will be rerannually to reflect current guideline for the resident of the facility to be named oblige. The surety bond will be rerannually to reflect current guideline for the residents of the facility to be named oblige. The surety bond will be rerannually to reflect current guideline for the resident of the facility to be named oblige. The surety bond will be rerannually to reflect current guideline for the facility to be named oblige. The surety bond will be rerannually to reflect current guideline for	 Ince satisfactory to the ecurity of all personal ed with the facility. Inot met as evidenced Inot occur: Inot met as evidenced Inot met as evidenced Inot met as the obligee because the color of the facility to be named as the obligee. Inot met as evidence as the obligee. The surety bond will be renewed annually to reflect current guidelines. Inot occur: Inot occur: Inot occur: Inot met as evidence as the otal complication of the facility of the same deficient practice: Inot met as evidence as the obligee. Inot met as evidence as the obligee. Inot occur: Ino

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

09/25/2014

PRINTED: 10/14/2014

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.

Electronically Signed

		AND HUMAN SERVICES	I		FOF OMB N	D: 10/14/2014 MAPPROVED O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED
		345166	B. WING			9/04/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	
STOKES	COUNTY NURSING I	HOME			570 NC 8 AND 89 HIGHWAY ANBURY, NC 27016	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Continued From pa 483.15(h)(2) HOUS MAINTENANCE SE	SEKEEPING &	F 1		regulatory changes identified and implemented will be reported quarterly to the Quality of Life Committee and Housewide Quality Improvement Committee. How we will monitor our performance to make sure that solutions are sustained: The regulatory changes identified and implemented will be reported quarterly to the Quality of Life Committee and Housewide Quality Improvement Committee in February, May, August, ar November.)
SS=E	The facility must pro- maintenance service sanitary, orderly, are This REQUIREMEN by: Based on observation facility failed to prov- necessary to maintainterior by not repaine base boards, clean wheelchairs and ge conditioner filter to Findings included: 1. Observation on approximately 30 d	ovide housekeeping and tes necessary to maintain a nd comfortable interior. NT is not met as evidenced tions and staff interviews the vide maintenance service ain a safe and comfortable ring sheet rock on walls, loose ing light screens, repairing tri chairs and securing air			Corrective action to be accomplished for the resident found to be affected by the deficient practice: The Housekeeping Manager had the entire Long Term Care Facility deep cleaned beginning on September 3, 201 thru September 10, 2014. This included scrubbing sinks, scrubbing commodes, cleaning vents, dusting and washing of walls, beds and baseboard. Furniture w pulled away from the walls swept, mopp and walls wiped down.	4 : as

Facility ID: 943474

If continuation sheet Page 2 of 24

TATEN/EN'T			(V2) MILLI TU		OMB NO.		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · ·	E SURVEY PLETED	
		345166	B. WING		09/	04/2014	
NAME OF I	PROVIDER OR SUPPLIER	• •		STREET ADDRESS, CITY, STATE, ZIP CODE			
STOKES	COUNTY NURSING	НОМЕ		1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 253	Continued From pa	age 2	F 25	3			
	the filter in the botto unit hanging out an making a knocking 3. Observation or that the bumper be loose from the wall the left side and ha foam cover. 4. Observation or electrical outlet plat the wall exposing a 5. Observation or the geri chair for ro covers on both arm board on the left sid piece of base board the bathroom door inches in size. 6. Observation or an area on the wall with peeling sheet length and 3 inches 7. Observation or the wheelchair in ro room 218-B with bo disrepair. During an interview 11:55 AM revealed	n 9/4/14 at 10:45 AM revealed om of the (a/c) air conditioner id on the floor and a/c unit noise in room 214-A. n 9/4/14 at 10:50 AM revealed hind bed-B in room 213 was with sheet rock cracked on ndle to geri chair has missing n 9/4/14 at 10:55 AM revealed the cover hanging loose from nickel size hole in the wall. n 9/4/14 at 11:00 AM revealed om 205-A had torn arm rest n rest and loose floor base de of the bathroom door and a d missing on the right side of approximately 2 inches by 1 n 9/4/14 at 11:10 AM revealed in front of the nurse 's station rock approximately 6 inches in s wide. n 9/4/14 at 11:15 AM revealed om 210-B and geri chair in oth arm rest torn and in		 Bugs in light fixture of room 21 removed and fixture cleaned or related to Observation #1. The filter in bottom of AC unit with room 214A and the fan cage broken and making a knocking repaired on 9/19/14 related to 6 #2. The Bumper on bed 213B was down, the wall repaired and but replaced on 9/22/14 related to Observation #3. The Electrical outlet plate has I replaced and the wall repaired related to Observation #4. The 2 inches of base board har replaced and wall repaired in roon 9/17/14 related to Observation #4. The 6 inch area of wall in front station with damaged sheetroc repaired on 9/22/14 related to 0 #6. All geri chairs and wheel chairs arm rests are being pulled in g 	n 9/17/14 was rehung that was noise was Observation taken mper been on 9/22/14 s been oom 205A ion #5. of nurseMs k has been Observation		
	that are kept at the maintenance make up. If it is in normal page maintenance always maintenance	nurses station and when es rounds the pick the forms business hours staff can also and if it is urgent there is the staff on call. The repairs are nless a part has to be ordered.		three to four to the maintenance department for repair. This will weekly until all have been repa Supplies were purchased with initiated on 9/22/14.	e be done ired. repairs		

Facility ID: 943474

If continuation sheet Page 3 of 24

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, STOKES COUNTY NURSING HOME Isto NC 8 AND 89 HIGHWAY DANBURY, NC 27016 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WOR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN C (EACH CORRECTIVE A) CONTINUES THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG ID PREFIX TAG PROVIDER'S PLAN C (EACH CORRECTIVE A) CONTRUET BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG ID PREFIX TAG PROVIDER'S PLAN C (EACH CORRECTIVE A) CONSTRUCTION F 253 Continued From page 3 12:00 PM indicated that request for maintenance repairs are done by work orders located at the desk and staff can report it to the nurse or fill the form out their self and maintenance will pick the form up when they make rounds. F 253 by the same deficient p The Housekeeping Ma entire Long Term Care cleaned beginning on S thru September 10, 20 scrubbing sinks, scrubi cleaning vents, dusting walls, beds and basebo pulled away from the w and walls wiped down. The light fixtures of all cleaned. The filters in bottom of been rehung in all roon mechanism implement filters from falling dowr	
STOKES COUNTY NURSING HOME 1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016 (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 C (EACH OERCITVE AV CROSS-REFERENCED TO DEFICIENCY TAG F 253 Continued From page 3 12:00 PM indicated that request for maintenance repairs are done by work orders located at the desk and staff can report it to the nurse or fill the form out their self and maintenance will pick the form up when they make rounds. F 253 by the same deficient p The Housekeeping Ma entire Long Term Care cleaned beginning on S thru September 10, 20 scrubbing sinks, scrubi cleaning vents, dusting walls, beds and basebo pulled away from the w and walls wiped down. The light fixtures of all cleaned. The light fixtures of all cleaned. The light fixtures of all cleaned. The light fixtures of all cleaned. The filters in bottom of been rehung in all roon mechanism implement filters from falling dowr	09/04/2014
STOKES COUNTY NURSING HOME DANBURY, NC 27016 (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 C (EACH OERFECTIVE AU CROSS-REFERENCED TO DEFICIENT TAG F 253 Continued From page 3 12:00 PM indicated that request for maintenance repairs are done by work orders located at the desk and staff can report it to the nurse or fill the form out their self and maintenance will pick the form up when they make rounds. F 253 by the same deficient p The Housekeeping Ma entire Long Term Care cleaned beginning on S thru September 10, 20 scrubbing sinks, scrubi cleaning vents, dusting walls, beds and basebo pulled away from the w and walls wiped down. The light fixtures of all cleaned. The light fixtures of all cleaned. The light fixtures of all n cleaned. The light fixtures of all cleaned.	ZIP CODE
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE AL CROSS-REFERENCED TO DEFICIENT F 253 Continued From page 3 12:00 PM indicated that request for maintenance repairs are done by work orders located at the desk and staff can report it to the nurse or fill the form out their self and maintenance will pick the form up when they make rounds. F 253 by the same deficient p The Housekeeping Ma entire Long Term Care cleaned beginning on S thru September 10, 20 scrubbing sinks, scrubbing orders. He depends on staff to let him know when repairs are needed and addresses problems and repairs as they arise. The filters on the a/c units are checked monthly. F 253 by the same deficient p The Housekeeping Ma entire Long Term Care cleaned beginning on S thru September 10, 20 scrubbing sinks, scrubing walls, beds and basebo pulled away from the w and walls wiped down. The light fixtures of all cleaned. The light fixtures of all cleaned. The filters in bottom of been rehung in all room mechanism implement filters from falling down	
 12:00 PM indicated that request for maintenance repairs are done by work orders located at the desk and staff can report it to the nurse or fill the form out their self and maintenance will pick the form up when they make rounds. During an interview with the maintenance director on 9/4/14 at 3:03 PM revealed that he makes rounds several times a day to pick up work orders. He depends on staff to let him know when repairs are needed and addresses problems and repairs as they arise. The filters on the a/c units are checked monthly. The light fixtures of all cleaned. The light fixtures of all in cleaned. The filters in bottom of been rehung in all room mechanism implement filters from falling down. 	CTION SHOULD BE COMPLETI D THE APPROPRIATE DATE
repairs are done by work orders located at the desk and staff can report it to the nurse or fill the form out their self and maintenance will pick the form up when they make rounds. During an interview with the maintenance director on 9/4/14 at 3:03 PM revealed that he makes rounds several times a day to pick up work orders. He depends on staff to let him know when repairs are needed and addresses problems and repairs as they arise. The filters on the a/c units are checked monthly. The light fixtures of all cleaned. The filters in bottom of been rehung in all room mechanism implement filters from falling down	
form out their self and maintenance will pick the form up when they make rounds. During an interview with the maintenance director on 9/4/14 at 3:03 PM revealed that he makes rounds several times a day to pick up work orders. He depends on staff to let him know when repairs are needed and addresses problems and repairs as they arise. The filters on the a/c units are checked monthly. The light fixtures of all cleaned. The filters in bottom of been rehung in all room mechanism implement filters from falling down The Electrical outlet pla inspected and replaced	ractice:
Baseboards and sheet inspected and repaired throughout the unit. Measures to be put in p changes made to ensu practice will not occur: A Maintenance and Ho Checklist of all areas h and implemented. Star	Facility deep September 3, 2014 14. This included: bing commodes, and washing of bard. Furniture was alls swept, mopped rooms were AC units have ns with a ed to prevent the tas have been d as needed rock have been as needed blace or systemic re that the deficient usekeeping as been developed

		AND HUMAN SERVICES			F	TED: 10/14/2 DRM APPRO <u>NO: 0938-0</u>	VE		
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3	(X3) DATE SURVEY COMPLETED			
		345166	B. WING	i		09/04/2014	4		
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE				
STOKES	S COUNTY NURSING I	НОМЕ			570 NC 8 AND 89 HIGHWAY ANBURY, NC 27016				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLE DATE	TIO		
F 253	Continued From pa	age 4	F	253	make sure that solutions are sustained A Maintenance and Housekeeping Checklist of all areas has been develo and implemented. This checklist will be completed on a monthly basis for all areas and submit to the Housewide Quality Improvement	ped ted			
F 281 SS=D	PROFÈSSIONAL S	RVICES PROVIDED MEET STANDARDS ded or arranged by the facility ional standards of quality.	F	281	Committee by the Maintenance Direct and Housekeeping Manager.	9/19/14	4		
	by: Based on record rephysician review, the physician orders for and #8) who required findings included: 1. Resident #6 was 9/14/12 with a diag with behavioral dist senile depressive of hyperlipidemia. Review of Resident 2/27/14 revealed di weekly to once week Review of Resident 8/13/14 revealed a	NT is not met as evidenced eview, staff interview and he facility failed to follow r 2 of 4 residents (Resident #6, ed weekly weights. The admitted to the facility on noses that included dementia curbance, paralysis agitans, lisorder, atrial fibrillation, and t #6's physician ordered dated iscontinue weights from twice ekly. t #6's care plan updated goal that said she will not eight loss for next 90 days.			Corrective action to be accomplished the resident found to be affected by the deficient practice: Resident #6 had a weight obtained an documented on 9/1/2014 resulting in a weight loss less than 5% . Any weight >5% will be reported to the physician a the weight loss protocol will be initiated Resident #6 has received weights according to care plan since 9/1/2014 weight. Resident #8 had a weight obtained an documented on 9/5/2014 resulting in a >5% weight loss. After completing a 3 daily weight checks on 9/6/2014, 9/7/2 and 9/8/2014 revealed consistent weight	e d loss and d. d a 014			

Facility ID: 943474

If continuation sheet Page 5 of 24

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	I		0	FORM MB NO.	0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		345166	B. WING			09/0	04/2014
NAME OF	PROVIDER OR SUPPLIER	·		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
STOKES	COUNTY NURSING	НОМЕ			570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 281	Continued From pa	age 5	F 28	81			
		ncluded weekly weight with culations weight loss protocol			not consistent with the previously documented weight loss.		
Review of August 20 weight loss for > or -5 ^o The weigh recorded v	Review of Residen			Resident #8 has received weights according to care plan since 9/8/20)14.		
		2014 revealed weight once weekly, follow oss protocol for monthly calculated loss -5%.			Care Plans and treatment sheets w monitored by SNF DON and MDS coordinator weekly for quality	vill be	
	recorded weight wa	revealed Resident #6's last as on 8/18/14. The weight e lift was broken on 8/25/14			improvement compliance. Weights will be obtained on all resi	dents	
	record indicated the lift was broken No further weights could be obtaine facility.				in accordance to their individualized careplan. If a scale is found to have malfunction this will be reported to	d	
	2/4/14 with a diagn	s admitted to the facility on loses that included dementia,			maintenance immediately.		
		e and cartilage disease, hypothyroidism, atrial ation and psychosis. ew of Resident #8's physician orders dated 4 indicated weights to be taken weekly on ays on 3rd shift. The physician order dated			Resident weights will be obtained u scales from the hospital when scale the Stokes County Nursing Facility	es in	
	2/4/14 indicated we				in working order as to not delay res care.	sident	
	8/1/14 indicated dietary consult due to steady weight loss in last month.				Scales were repaired and have bee working order since 8/29/14.	en in	
	Review of Resident #8's care plan updated 8/6/1 revealed a goal stating, "she will have no unplanned weight loss for the next 90 days; maintain adequate nutrition for the next 90 day. The interventions included, total feed for all meals, snacks, and liquids; monitor and record intake of meals and snacks form all sources, and report amounts to hall nurse; weekly weights and	ating, "she will have no loss for the next 90 days;			Corrective actions to be accomplish residents having potential to be affer by the same deficient practice:		
		d liquids; monitor and record d snacks form all sources, and hall nurse; weekly weights and			Care Plans and treatment sheets w monitored by SNF DON and MDS coordinator weekly for quality improvement compliance.	vill be	
		t #8's treatment record for the			Weights will be obtained on all resi in accordance to their individualized	d	
		014 revealed weekly weights lation - follow weight loss			careplan. If a scale is found to have malfunction this will be reported to	e a	

Facility ID: 943474

If continuation sheet Page 6 of 24

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUT	PLE CONSTRUCTION		0938-039 SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
		345166	B. WING		09/0	04/2014
NAME OF F	PROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP COL	DE	
STOKES		HOME		1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 281	Continued From pa	ge 6	F 28	1		
	protocol for loss mo	-	_	maintenance immediately.		
	Resident #8's last r 8/23/14. The note f re-weight. On 8/24 record indicated the obtained (UTO). T indicated that on 8/ was UTO due to he Review of Service I	t #8's weight record revealed ecorded weight was on or 8/23/14 identified a 3 day /14 and 8/25/14 the weight e weight was unable to be The weight record further 29/14 Resident #8's weight e bath stretcher being broken. Request Form dated 8/12/14 etcher does not work/won't go		Resident weights will be obtain scales from the hospital when the Stokes County Nursing Fa- in working order as to not dela care. Scales were repaired and hav working order since 8/29/14. Measures to be put in place of changes made to ensure that practice will not occur:	a scales in acility are not ay resident ve been in r systemic	
	down, put new batt signed as complete Interview with Nurs 9/4/14 at 9:04 am r resident bath days.	ery will not work". Work is ed by maintenance on 8/13/14. ing Assistant (NA) #5 on evealed weights are taken on NA #5 indicated the bath achine was utilized for resident		Care Plans and treatment she monitored by SNF DON and N coordinator weekly for quality improvement compliance. Weights will be obtained on a	MDS	
	who were not able The bath stretcher and was not availal indicated that staff	to utilize the stand up scale. had not been working properly ble for use. NA #5 further had been utilizing the scale in the hospital portion of the		in accordance to their individu careplan. If a scale is found to malfunction this will be reporte maintenance immediately.	alized have a	
	facility. Occasional working downstairs obtained. NA #5 inc	ly the stretcher would not be and weights could not be licated that when the bath king NAs were told to		Resident weights will be obtain scales from the hospital when the Stokes County Nursing Fa in working order as to not dela care.	scales in acility are not	
	revealed the bath s working. NA #2 sta scale from the hosp NA #2 indicated sho engineering/mainte	2 on 9/4/14 at 9:12 am tretcher scale had not been ated staff would utilize the bital until when it was working. e notifies the charge nurse and nance when the scales are not ated maintenance had been		Weights will be reviewed wee SNF DON or MDS coordinato determine if weight loss has o weight loss occurs, the physic notified and the weight loss pr be initiated.	r to occurred. If ian will be	

Facility ID: 943474

If continuation sheet Page 7 of 24

	CS FOR MEDICARE	& MEDICAID SERVICES	(X2) MI II	тірі	E CONSTRUCTION		0938-039 SURVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		345166	B. WING	3. WING			04/2014
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STOKES		НОМЕ			570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 281	Continued From pa	age 7	F 2	81			
	scales were operating for use. Interview with NA #4 on 9/4/14 at 9:18 am revealed the bath stretcher scale had not been working properly lately. NA #4 could not indicate				working order since 8/29/14. Maint will be notified of any further repair needed.	S	
	when the bath stret working. NA #4 sta done due to the str	cher scale was not longer ated weights were not being etcher scale located in the			Additional parts are now on site to immediate repairs for the wiring ha issue. Extra parts will be maintaine	rness	
	The NA stated it wa	the facility being down as well. as communicated by nursing to ain the weights due to the			Maintenance will conduct monthly checklist on equipment to ensure operational.		
	revealed he was av	Dietician on 9/4/14 at 1:14 pm ware the facility had issues			How we will monitor our performan make sure that solutions are susta	ined:	
	dietician continued	cales working properly. The that it was communicated to f that maintenance was fixing			Care Plans and Treatment Sheets monitored weekly by the SNF DON MDS coordinator to ensure weights being obtained in accordance with resident care plans.	l or s are	
revealed the sca who could not st some time. Main 8/29/14 and nurs working. Curren Nurse #3 stated were always wei the stand up sca the stretcher sca would use the sc #3 continued tha working for the h Interview with Nu indicated the stre and on. Nurse a to document UT	revealed the scale who could not stan some time. Mainte 8/29/14 and nurse working. Currently	e #3 on 9/4/14 at 2:14 pm for taking weights for residents d was working off and on for mance repaired the scale on #3 indicated she witnessed it the scale is back down. e residents who could stand			Compliance with completion and documentation of weights will be co and reported to the SNF Quality of and Housewide Quality Improveme Committee monthly.	Life	
	the stand up scale. the stretcher scale would use the scale	ed and there was no issue with Nurse #3 indicated that when was not functioning, NAs e from the hospital unit. Nurse occasionally the scale is not pital unit.			A maintenance checklist of equipm be kept with any findings reported t Housewide Quality Improvement Committee monthly.		
	indicated the stretc and on. Nurse #2 to document UTO t	e #2 on 9/4/14 at 2:16 pm her scale has been working off stated that the NAs were told to indicate that the residents' to obtain. Weights would be					

		AND HUMAN SERVICES				FORM	10/14/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		345166	B. WING			09/	04/2014
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STOKES	COUNTY NURSING I	HOME			570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 281 F 315 SS=G	obtained when the solution obtained when the solution of items that were in by work orders sub- indicated the scales problems. The wire was utilized and war malfunction. In the work, maintenance use the scale down repairs were made. weeks to get parts of scale. Interview with the A 3:13pm revealed it equipment be in work indicated she was a stretcher/weight scale administrator stated maintenance to pur recurrent issues co 483.25(d) NO CATH RESTORE BLADD Based on the reside assessment, the far resident who enters indwelling catheter resident's clinical co catheterization was who is incontinent of treatment and servited the service of the servic	A aintenance Director on revealed he was made aware in need of repair as evidenced mitted by staff. Maintenance is were always giving him es are pinched when the scale is the source of the machines instance the scales do not indicated he would tell staff to stairs in the hospital unit Maintenance stated it takes delivered for the lift/electronic dministrator on 9/4/14 at was her expectation that the orking order. She further aware of the bath ale would malfunction. The d she would expect ichase extra parts so that the uld be fixed immediately. HETER, PREVENT UTI, ER ent's comprehensive cility must ensure that a is not catheterized unless the ondition demonstrates that necessary; and a resident of bladder receives appropriate ices to prevent urinary tract store as much normal bladder		315			10/1/14

Facility ID: 943474

If continuation sheet Page 9 of 24

		& MEDICAID SERVICES	0.000				0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				· · ·	E SURVEY PLETED
		345166	B. WING			09/0)4/2014
NAME OF I	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
STOKES	COUNTY NURSING	НОМЕ			70 NC 8 AND 89 HIGHWAY ANBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIOI DATE
F 315	Continued From pa	age 9	F 3	15			
	This REQUIREME	NT is not met as evidenced					
	Based on observa record review, the t medical justification catheter for 1 of 3 s #5). The findings in Resident #5 was an 12/4/13 with a diag Diabetes Mellitus a Review of Residen (MDS) dated 12/11 a stage two pressu catheter. Resident (CAA) triggered for indwelling urinary of Review of the care Resident #5 reveal incontinence / urina a problem with a g no urinary tract infe current pressure ul next 90 days and n formation for the ne on the care plan the had been resolved	dmitted to the facility on noses that included dementia, nd Chronic Renal Disease. t #5's Minimum Data Set /13 revealed the resident had re ulcer and an indwelling 's Care Area Assessment rurinary incontinence and			Corrective action to be accomplish the resident found to be affected by deficient practice: Resident #5 Education with physicia Resident #5, nursing leadership, MI coordinator and staff regarding the appropriate indications for continuin of an indwelling catheter beyond 14 This education reflects appropriate indications as listed in FTag 315. A result, the indwelling foley catheter Resident # 5 has been removed. Physician orders and care plan refle preventative skin care measures for resident. Corrective actions to be accomplish residents having potential to be affe by the same deficient practice: Education with all providers, nursing leadership, MDS coordinator and st regarding the appropriate indication continuing use of an indwelling cath beyond 14 days as listed in FTag 3 been provided through distribution of memorandum. This memorandum	an for DS ng use days. s a for ect r this ned for ected g caff is for neter 15 has of a	
	catheter and draina needed, daily bath and internal labia a any areas of redne current ulcers or fo nursing assistants	led changing the urinary age bag monthly and as assuring catheter, external re cleansed well, monitor for ss, irritation, or worsening of rmation of new ulcers and to report promptly to hall ritten on the care plan to			the appropriate indications for indwo catheter use per FTag 315. Residents with indwelling catheters monitored weekly by MDS coordina determine if catheter use is still appropriate as listed in FTag 315. W resident no longer meets criteria for	will be tor to Vhen	

Facility ID: 943474

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	1		OMB NO.	APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY PLETED
		345166	B. WING		09/0)4/2014
NAME OF I	PROVIDER OR SUPPLIER	• •		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
STOKES		НОМЕ		1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETIO DATE
F 315	Continued From pa	age 10	F3	315		
	continue with the sa 5/28/14 and 8/21/14	ame plan of care on 3/5/14, 4.		indwelling foley catheter, the be notified and an order will to discontinue the foley cathe	be obtained	
r L F t		t #5's MDS dated 3/5/14 ent had a stage two pressure lling catheter.		criteria for appropriate use is stated on the criteria sheet a FTag 315.	e is clearly	
		ated 4/23/14 to maintain the a sacral decubiti wound until		Review of all residents with i foley catheters has been cor MDS coordinator and approp indications are documented	npleted by the priate	
		ated 4/24/14 was to maintain r to straight drainage for ontinence.		developed criteria sheet as li 315.		
	chart revealed that	t #5's pressure ulcer healing on 4/29/14 the width x length x ire ulcer was 0 x 0 x 0. It was		Measures to be put in place changes made to ensure tha practice will not occur:		
		hat the pressure ulcer was the wound is completely elium (new skin).		Education with all providers, leadership, MDS coordinator regarding the appropriate inc continuing use of an indwelli	and staff dications for	
		n 4/30/14 was to discontinue treatment due to the wound		beyond 14 days as listed in F been provided through distril memorandum. This memora the appropriate indications for	Tag 315 has oution of a andum lists	
	revealed the reside	t #5's MDS dated 5/28/14 ent was assessed as having		catheter use per FTag 315.	C C	
severely decision urinary last 30 Review reveale analysis	severely impaired f decision making. F urinary catheter, a	n memory problems, was for cognitive skills and daily Resident #5 had an indwelling urinary tract infection in the ad no pressure ulcers.		Residents with indwelling cat monitored weekly by MDS co determine if catheter use is s appropriate as listed in FTag resident no longer meets crit	oordinator to still 315. When eria for	
	revealed an order want of a second se	t #5's physician's orders written on 7/14/14 for a urinary e and sensitivity due to foul eased confusion and		indwelling foley catheter, the be notified and an order will to discontinue the foley cathe criteria for appropriate use a stated on the criteria sheet a	be obtained eter. The re clearly	

	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB NO. (X3) DAT	E SURVEY
ND PLAN C	OF CORRECTION	DENTIFICATION NUMBER:		G	COM	PLETED
		345166	B. WING		09/	04/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STOKES	COUNTY NURSING	НОМЕ		1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 315	were positive for E Physician's order of resident to start on 7 days for a urinary the Keflex was disc started on Bactrim Review of Residen revealed the reside short and long term severely impaired f decision making. F urinary catheter, a last 30 days and ha Observation on 9/3 Resident # 5 had a draining to a collect side of the bed in a Physician's order d urinary catheter ins stage 2 sacral ulce Interview on 9/4/14 revealed that Resid placed due to a sac Nurse # 1 further s pressure ulcer hea catheter was contir incontinence.	-coli and Proteus mirabilis. on 7/14/14 was reviewed for the Keflex 500 mg twice a day for y tract infection. On 7/20/14 continued and Resident #5 was DS twice a day for 5 days. It #5's MDS dated 8/20/14 ent was assessed as having n memory problems, was for cognitive skills and daily Resident #5 had an indwelling urinary tract infection in the ad no pressure ulcers. 8/14 at 10:00 AM revealed that in indwelling urinary catheter tion bag secured to the right a protective cover. Hated 9/4/14 was to leave the serted due to a diagnosis of er.	F 31	 Physicians will be re-educated or appropriate criteria for use of inducatheters as listed in FTag 315 at monitoring process to ensure quainitiatives are being met using the as listed in FTag 315. How we will monitor our performa make sure that solutions are sust Residents with Indwelling foley cawill be reviewed weekly by the MI coordinator for appropriateness of according to criteria listed in FTag and acquired urinary infections. The criteria for appropriate use is clear stated on the criteria sheet as listed FTag 315. Indwelling foley catheters according to criteria sheet as listed in FTag and acquired urinary infections. The criteria at the time of recognition Appropriate indications for use of indwelling foley catheters according to criteria listed in FTag 315 will be of and reported to the SNF Quality of and Housewide QI committee models. 	welling and a ality e criteria ance to cained: atheters DS of use g 315 the urly ed in ters will eeting mg to collected of Life	
	of Nursing (DON) r would have been for catheter to be remo pressure ulcer unle	at 2:00 PM with the Director revealed her expectations or Resident #5's urinary oved upon healing of the ess there was another intaining the indwelling				

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		E & MEDICAID SERVICES				. 0938-039 TE SURVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	COM	
		345166	B. WING		09	/04/2014
NAME OF	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
STOKES	COUNTY NURSING	НОМЕ		1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 315	Continued From pa	age 12	F 31	5		
	catheter. The Director of Nursing also reported that the DON would attend the care plan meeting and bring issues to the meeting and carry out any changes that needed to be made.					
	F 323 483.25(h) FREE OF ACCIDENT SS=D HAZARDS/SUPERVISION/DEVICES		F 323	3		9/24/14
	environment rema as is possible; and	nsure that the resident ins as free of accident hazards each resident receives ion and assistance devices to				
	by: Based on record r facility failed to pro bed mobility for 1 o	NT is not met as evidenced eviews and staff interviews the vide a two person assist for of 2 sampled residents iewed for accidents.		Corrective action to be accompli the resident found to be affected deficient practice:		
	Resident #25 was 8/21/12 with the di	admitted to the facility on agnosis of Alzheimer ' s dney disease and depressive		All staff have been re-educated of Resident #25 requiring two person patient handling and transfers. All staff has been instructed to have	ons for ave two	
	assessment refere that Resident #25	um Data Set (MDS) with an ince date of 7/16/14 revealed was severely cognitively		persons in place at the time care provided for Resident #25. Nursing Assistant #1 has been co	ounseled	
	activity of daily livir	extensive assistance with ng (ADL ' s) and was totally for bed mobility requiring two		related to Resident #25 being a t person assist and safe resident h Nursing Assistant #1 has comple	nandling.	
	The care plan date	d 7/17/14 identified a problem ol and on 8/12/14 the care plan		resident handling education for re training in addition to the required training.	emedial	

Facility ID: 943474

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATI	0938-039 SURVEY PLETED	
			A. BUILDIN	G	Com		
		345166	B. WING		09/	04/2014	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
STOKES	COUNTY NURSING	HOME		1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 323	resident with poor t assist for incontinen- recent fall and poor The Morse Fall Sca Resident #25 as be Review of the fall in dated 8/12/14 at 5:0 #25's bed was in lo Aide #1 was perform repositioning Resid bed unto his right s right elbow and her forehead. Interview with NA # revealed that she w bed and rolled him the floor, she further low position and sh assistance of two s help and did not ha During an interview 8/4/14 at 3:15 PM r	lentified a problem of falls, runk control and two person nce care while in bed due to	F 32	3 Corrective actions to be accompresidents having potential to be aby the same deficient practice: All staff members have received safe resident handling training in to annual resident handling train The Nursing Assistant Report For been updated to include residen requirements to ensure clear communication of each resident These forms are updated with a changes in resident condition de care plan revision. These forms reviewed with each Resident descare plan revision. These forms reviewed for any needed Staff members are required to g assistance from co-workers for phandling for those residents required to get the present assist. Measures to be put in place or s changes made to ensure that the practice will not occur:	affected remedial addition ing. orm has t assist Ms needs. ny eming a will be signated changes. ain patient uiring a		
		rs and mobility then staff are		Nursing Assistant Report Form H updated to include each residen assistance requirements. All staff members will complete resident handling education and roster after completion. Education on 9/24/14. Resident Fall Awareness progra	:Ms remedial sign a ın began		

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		AND HUMAN SERVICES		FORM	: 10/14/2014 APPROVED . 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345166	B. WING		09/0	04/2014	
NAME OF	PROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STOKES	COUNTY NURSING I	НОМЕ			570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From pa	ıge 14	F	323	number of days since the last resid All staff members are challenged to maintain a safe environment for re- to prevent falls and in turn reach se goals. Staff and Residents celebrai fall prevention accomplishments ea- time a goal is met. All incident reports will be reviewed MDS Coordinator, Charge Nurse, S DON and CNO to identify any injur resulting from falls, appropriate notifications and treatments and opportunities for improvements that have prevented the fall. How we will monitor our performant make sure that solutions are susta All incident reports will be reviewed MDS Coordinator, Charge Nurse, S DON and CNO to identify any injur resulting from falls, appropriate notifications and treatments and opportunities for improvements that have prevented the fall. Fall Awareness Program will be mod daily for days since last patient fall. Monitoring will occur daily by all stat members and leadership. When fall occur, the incident will be investiga determine any preventable actions preventable actions identified will b addressed appropriately. Falls will continue to be recorded a reported to the Housewide Quality Improvement Committee monthly.	o sidents te their ach I by the SNF ies t would ce to ined: I by the SNF ies t would onitored onitored ff lls ted to . Any e	

Event ID: DPMT11

Facility ID: 943474

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			X3) DATE	E SURVEY PLETED
		345166	B. WING			09/0	04/2014
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STOKES	COUNTY NURSING I	IOME			570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 329 SS=E			F 3	29			9/23/14
	unnecessary drugs drug when used in duplicate therapy); without adequate m indications for its us adverse consequer should be reduced combinations of the						
	resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and c record; and residen drugs receive gradu behavioral intervent	chensive assessment of a must ensure that residents antipsychotic drugs are not inless antipsychotic drug by to treat a specific condition locumented in the clinical ts who use antipsychotic ual dose reductions, and tions, unless clinically an effort to discontinue these					
	by: Based on record re observation, the fac use of Mucinex for sampled residents medications (#15). over-the-counter m loosen mucus, relie cough. The medica	NT is not met as evidenced eview, staff interviews and cility failed to discontinue the chest congestion for 1 of 5 reviewed for unnecessary Mucinex is a brand of edicines that help to thin and ve congestion, and suppress tion was initially ordered in the resident had an upper			Corrective action to be accomplishe the resident found to be affected by deficient practice: Resident #15 had Mucinex ER 600m tablet changed to as needed order o 9/3/14 at 1445 by NP. On 9/12/14 at Guafenesin liquid 100mg/5ml syrup, QID prn chest congestion for 10 day	the ng n : 1300, 10 ml	

Facility ID: 943474

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 345166 B. WING 09/04/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1570 NC 8 AND 89 HIGHWAY STOKES COUNTY NURSING HOME DANBURY, NC 27016 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 329 Continued From page 16 F 329 respiratory infection and continued daily until written. This prompt release medication 9/3/14 in the absence of continued congestion or contains the identical medication as thick secretions. Findings included: Mucinex Extended Release tablets, but must be given more frequently. Resident On January 16, 2014, nursing notes documented #15 also receives Zyrtec 10mg po daily for a nonproductive cough and a hoarse voice. allergy since admission and has a longstanding medical history of congestion and sinus drainage. According to a physician's order dated January 24, 2014, resident #15 was prescribed Mucinex, Extended Release 600 milligrams 1 tablet by Discussion between pharmacist and mouth every night for congestion/cough. attending physician on 9/23/14 at 0910 reveals the physician is considering A 2/19/14 Nurses Notes revealed, "continues on adding scheduled Mucinex ER 600mg antibiotic for upper respiratory infection." tablet back to resident #15Ms regimen, feeling it is a good chronic med for this Review of the monthly Medication Administration individual patient due to the return of Records for February, March, April, May, June, congestion symptoms following July and August revealed this medication was medication change on 9/3/14 to PRN. administered. Corrective actions to be accomplished for Review of nurses' notes and pharmacist's notes residents having potential to be affected for the months of June, July and August revealed by the same deficient practice: no respiratory symptoms documented. Indication for use of medication will be A Nurse Practitioner's Nursing Home Progress included in medication order at time of Note dated Aug 13, 2014 read, "She can have writing. Mucinex 600 milligrams 1 daily for congestion". There was no mention of continued congestion in If the indication for use is not included in the notations. med order, the nurse will request indication from provider. Resident #15 was observed on 9/3/14 at 9:23 AM and did not have congestion. If the indication for use is not included in med order, the pharmacist will request During an interview on 9/3/14 at 2:35 PM the indication from provider at time of next Nurse Practitioner said, "Sometimes folks get put monthly chart review. on it for congestion. We can make it PRN (as needed)". She wrote a new telephone order Indications for use are printed out on the dated 9-3-14 at 2:45 that read, Discontinue monthly Medication Administration Record scheduled Mucinex ER 600mg and use PRN (MAR) following each medication order.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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PRINTED: 10/14/2014 FORM APPROVED

	<u>CS FOR MEDICARE</u> OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPI	E CONSTRUCTION		0938-039 SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:				COMPLETED 09/04/2014		
		345166	B. WING					
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
STOKES		НОМЕ		-	570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 329	F 329 Continued From page 17		F 3	29				
	"She may have nee secretions". He did documentation to s medication for thick Interview with the p AM revealed she di medical record abo secretions. She als	AM the medical doctor said, eded it to reduce thick d not provide any support the use of the			Outcomes for each medication will followed by the physician, pharmace nursing staff, and documented in the chart. Measures to be put in place or syste changes made to ensure that the de practice will not occur: Medical staff members were remininclude efficacy for all modalities of treatment, positive or negative, in the progress notes at their monthly me on 9/23/14. If the issue which cause treatment to be initiated has resolve treatment may be discontinued, or frequency lowered, at physician dis with documentation to reflect rease changes. This communication is recorded in the minutes of the medi- staff meeting. Pharmacist will continue to address indications for medication manager monthly reviews. How we will monitor our performan- make sure that solutions are sustaff Pharmacist will continue to address indications for medication manager monthly reviews. If appropriate, the pharmacist will provide written recommendations for medication c and monitoring to the attending phy Any recommendations made are con to the Nursing Home Director of Nu-	temic leficient ded to he eeting sed the ed, scretion on for lical sment in ce to ined: sment in e hanges ysician. opied		

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. 093 (X3) DATE SUR	
	F CORRECTION	IDENTIFICATION NUMBER:		G	· /	IPLETED
		345166	B. WING		09/04/2014	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STOKES		HOME		1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 456	Continued From pa	ige 18	F 450	6		
F 456 SS=E	483.70(c)(2) ESSE OPERATING CON	NTIAL EQUIPMENT, SAFE DITION	F 450	6		9/24/14
	mechanical, electri	aintain all essential cal, and patient care operating condition.				
	by: Based on record re	NT is not met as evidenced eview and staff interview, the		Corrective action to be accomplis		
	facility failed to ensure 1 of 1 mechanical weight device was operable for 4 of 4 residents (Resident #6, #8, #24, #36) who were care planned for weekly weights. The findings		the resident found to be affected I deficient practice: Resident #24 was weighed on 9/9	-		
	included:	admitted to the facility on		resulting in weight loss less than 9 Weights have been obtained on F #24 since 9/9/14 according to car	5%. Resident	
	9/14/12 with a diag	noses that included dementia urbance, paralysis agitans,		Resident #36 was weighed on 9/6		
		lisorder, atrial fibrillation, and		resulting in a reported weight gair Weights have been obtained according care plan for Resident #36 since	1.	
		t #6's physician's order dated iscontinue weights from twice		9/6/2014. Staff members have been educat	ed on	
	Review of Resident	t #6's care plan updated goal of, "she will not have		appropriate use of hospital scales scales in SNF are not in working of are malfunctioning.	if bath	
	unplanned weight le interventions includ weight calculations	led weekly weight with monthly , weight loss protocol PRN (as		Staff have been instructed to not document unable to obtain due to		
	needed).			ability to use alternate scales from hospital.	n the	
	August 2014 revea	t #6's treatment sheet for led, weight once weekly, follow I for monthly calculated loss		Staff members have received rem education related to the important completing work orders for mainte	ce of	

		& MEDICAID SERVICES				0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		345166	B. WING		09/04/2014		
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
STOKES		НОМЕ					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 456	Continued From pa	age 19	F 45	6			
		revealed Resident #6's last as on 8/18/14. The weight		in working order.			
	 record indicated the lift was broken on 8/25/14. No further weights could be obtained by the facility. 2. Resident #8 was admitted to the facility on 2/4/14 with a diagnoses that included dementia, bone and cartilage disease, hypothyroidism, atrial fibrillation and psychosis. 			Staff members have been instruct escalate equipment needs to management in a timely manner quality resident care.			
				Scales were repaired and have be working order since 8/29/14.			
	2/4/14 indicated we	t #8's physician orders dated eights to be taken weekly on t. The physician order dated		Corrective actions to be accompli residents having potential to be a by the same deficient practice:			
	weight loss in last r			Any Resident with a 5% weight lo have the weight loss protocol initi physician notified.			
	Review of Resident #8's care plan updated 8/6/14 revealed a goal stating, "she will have no unplanned weight loss for the next 90 days; maintain adequate nutrition for the next 90 days. The interventions included, total feed for all meals, snacks, and liquids; monitor and record			Treatment sheets are monitored by MDS Coordinator or SNF DON missing weights. Prompt follow up take place for any missed weights on the treatment sheets.	I for any o will		
	report amounts to h record; monthly we	d snacks from all sources, and hall nurse; weekly weights and ight calculations. t #8's treatment record for the		Staff members have been educat appropriate use of hospital scales scales in SNF are not in working are malfunctioning.	s if bath		
mo with		014 revealed; weekly weights ation - follow weight loss more than 5%.		Staff have been instructed to not document unable to obtain due to ability to use alternate scales from			
	Resident #8's last r 8/23/14. The note f re-weight. On 8/24	t #8's weight record revealed recorded weight was on for 8/23/14 identified a 3 day 4/14 and 8/25/14 the weight		hospital. Staff members have received ren education related to the importan	nedial ce of		
	obtained (UTO). 7	e weight was unable to be The weight record further /29/14 Resident #8's weight		completing work orders for mainter when equipment is malfunctioning in working order.			

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	OMB NO. (X3) DATE	E SURVEY	
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:		NG	COM	PLETED	
		345166	B. WING _		09/	09/04/2014	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
STOKES	COUNTY NURSING	НОМЕ		1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 456	Continued From pa	ige 20	F 4	56			
	was UTO due to he	bath stretcher being broken.					
				Staff members have been inst	ructed to		
		is admitted to the facility on noses that included Diabetes		escalate equipment needs to management in a timely mann	or to onsuro		
		n, Paralysis, Parkinson's		quality resident care.			
		t #24's care plan updated loal of, "she will not have		Scales were repaired and have working order since 8/29/14.	e been in		
		oss for next 90 days. The		Measures to be put in place or	systemic		
		changes made to ensure that					
		rs, encourage fluid intake, monthly weight calculations		practice will not occur:			
	weight loss protoco			Weekly monitoring of the treat	ment		
				sheets by the MDS Coordinate	or or SNF		
		t #24's weight record revealed		DON to ensure weights are be			
	The weight record i	eight was taken on 8/4/14. Indicated a date of 8/9/14 that It working. No further weights		completed on each resident ad their care plan.	cording to		
	could be obtained b			Nursing Staff have been re-ed	ucated on		
				the importance of escalating e			
	8/27/14 with a diag	is admitted to the facility on noses that included dementia, disease and diabetes mellitus		needs to leadership for promp for repairs/replacement.	tattention		
	type II.			Scales were repaired and have			
	Review of Resident	t #36's weight record revealed		working order since 8/29/14. N will be notified of any further re			
		ith was recorded on 8/9/14.		needed.	pan s		
	No weights beyond	8/9/14 could be located for					
	Resident #36.			Additional parts are now on sit			
		t #36's care plan dated 8/14/14 "he will have no unplanned		immediate repairs for the wirin issue. Extra parts will be main			
		next 90 days. The approaches		Maintenance will conduct mon	thly		
	included; weekly we	eights with monthly		checklist on equipment to ensu			
	calculations follow	weight loss protocol PRN.		operational.			
	Review of Service I	Request Form dated 8/12/14		How we will monitor our perfor	mance to		
		etcher does not work/won't go		make sure that solutions are s			

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STATEMENT	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		U936-U39 E SURVEY PLETED	
AND PLAN (JF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COM	COMPLETED	
		345166	B. WING _			04/2014	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE		
STOKES	COUNTY NURSING	HOME		1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 456	down, put new batte order was signed a on 8/13/14. Interview with Nurs 9/4/14 at 9:04 am r residents' bath days stretcher/weight ma residents who were up scale. The bath working properly ar NA #5 further indica utilizing the scale lo hospital portion of t stretcher would not weights could not b that when the bath were told to docum Interview with NA # revealed the bath s working. NA #2 sta scale from the hosp NA #2 indicated she engineering/mainte not working. NA #2 been working on th the scales were op Interview with NA # revealed the bath s working properly la when the bath stret working. NA #4 sta done due to the stret hospital portion of t The NA stated it wa	ery will not work". The work s completed by maintenance ing Assistant (NA) #5 on evealed weights are taken on s. NA #5 indicated the bath achine was utilized for e not able to utilize the stand stretcher had not been nd was not available for use. ated that staff had been ocated downstairs in the he facility. Occasionally the be working downstairs and e obtained. NA #5 indicated stretcher is not working NAs ent UTO (unable to obtain). 2 on 9/4/14 at 9:12 am tretcher scale had not been ited staff would utilize the bital until when it was working. e notifies the charge nurse and nance when the scales are 2 stated maintenance had e scales, but was unaware if erating for use. 4 on 9/4/14 at 9:18 am tretcher scale had not been tely. NA #4 could not indicate cher scale was not longer ited weights were not being etcher scale located in the he facility being down as well. as communicated by nursing to ain the weights due to the	F 45	 Weekly monitoring of the tressheets by the MDS Coordinat DON to ensure weights are completed on each patient at their care plan. Weekly monitoring of the nupatients on the weight loss pMDS coordinator. Compliance with completion documentation of weights wand reported to the Quality Improved Committee monthly. A maintenance checklist of a be kept with any findings rep Housewide Quality Improved Committee monthly. 	ator or SNF being according to mber of protocol by the and ill be compiled of Life and ment equipment will ported to the		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	APPROVED	
						OMB NO. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345166	B. WING			09/	04/2014	
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
STOKES	COUNTY NURSING H	IOME			1570 NC 8 AND 89 HIGHWAY			
OTOREO				0	DANBURY, NC 27016			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 456	Continued From pa	ge 22	F 4	56				
	Interview with Nurse revealed the scale f who could not stand some time. Mainte 8/29/14 and nurse # working. Currently Nurse #3 stated the were always weight the stand up scale. the stretcher scale from added that occasion for the hospital unit. Interview with Nurse indicated the stretcl and on. Nurse #2 to document UTO t weight was unable obtained when the scales problems. The wire was utilized and wa malfunction. In the work, maintenance use the scale down repairs were made. weeks to get parts of scale. Interview with the A 3:13pm revealed it	e #3 on 9/4/14 at 2:14 pm for taking weights for residents d was working off and on for nance repaired the scale on #3 indicated she witnessed it the scale is back down. e residents who could stand ed and there was no issue with Nurse #3 indicated that when was not functioning NAs would the hospital unit. Nurse #3 nally the scale is not working						

Facility ID: 943474

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		AND HUMAN SERVICES			FORM	: 10/14/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		345166	B. WING		09/	04/2014
NAME OF F	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE		
STOKES	COUNTY NURSING	HOME		1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ILD BE	(X5) COMPLETION DATE
F 456	administrator stated maintenance to pur	aware of the bath ale would malfunction. The	F 4	456		

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