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	345123	A. BUILDING _____ B. WING _____	06/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA VILLAGE INC	600 CAROLINA VILLAGE ROAD SUITE Z HENDERSONVILLE, NC 28792

(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: A description of the manner of protecting personal	F 156		6/6/14

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

Electronically Signed | 06/24/2014

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.

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F 156	Continued From page 1 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 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.	F 156		

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F 156	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observations, resident interview and staff interviews, the facility failed to post required information related to Medicare and Medicaid benefits. The findings included: Resident #69, the resident council representative, was interviewed on 06/05/14 at 9:31 AM. She stated she thought information related to Medicare and Medicaid was located in the survey book in the front lobby. An observation on 06/05/14 at 9:50 AM revealed no information regarding Medicare or Medicaid was located in the survey book that was in the front lobby. Continued observations revealed no Medicare or Medicaid information was posted on the walls of the lobby or the halls leading to the resident rooms. Interview with the Administrator on 06/05/14 at 11:47 AM revealed that no one was admitted to the facility under 65 years of age and therefore they would already have Medicare benefits. In addition, he stated the facility does not accept Medicaid. He confirmed the information was not posted in the facility. Interview with the Executive Director on 06/05/14 at 12:06 PM revealed that most residents received a senior citizens handbook from the community that provided information about Medicare and Medicaid. This handbook was not routinely given to newly admitted residents. He	F 156	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. Although we are not a provider that is Medicaid Certified, the information related to Medicare and Medicaid benefits have been posted in our lobby with a copy in the survey book located in the lobby as well. 2. An audit was completed by the administrator to ensure all other required postings were in place. 3. The Activities Director provided education to the Resident Council regarding the posted location related to Medicare/Medicaid benefits. 4. The administrator or designee will monitor the required postings each month for 3 months then quarterly to ensure required postings are in place.	

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F 156	Continued From page 3 further stated that the facility usually only accepted residents from the village community who had Medicare and would not need Medicaid. For those discharged back to their homes outside of the village, information about finances and how to contact social security would be verbally provided upon discharge.	F 156		
F 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on resident interview and staff interviews, the facility failed to deliver residents' mail on Saturdays. The findings included: Resident #69, the resident council representative, stated during an interview on 06/05/14 at 9:31 AM that residents received mail Mondays through Fridays, but not on Saturdays. Resident #69 explained the mail was delivered in bulk, separated and then distributed by volunteers but not on the weekends. Interview with the Activity Director on 06/05/14 at 11:33 AM revealed the mail was delivered to the main building in the village and separated there. During the week the Activity Director or the Social Worker picked up the mail at the main building, sorted it to ensure that bills and items that	F 170	1. Provisions were made to ensure residents would receive their mail on Saturdays. Carolina Village staff will sort the mail upon delivery. The mail will be provided to the facility and direct care staff members will deliver mail to residents. 2. An audit was completed by the administrator to ensure all other required services were in place. 3. The Director of Nursing or designee will provide education for direct care staff to update them on their roles of delivering mail on Saturdays. The Activities Director or designee will provide education to the Resident Council regarding Saturday delivery of mail. 4. The administrator or designee will	6/25/14

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F 170	Continued From page 4 needed to be sent to the responsible parties were forwarded appropriately, and then volunteers delivered the rest of the mail to the residents. She further stated there used to be a nurse aide who would deliver the mail on Saturdays, however, since the Activity Director or Social Worker were not there on Saturdays to sort the mail, some residents received bills that their responsible parties should have received. To avoid that mistake, Saturday delivery was stopped. Interview with the Social Worker on 06/05/14 at 11:41 AM revealed there was no mail delivery on Saturday. She stated upon admission, a discussion was held with residents and families to discuss what mail should be forwarded to families. The Administrator stated on 06/05/14 at 11:43 AM that he thought a discussion was held during resident council about having no mail delivery on Saturdays,. He further stated there had been no complaints about mail not being delivered on Saturdays as is the current practice. The Administrator provided a resident council meeting note dated 03/28/13 and one just completed dated 06/05/14 that stated the residents were in agreement to having mail delivered 5 days a week.	F 170	monitor to ensure mail being delivered on Saturdays once per week for 3 weeks, then 2 times per month, then quarterly.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further	F 318		6/25/14

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F 318	Continued From page 5 decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to implement a therapy recommendation for placing a hand roll into the left hand of 1 of 1 sampled residents. (Resident #1). The findings were: Resident #1 was admitted to the facility on 12/09/13 with diagnoses of aftercare trauma fracture left leg, dehydration, bone and cartilage disease, insomnia, mitral valve disorder and rehabilitation. The most recent Minimum Data Set (MDS) dated 05/07/14 revealed Resident #1 had severe cognitive impairment and required extensive assistance with most activities of daily living (ADL). The MDS also revealed she had no range of motion limitation in both upper and lower extremities. A record review of a care plan revealed a new problem identified on 05/28/14 of contractures to upper and lower left extremities with therapy to evaluate and treat as indicated. A record review of a Rehabilitation Screen dated 05/27/14 revealed that an evaluation was needed because nursing had noted a decline in Resident #1's left hand status. Further review revealed comments by the Therapy Director that use of a left hand roll could improve functional grasp. On 06/04/14 at 3:00 PM Resident #1 was observed with no left hand roll in place. The same observations were made on 06/05/14 at 10:42 AM and 06/05/14 at 1:58 PM.	F 318	1. Although resident #1 does not have any contractures, an order was obtained to continue therapy recommendations. 2. The nursing administration team completed a chart audit of all residents in building to ensure all therapy recommendations are implemented. 3. A communication form has been developed and will be discussed in the interdisciplinary team meeting for review and implementation. The Director of Nursing or designee will provide education to all nurses and therapist to ensure understanding of procedural changes of therapy communications. The facility will provide education regarding assistive devices for all new staff members upon facility orientation. 4. The Director of Nursing or designee will audit charts once per week for one month, then biweekly for one month, then once per month. The Director of Nursing or designee will conduct audits for assistive devices three times a week for three weeks, two times a week for three weeks, then weekly for compliance. The Director of Nursing will report the findings to the QA committee quarterly.	

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F 318	Continued From page 6 On 06/05/14 at 8:15 AM an interview was conducted with the Therapy Director. He revealed that nursing prompted him to review Resident #1 for a decline in her left hand status. Further interview revealed he recommended that a hand roll be placed in Resident #1's left hand to prevent further decline of functional grasp, and that nursing would be responsible for obtaining the physician order and implementation of the recommendation. On 06/06/14 at 9:30 AM an interview was conducted with Nurse #1 revealed that a soft roll is placed in Resident #1's left hand at times, but she was not sure if it is monitored as to when, and how often to place the roll in her left hand. On 06/06/14 at 3:50 PM the Director of Nursing (DON) was interviewed. She verified that the recommendation for Resident #1 to have a hand roll placed in her left hand was missed by nursing and the recommendation was not implemented. Further interview with the DON revealed that the recommendation should have been clarified with the Therapy Director and implemented.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323		6/25/14

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F 323	Continued From page 7 by: Based on observations, record review and staff interviews, the facility failed to activate on a personal pad alarm which was care planned for 1 of 3 sampled residents reviewed for falls. (Resident #79). The findings included: Resident #79 was admitted to the facility on 07/05/12. His diagnoses included Alzheimer's disease, anemia, depressive disorder, and anxiety. Resident #79 had a care plan developed since 07/17/12 which addressed him being at high risk for falls and having had multiple falls related to incontinence, poor cognitive status, unsteady gait and other factors. The goal was to remain free from a fall and /or a fall related injury for 3 months. Interventions included alarms as ordered for safety and check proper placement and function of alarms. Per nursing notes and post fall review with the Minimum Data Set (MDS) coordinator on 06/05/14 at 3:48 PM, Resident #79 continued to fall as follows: *01/08/14 at 5:20 PM from bed. A concave mattress was ordered. *02/12/14 at 6:20 PM stood up, the alarm rang and he fell from wheelchair. The intervention was to make sure he was toileted after meals. *02/20/14 at 8:00 AM, resident got up, alarm did not ring, and he fell against the wall while on the commode by himself. The alarm was replaced and he was placed on the early riser list. *03/01/14 at 9:00 PM found on floor out of bed, alarm was ringing. It was suspected the alarm	F 323	1. Resident #79's alarm was activated immediately. 2. An audit was completed to ensure other residents with alarms were properly activated. 3. The Director of Nursing or designee will provide education to C.N.A.s and nurses regarding how to properly ensure alarms are activated. The alarms will be added to the MAR so that the nurses will check on the placement and function of each alarm every shift. The facility will provide education regarding safety devices for all new staff members upon facility orientation. 4. The Director of Nursing or designee will inspect the alarms to ensure they are active 2 times per day for 5 days times 3 weeks, then once per day for 5 days for 3 weeks, then 2 times per week for 3 weeks, then the Director of Nursing or designee will conduct audits for safety devices weekly for compliance. The Director of Nursing will report the findings to the QA committee quarterly.	

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startled him so alarm was discontinued and therapy screened him but did not initiate therapy services.
*03/13/14 at 6:50 AM found on floor. Therapy screened again and began services since he seemed to be walking more.
*03/14/14 at 11:00 PM found sitting on the floor. His medications were reviewed, no changes were made and son requested alarms be implemented again. (replaced after next fall).
*03/15/14 2:55 PM found on floor in front of his recliner when staff entered to reimplement the bed and chair alarm. Alarm subsequently replaced after this fall.
*03/24/14 at 7:45 PM, resident fell, wife had turned alarm off. Laboratory testing was done and wife was educated to not turn off alarms.
*04/05/14 at 9:45 PM staff noticed alarm not functioning, left room to change batteries and resident got up from bed and fell before staff returned with new batteries. Staff was educated.
*05/07/14 at 7:45 PM attempted to get up and fell, alarm sounded.
*05/12/14 at 1:30 AM found on floor by bed, alarm was ringing. Recreational therapy started-a daytime program. The physician ordered trazodone (an antidepressant) 50 milligrams to be routinely given three times per day as of 05/28/14.

The most recent Minimum Data Set (MDS), an annual dated 05/14/14 coded Resident #79 with long and short term memory problems and having severely impaired decision making skills. He was coded with disorganized thinking and inattention, requiring extensive assistance with bed mobility, transfers, and walking. He was unable to stabilize himself without human assistance. Resident #79 was also coded as

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having 2 or more falls with no injury and 2 or more falls with injury not of a major kind since the previous assessment.

The Care Area Assessment related to falls dated 05/15/14 stated Resident #79 had multiple falls since last review and multiple interventions have been tried and were in place. The resident's wife had been educated not to assist Resident #79 out of sitting position by herself, to not turn off alarms, and to call staff for assistance with care. He continued to be a high risk for falls.

The current care plan for falls last updated 05/15/14 included the addition of a dycem pad (nonskid surface) in his chairs, a special cushion (curved) and wheelchair (reclining), staff to toilet resident before and after meals, to attempt to get him up prior to breakfast, safety alarms as ordered per family request, and to ensure proper function and placement of alarms as ordered and as indicated.

Nursing notes revealed the alarm alerted staff of Resident #79 rising unassisted:
*05/14/14 at 5:21 AM, the alarm sounded 2 times this night;
*05/17/14 at 10:22 PM alarm sounded and staff found resident attempting to get out of bed;
*05/25/14 at 4:57 AM bed alarm sounded several times alerting staff resident was rising unassisted.

Current physician orders for June 2014 included the safety alarms to the chair and bed to alert staff of rising and concave mattress to the bed.

On 06/05/14 at 7:55 AM, Resident #79 was observed in bed with top padded half rails, a concave mattress and the pressure alarm turned

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on and working. At 8:31 AM Nurse Aide (NA) #1 was observed providing care and transferred Resident #79 into his wheelchair. Resident #79 held onto the arms of the locked wheelchair and used his legs to walk /turn around and sit. At this time the alarm was not yet attached to the wheelchair. At 8:48 AM, NA #1 brought Resident #79 to the small dining area for breakfast. The alarm box was on the back of the wheelchair, however, it was turned off. At 8:53 AM he tried to push himself up from the wheelchair but NA #1 came into the room and moved him closer to the table but did not check the alarm. At 8:58 AM, the Director of Nursing spoke to the resident and did not check the alarm function. From 9:00 AM through 9:09 AM various staff entered and left the area, sometimes having Resident #79 out of staff sight for several minutes. At 9:07 speech therapy assisted the resident with breakfast. At 10:20 AM, he went to an activity and his alarm was noted to still be in the off position. The alarm remained off when he was in the dining room on 06/05/14 at 11:38 AM. Then on 06/05/14 at 1:45 PM, Resident #79 was observed in his room in his recliner. The alarm box had been moved to accommodate him being in the recliner but the alarm remained in the off position. On 06/05/14 at 2:42 PM, NA #1 and surveyor entered the room where the alarm was still in the off position. NA #1 stated he normally always turned the alarm on and off with each transfer and he must have pushed the off switch over accidentally thinking he was turning it on.

Review the the Medication Administration Records and Treatment Administration Records for May and June of 2014 revealed no documentation that the alarms were checked as being on and functioning by nursing staff.

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F 323	Continued From page 11 Interview on 06/05/14 at 3:48 PM with the MDS coordinator revealed that her expectation is that the alarms were in place and functioning. She further stated the alarm alerted staff when he was getting up and third shift was responsible for checking the alarms. The Assistant Director of Nursing stated on 06/05/14 at 4:31 PM stated the alarms were a request by the family. She further stated on 06/06/14 at 2:30 PM that when Resident #79 was alert and awake he was able to walk the entire building. The Director of Nursing stated on 06/06/14 at 3:41 PM that she expected the alarms to be in place for Resident #79. She further stated the nurse aides were responsible for charting the placement and function of the alarms.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 observations and staff interviews the facility failed to clean one of three ice scoop	F 371	1. The ice scoop holder was immediately pulled and cleaned accordingly.	6/6/14

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F 371	Continued From page 12 holders. The findings are: Observations made on 06/05/14 at 10:45 AM in the facility kitchen indicated dietary staff using ice scoops retrieved from a blue plastic ice scoop holder on top of the ice machine to fill ice chests and glasses for resident use. Observations made on 06/05/14 at 10:50 AM revealed a blue plastic container that was positioned on top of the ice machine in the facility kitchen. A total of four plastic ice scoops were stored inside the container; one large scoop and three smaller scoops. The lower portion of the container had a clear liquid solution which contained a brown floating residue pooled in the bottom. The ice scoops were resting in the liquid and the floating debris. An interview was conducted with the Dietary Manager (DM) on 06/05/14 at 11:00 AM. Upon observation of the ice scoops in the liquid, the DM indicated the ice scoop containers should be cleaned every day. He acknowledged he could not identify the substance in the bottom of the ice scoop holder. He stated that cleaning the container was not on the daily cleaning schedule, but would be added. The DM revealed it was his expectation that the ice scoop container should be cleaned every day.	F 371	2. An audit was completed on the other ice machines to ensure all other ice scoop holders were clean. 3. The Dietary Manager will provide education on maintaining clean ice scoop holders. A revision of the cleaning schedule was completed by the dietary manager to include daily cleaning of the ice scoop holders. 4. The dietary manager or his designee will inspect the cleanliness of the ice scoop holder 5 times per week for 3 weeks. The DM/designee will continue to monitor 2 times per week for 3 weeks, then 1 time per week for three weeks. The DM will report his findings to the QA committee quarterly.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431		6/25/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345123	A. BUILDING _____ B. WING _____	06/06/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 13 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, record review, and staff interview the facility failed to discard expired medications for 1 of 2 medication storage rooms. The findings were: A review of facility policy regarding expired medications revealed that outdated medications should be removed from stock. On 06/05/14 at 2:00PM 7 vials of single use Lorazepam with an expiration date of 03/01/14 was observed in the 100 hall lock box medication	F 431	1. The medications were immediately removed and it was immediately determined that none of the expired medications were administered to the residents. 2. All medication storages areas were audited for compliance. 3. The Director of Nursing or designee	

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F 431	Continued From page 14 room refrigerator. In addition, 2 single use Miralax power packets with an expiration date 07/13 was observed in the medication room cupboard. On 06/05/14 at 2:05 PM an interview was conducted with Nurse #2. She verified that 7 vials of Lorazepam had an expiration date of 03/01/14. On 6/05/14 at 2:30 PM an interview was conducted with the Pharmacy Consultant. She verified that the 7 bottles of Lorazepam observed in the lock box in the 100 hall medication room refrigerator had an expiration date of 03/01/14, and the two single packets of Miralax had an expiration date of 07/13.	F 431	will provide education to nurses regarding manufacturers expiration date for medications. Per facility policy any medication that is expired will be removed from storage areas and disposed of accordingly by licensed staff members. 4. The Director of Nursing or designee will audit medication storage areas 3 times per week for 3 weeks, then 2 times per week for 3 weeks, then weekly for one month. The Director of Nursing will report the findings to the QA committee quarterly.	