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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING ______ B. WING ______	06/22/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH ROAD BOX 38 ALBEMARLE, NC 28001

(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 253 SS=E	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to maintain the removable air filters in Packaged Terminal Air Conditioning (PTAC) units in resident rooms in five of five hallways with certified Medicare and Medicaid beds. PTAC units had visible dust on the removable air filters in resident rooms on the 200, 300, 400, 500 and 600 halls. The facility also failed to keep resident bathroom vents dust free in resident bathrooms on three of five hallways with certified Medicare and Medicaid beds. The resident bathroom vents had visible dust on the vent in rooms on the hallways of 200, 300, and 500. The findings included: 1. An observation on 6/20/17 at 9:08 AM revealed visible dust on the removable air filter for the PTAC unit in room 304. An observation on 6/20/17 at 9:26 AM revealed visible dust on the removable air filter for the PTAC unit in room 308. An observation on 6/20/17 at 2:58 PM revealed visible dust on the removable air filter for the PTAC unit in room 400. An observation on 6/20/17 at 3:05 PM revealed visible dust on the removable air filter for the PTAC unit in room 304. An observation on 6/20/17 at 3:09 PM revealed visible dust on the removable air filter for the PTAC unit in room 308. An observation on 6/20/17 at 3:22 PM revealed	F 253	Preparation and or/execution of this Plan of Correction does not constitute admission of agreement by the provider of the truth of the facts alleged or conclusions set forth in this statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law. On 6/20/2017 all Package Terminal Air Conditioner/Heat Pump filters in all resident's rooms were cleaned and replaced back into Package Terminal Air unit following cleaning. Package Terminal Air Conditioner/ Heat Pump filter cleaning was performed by maintenance teammate. On 7/3/2017 Maintenance Teammate was reeducated on the manufacturing guidelines on proper cleaning of the Package Terminal Air Condition /Heat Pump filter (PTAC) by the Manager of Plant Operations and Maintenance. The facility updated the Preventive Maintenance Program for cleaning of the Package Terminal Air Condition/ Heat Pump filters to occur once monthly as directed by the Package Terminal Air Condition Heat Pump operational manual.	7/19/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/05/2017

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 253	Continued From page 1 visible dust on the removable air filter for the PTAC unit in room 400. An observation on 6/21/17 at 10:54 AM revealed visible dust on the removable air filter for the PTAC unit in room 407. An observation on 6/21/17 at 10:55 AM revealed visible dust on the removable air filter for the PTAC unit in room 408. An observation on 6/21/17 at 10:57 AM revealed visible dust on the removable air filter for the PTAC unit in room 501. An observation on 6/21/17 at 10:59 AM revealed visible dust on the removable air filter for the PTAC unit in room 506. An observation on 6/21/17 at 11:31 AM revealed visible dust on the removable air filter for the PTAC unit in room 208. An observation on 6/21/17 at 11:33 AM revealed visible dust on the removable air filter for the PTAC unit in room 207. An observation on 6/21/17 at 11:35 AM revealed visible dust on the removable air filter for the PTAC unit in room 500. An observation on 6/21/17 at 11:37 AM revealed visible dust on the removable air filter for the PTAC unit in room 603. An observation on 6/21/17 at 11:38 AM revealed visible dust on the removable air filter for the PTAC unit in room 604. An observation on 6/21/17 at 11:39 AM revealed visible dust on the removable air filter for the PTAC unit in room 606. A round conducted on 6/21/17 at 3:01 PM with the Maintenance Mechanic 2 revealed observations of visible dust on the removable air filters for the PTAC units in rooms 200, 202, 203, 204, 205, 207, 208, 209, and 210.	F 253	This cleaning will be completed by the maintenance teammate. The environmental service supervisor or the environmental service assistant to the supervisor will monitor the cleanliness of the PTAC filters by auditing at least 5 PTAC's monthly to ensure cleanliness of filters. These audits will be reviewed by the administrator monthly. All bathroom vents in resident rooms were cleaned on 6/20/2017 by Environmental Service Supervisor. All resident bathroom vents will be dusted monthly by environmental service teammates. The Environmental Services- Plus Discharge Cleaning form was implemented on July 5th. This form will be used by environmental service teammates to check off when bathroom vents are cleaned monthly. This document will be reviewed by the Environmental Service Supervisor. Environmental Service Teammates were in-serviced on The Environmental Services- Plus Discharge Cleaning form that includes resident bathroom vents to be dusted at least monthly on July 5, 2017. Environmental teammates were also educated on how to properly dust bathroom vents on July 5, 2017. This in-service was provided by the Supervisor of Environmental Services.	

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An interview with the Maintenance Mechanic 2 on 6/21/17 at 3:08 PM revealed the routine cleaning of the removable air filters on the PTAC units was the Maintenance Department's responsibility. The Maintenance Mechanic 2 stated the cleaning of the removable air filters was completed based on a Preventive Maintenance (PM) schedule. The Maintenance Mechanic 2 viewed the removable air filter from the PTAC units from rooms 200, 202, 203, 204, 205, 207, 208, 209, and 210. The Maintenance Mechanic 2 acknowledged there was a heavy dust build up on the removable air filters and the filters needed to be cleaned or exchanged with a new filter. The Maintenance Mechanic 2 stated he did not have a PM log showing the last time the PTAC unit removable filters had been cleaned. The Maintenance Director further clarified the facility had recently undergone a transition of management and he was awaiting a new PM schedule for cleaning the removable filters in the PTAC units. The Maintenance Mechanic 2 stated it was his expectation the removable air filters in the PTAC units be maintained and inspected to minimize dust buildup and that monthly inspections, cleaning, and maintenance to the air filters would minimize dust build up.

An interview conducted with the administrator on 6/2/17 at 3:32 PM revealed it was the administrator's expectation the removable air filters on the PTAC units in the residents' rooms should be cleaned at least once per month and as needed.

2. An observation on 6/21/17 at 10:52 AM revealed visible dust on the vent in the resident bathroom in room 501.
An observation on 6/21/17 at 11:27 AM revealed

The environmental service supervisor or the assistant to the environmental service supervisor will audit at least 5 resident bathroom vents monthly to ensure cleanliness of bathroom vents. The resident bathroom vent dusting audit will be reviewed by the administrator monthly.

The administrator will discuss findings of resident bathroom vent cleaning audits and Package Terminal Air Condition/Heat Pump filter audits at monthly Quality Assurance Performance Improvement meetings. Audits will continue monthly until 3 months of compliance is sustained.

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F 253	Continued From page 3 visible dust on the on the vent in the resident bathroom between rooms 309 and 311. An observation on 6/21/17 at 11:31 AM revealed visible dust on the vent in the resident bathroom between rooms 208 and 210. A round conducted with Environmental Services #1 on 6/21/17 at 3:20 PM revealed observations of visible dust on the vents in the resident bathrooms between rooms 208 and 210 and between rooms 207 and 209. An interview with Environmental Services #1 on 6/21/17 at 3:23 PM revealed the routine cleaning of the bathroom exhaust vents in the resident bathrooms was the responsibility of the housekeeping department. The housekeepers were responsible for cleaning the exhaust vents in the resident bathrooms as part of the high dusting for routine cleaning. Environment Services #1 viewed the bathroom exhaust vent in the bathroom between rooms 208 and 210 and between rooms 207 and 209. Environmental Services #1 acknowledged there was dust on bathroom vent. Environment Services #1 stated it was her expectation the exhaust vents in the resident bathrooms be cleaned as part of routine housekeeping. An interview conducted with the administrator on 6/21/17 at 3:37 PM revealed it was the administrator's expectation the exhaust vents in the residents' bathrooms should be cleaned as needed as part of routine housekeeping.	F 253		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment	F 278		7/19/17

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F 278	Continued From page 4 must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) for a level II Preadmission Screening and Resident Review (PASRR) (Resident #39). A Coding error was discovered in	F 278	Resident #39 MDS 10/5/2016 annual comprehensive assessment was corrected by Minimum Data Set RN on 6/20/2017 to reflect the correct PASRR level II.	

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F 278	Continued From page 5 the MDS assessment for one of one sampled resident reviewed for level II PASRR. The findings included: Resident #39 was readmitted on 1/1/14 and was originally admitted on 9/28/2009. Resident #39 was admitted and readmitted with multiple diagnoses that included Schizophrenia, anxiety disorder, depression, and insomnia. The annual comprehensive Minimum Data Set (MDS) assessment dated 10/5/16 indicated Resident #39 was not considered by the state level II PASRR process to have serious mental illness and/or intellectual disability. Resident #39's coded diagnoses included: dementia, depression, and schizophrenia. Resident #39 was coded as having had received antipsychotic medication for seven of the seven days during the assessment period and antidepressant medication for seven of the seven days of the assessment period. A review of the medical record of Resident #39 revealed a level II PASRR authorization sheet with a date of 1/5/10. Resident #39 was routinely seen by psychiatric services, with a recent follow up on 4/27/17. A review of Resident #39's June Medication Administration Record (MAR) revealed psychotropic medications included: Sertraline, quetiapine fumarate, and perphanazine. Resident #39's care plan with a last review date of 5/3/17 included the following: delusional behaviors, psychosis, schizophrenia, anxiety, depression, dementia, psychotropic medication use, and behavioral issues.	F 278	On 6/21/2017 a chart audit was completed on all level II PASRR residents (only one in facility #39) to ensure correct coding on comprehensive MDS assessment by Director of Nursing. Minimum Data Set RN's reviewed RAI manual for correct coding of level II PASRR on comprehensive Minimum Data Set Assessment on June 20, 2017. Director of Nursing or Assistant Director of Nursing will complete monthly audit by reviewing last Minimum Data Set comprehensive assessment for all residents with Level II PASRR. These Minimum Data Set audits will be reviewed by the administrator. The Director of Nursing will present The Minimum Data Set PASRR II audit at the monthly Quality Assurance Performance Improvement meeting. The Minimum Data Set PASRRII audit will continue until three months of compliance is sustained.	

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F 278	Continued From page 6 An interview conducted with the MDS Nurse on 6/20/17 at 4:41 PM revealed she was responsible for coding Section A of the MDS assessments. The MDS coordinator verified Resident #39 was still an active level II PASRR currently and was at the time of the 10/5/16 annual comprehensive MDS assessment. She indicated she coded the assessment for Resident #39 incorrectly and Resident #39 should have been coded as having had a level II PASRR. During an interview that was conducted with the Administrator on 6/20/17 at 4:46 PM, the Administrator acknowledged Resident #39 had been a level II PASRR since her initial admission to the facility in 2009. The Administrator further acknowledged Resident #39's level II PASRR status had been inaccurately coded on Resident #39's annual comprehensive (MDS) assessment dated 10/5/16. The Administrator stated her expectation was for the MDS assessments to be coded accurately.	F 278		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 441		7/19/17

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conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

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F 441	Continued From page 8 (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interviews, observation, manufacturer ' s specifications, and facility policy, the facility failed to disinfect a multi-use point of care blood testing device used for clotting studies in 2 of 2 devices. Findings included: A review of the facility ' s infection control policy dated July 2016 revealed the use of universal precautions that defined all body fluids as potentially infected. A review of the facility ' s master list dated September 2014 for cleaning noncritical equipment and devices revealed that CoaguCheck XS meters were to be cleaned with bleach wipes between patients and as needed when soiled. The Centers for Disease Control and Prevention (CDC) Summary statement on Infection Prevention was summarized below and at the following link: https://www.cdc.gov/injectionsafety/faqs.html "Infectious agents, such as HBV, can be	F 441	On 6/21/2017 The CoaguCheck XS meters were suspended from fingerstick use and removed from nurses station. All orders for PT/INR checks were changed to venipuncture. On 6/21/2017 all licensed nurses were notified that all PT/INRs would be obtained via venipuncture and sent to CHS-Stanly lab until further notice. All licensed nursing teammates received education by the Director of Nursing or Staff Development Coordinator RN, on the protocol for cleaning and disinfecting finger stick PT/INR monitors using 1:10 bleach wipes. All licensed nursing teammates completed in-service training by 7/3/2017. Resumed PT/INR monitoring with CoaguCheck XS meters on 7/4/2017. The Director of Nursing, Assistant Director of Nursing or Staff Development	

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transmitted through indirect contact transmission, even in the absence of visible blood. Indirect contact transmission is defined as the transfer of an infectious agent (e.g., HBV) from one patient to another through a contaminated intermediate object (e.g., blood glucose meter) or person (e.g., healthcare personnel hands)."

"The disinfection solvent you choose should be effective against HIV, Hepatitis C, and Hepatitis B virus. Outbreak episodes have been largely due to transmission of Hepatitis B and C viruses. However, of the two, Hepatitis B virus is the most difficult to kill. Please note that 70% ethanol solutions are not effective against viral blood borne pathogens ..."

A review of the manufacturer ' s (Roche) recommendation revealed, in part, to clean the device (CoaguCheck XS) with 70% isopropyl alcohol or 10% bleach solution. The manufacturer had not defined whether the choice of cleaning solution would be based on single or multi-use. The exterior may be cleaned with a cotton swab or cloth and the test strip guide may be cleaned with a cotton swab. There was no direction to avoid cleaning any areas in the test strip guide. There was a warning not to introduce foreign objects into the test strip guide. The cleaning agent must be applied for more than 1 minute. The device must be allowed to dry for 10 minutes before use.

On 6/21/17 at 12:50 pm an interview was conducted with Nurse #1. Nurse #1 stated that the CoaguCheck XS meter was used by the evening staff. Nurse #1 stated that the test strips calibrate the device when inserted. Nurse #1 stated that the meter was for multi-use. Nurse #1

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RN will observe three PT/INR checks by the CoaguCheck XS meter a week- (Monday - Sunday) for one month. These three weekly checks will occur by the following schedule: one check on first shift, one check on second shift and one check on third shift to ensure proper cleaning and disinfecting of the CoaguCheck XS meter.

After one month of monitoring the Director of Nursing, Assistant Director of Nursing or Staff Development RN will continue with observation of three CoaguCheck XS meter monthly. These three monthly checks will occur by the following schedule: one check on first shift, one check on second shift and one check on third shift to ensure proper cleaning and disinfecting of the CoaguCheck XS meter. This monthly schedule will continue until three months of compliance is sustained.

The Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator RN will discuss finding of the PT/INR cleaning/ disinfecting audits at the monthly Quality Assurance Performance Improvement Meeting. Audits will continue until 3 months of compliance is sustained.

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F 441	Continued From page 10 stated that the device was cleaned after each use with alcohol wipes. On 6/21/17 at 3:26 pm an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated that the CoaguCheck XS meter (point of care blood testing device) was for evaluating the resident ' s pro-time and INR (clotting study). There were two meters for the facility and approximately 10 to 15 residents required testing. The ADON stated that the policy and procedure for use of the CoaguCheck XS was to clean the meter with alcohol and wait 10 minutes until the alcohol dries. The ADON stated she used an alcohol wipe to clean the meter and the test strip guide after removing its cover, but had to avoid touching the white pad (where the device evaluated the blood) of the test strip guide. On 6/21/17 at 3:45 pm an observation was conducted of the ADON ' s demonstration of the CoaguCheck XS meter ' s use. The ADON wiped the body of the meter, but not the test strip guide or its cover, by using a disinfecting super sani-cloth wipe (not alcohol or bleach). The ADON placed a test strip in the guide of the CoaguCheck XS and waited for the device to calibrate. The ADON demonstrated where the resident ' s finger would be placed to provide blood onto the strip, which was 1.5 centimeters from the device ' s opening. The strip was discarded and the ADON removed the test strip guide cover and cleaned the cover, test strip guide and opening (avoiding the white pad) with an alcohol wipe. The lower portion of the guide around the white pad test strip area was not cleaned and the white pad test strip area was not cleaned. The guide and test area were not	F 441		

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F 441	Continued From page 11 cleaned with a cotton swab as recommended. The test strip guide and opening was not cleaned with a disinfectant that was effective against HIV, Hepatitis C, and Hepatitis B virus. On 6/21/17 at 4:05 pm an interview was conducted with the Director of Nursing (DON). The DON stated that the facility had two CoaguCheck XS meters that were shared throughout the facility. The body of the meter and the test strip guide were cleaned with alcohol wipes as directed by the manufacturer. The manufacturer recommended cleaning with alcohol or 10% bleach solution. The DON further stated that the facility practice was for staff to clean the meter with alcohol. The DON agreed that the use of alcohol could not kill the virus Hepatitis B (HBV). The DON also agreed that the use of the 10% bleach solution was disinfecting and would prevent transmission of viruses. The DON stated the choice to use the alcohol was at the recommendation of the manufacturer. The DON would not state how the facility would prevent the transmission of HBV by cleaning a multi-use, point of care device with alcohol. The DON stated she expected staff to follow the manufacturer's instructions and facility policy for cleaning and disinfecting the meter with alcohol.	F 441		