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
	345260	A. BUILDING _____ B. WING _____ MAR 28 2011	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The survey dates were from February 16-17, 2011 and February 27 through March 3, 2011. Immediate jeopardy was identified on March 1, 2011 and was removed March 3, 2011.	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.*	
F 157 SS=J	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	Resident Specific Resident #1 was admitted to the facility on 1/3/2011. Her diagnoses included Comminuted Intertrochanteric right Hip fracture, Rhobdomylosis, HTN, Mild Cognitive Impairment, and Alzheimer's dementia. Her medications included Metoprolol Tartrate, Mirtazepine, Plavix, Prednisone, Lisinopril, Colace, Ferrous Sulfate, and Lortab. She received Lortab for right hip pain once on 1/3, twice on 1/4, 1/5, 1/6, 1/7, 1/8, 1/9, 1/10, 1/11, and 1/13/2011. She received Lortab three times on 1/12/2011. She also experienced hemorrhoid pain on 1/9/2011 and an order was received for Annusol suppositories three times per day as needed. Resident received Colace 100mg two times per day since admission. On 1/9/2011, Lactulose 30cc daily was added to her medication regimen for constipation. On 1/10/2011, Senokot was added one tablet daily for constipation. Resident received Fleets enemas on 1/10/2011 (one) and 1/12/2011 (two). On 1/13/2011, both the resident and her brother requested she be sent to the emergency room for evaluation. She stated, "I don't feel good."	4/4/2011

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

Executive Director 3/25/11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interviews, physician interviews, facility guideline review and record review the facility failed to notify the physician of noted new onset abdominal/rectal pain with associated constipation for 1 of 6 sampled residents (Resident #1). The facility failed to notify the physician of a sub-therapeutic (low) International Normalization Ratio (INR) level for 1 of 3 sampled residents (Resident #11) Immediate Jeopardy (IJ) began on 1/8/11 for resident #1. The immediate jeopardy was identified on 3/1/11 and was removed on 3/3/11 (for resident #1), when the facility demonstrated it had implemented their credible allegation of compliance. The facility was left out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy (D) so that completion of staff in-services and incorporation of monitoring systems could be accomplished and included in the Quality Assurance Program. Findings include: Review of the facility "Guidelines for Physician Notification of Change of Condition/Clinical Problems in Center Residents", dated 10/31/08, revealed, for abdominal pain, if the resident had abrupt onset of severe pain or distension, or vomiting and fever the physician should be notified within 1 hour. If the resident had moderate diffuse or localized pain, unrelieved by antacids or laxatives the physician should be notified within 6-8 hours, and no later than the next business day. If the resident had mild to moderate discomfort, without associated	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* Attending physician was notified and order received for resident to be transported to the emergency room. Vital signs were: temperature 97.3, pulse 69, respirations 12, and blood pressure 58/32. Resident had documented bowel movements as follows: 1/5/2011-two soft, medium bowel movements 1/7/2011-one soft, medium bowel movement 1/8/2011-one soft, medium bowel movement 1/9/2011-one soft, small bowel movement 1/10/2011-Senokot one tablet daily was added for constipation; one Fleet's enema 1/11/2011-one hard, medium bowel movement 1/12/2011-one soft, small bowel movement 1/12/2011-two Fleets enemas given with no results documented Resident passed away in the hospital on 1/13/2011.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 157	Continued From page 2 symptoms the physician could be notified at the next regular visit or phone conversation within one day to 72 hours. 1.Resident #1 was admitted to the facility on 1/3/11 with diagnoses including a right hip fracture, rhabdomyolysis (rapid breakdown of skeletal muscle due to damage to muscle tissue), hypertension, and mild cognitive dysfunction. The undated, unsigned "Pain Assessment" had the following handwritten in the "location" section, "No c/o (complaint) pain - on admission soreness R (right) hip." The "severity" section was not completed. Further review revealed the "pain type/intensity" , "other non-verbal", "quality of life/activities of daily living", "cause of pain", "relief of pain" and "conclusion" sections were not completed. Nurse #2 was interviewed on 2/17/11 at 3:30PM. Nurse #2 admitted the resident to the facility on 1/3/11. She indicated the resident wasn't having a whole lot of pain in the first day. Then around the second or third day she would just scream when you touched her. The staff was not sure if maybe the resident did not want to go to therapy and that was the reason for her behavior. Therapy would come to work with the resident and she would just scream. The nurse stated she was responsible for the initial pain assessment and could not provide a reason for the incomplete pain assessment. Resident #1's physician orders for January 3, 2011 to January 13, 2011 revealed the resident was ordered to receive Ferrous Sulfate 325 mg (milligrams) twice daily and Colace (a stool softener) 100mg twice daily. The resident was	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* All Other Residents 1. (A) On 3-01-11, Nurse Management team, consisting of Interim Director of Nursing Services (I-DNS), Staff Development Coordinator (SDC) and Minimum Data Set Coordinators (MDSC) performed pain assessments on all residents in house to identify residents with pain. (B) On 3-01-11, Nurse Management team, consisting of Interim Director of Nursing Services (I-DNS), Staff Development Coordinator (SDC) and Minimum Data Set Coordinators (MDSC) performed bowel record review for residents of the facility to also include the look back period to the last documented bowel movement to identify residents with no bowel movement in three days. 2. (A) The resident's primary licensed nurse will be responsible for physician notification via telephone when a residents with a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 157	Continued From page 3 also ordered Lortab (Hydrocodone/Acetaminophen) 5mg/325mg 1 tab every 4 hours as needed. Review of the nurse's notes, dated 1/3/11 through 1/7/11 revealed the resident had complaints of right hip pain and "pain." She was receiving as needed pain medication (Lortab). Review of the resident's "Bowel Record" for 7-3 shift revealed she had no noted bowel movements on 1/3/11 and 1/4/11. The resident had 2 medium soft bowel movements on dayshift of 1/5/11. Review of the resident's "Bowel Record" for 7-3 shift revealed she had no noted bowel movements on 1/6/11. The resident had one medium soft bowel movement on 1/7/11 and 1/8/11 during dayshift. Resident #1 received a Lortab at 4:55AM on 1/8/11 for complaint "pain." There was no follow up to evaluate the effectiveness of the medication. The MAR reflected the resident received a Lortab for rectal pain at 9PM on 1/8/11. The effectiveness of the medication was not evaluated. The MAR noted the resident received Lortab at 4AM for complaint of rectal pain. It was noted as being "effective." On 1/9/11 at 12:50PM the nurse's notes reflected the resident was complaining of hemorrhoids	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* score of 3 or higher on a scale of 1(mild)-10 (continuous/severe) on the pain assessment form, with new orders implemented and care planned by MDSC and or primary licensed nurse, at the time of pain onset. The IDT (Interdisciplinary Team) will validate this process at least 5 times weekly in Clinical Morning Review. Responsible Party(s) will be notified of new medications or change in dosage of current medication as needed. (B) Bowel Protocol was initiated by the Nurse Management Team, consisting of the Interim Director of Nursing Services (I-DNS), Staff Development Coordinator (SDC) and Minimum Data Set Coordinators (MDSC) for residents noted with no bowel movement in three days. Bowel Protocol states: • On third day with no documented bowel movement give Lactulose 30 cc po (by mouth) or via tube (gastric or peg) prn (as needed)	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 157	Continued From page 4 hurting. A verbal order was received from the physician assistant for "Annusal HC (Hydrocortisone Cream) suppository 1 to 2 pr (per rectum) TID (three times daily) for hemorrhoidal pain prn (as needed)." The resident received a Lortab and Anusol HC for "rectal" pain at 12PM. There was no evaluation on the effectiveness of either medication. Resident #1 had a small soft bowel movement on 1/9/11. The MAR reflected resident #1 received a Lortab and Anusol HC for "rectal" pain at 4PM. There was no evaluation on the effectiveness of either medication. The nurse's note dated ,1/9/11 at 6:50PM noted the resident had received an Anusol HC suppository per rectum and Lortab for hemorroidal pain. There was no mention of whether or not there was stool present in the rectum when the Anusol suppositories were inserted. No assessment of the hemorrhoids or the abdomen was noted. The MAR noted resident #1 received Lortab at 8PM on 1/9/11 for "pain across top buttock." A verbal order dated 1/9/11 at 11PM read in part, "Lactulose 30cc (cubic centimeter) po (by mouth) daily, Senokot 1 po daily." On 1/10/11 at 6:15AM the nurse's note reflected the resident had been medicated with Anusol HC per rectum (at 5:30AM) and Lortab for complaint hemorroidal pain (at 3:35AM). The physical therapy (PT) notes for 1/10/11 noted	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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 fourth day with no documented bowel movement and no results from Lactulose give Dulcolax supp (suppository) pr (per rectum) prn (as needed) • On fifth day with no documented bowel movement and no results from Lactulose or Dulcolax give Fleets Enema pr (per rectum) prn (as needed) • Notify attending physician if no results within 30 minutes of Fleets enema administration. 3. (A) On 3-01-11, Nurse Management team, consisting of Interim Director of Nursing Services (I-DNS), Staff Development Coordinator (SDC) and Minimum Data Set Coordinators (MDSC) implemented, evaluated and / or updated resident care plans to reflect pain as needed concerning all residents in the facility. Careplans are made accessible through the resident's medical record for the licensed nurses and the nursing assistant will obtain any careplan updates in shift report from the licensed nurse on an as	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 157	Continued From page 5 the resident stated she could not participate in therapy. The therapist noted the resident had "decreased motivation." The PT noted the resident had pain in her abdomen and right hip. Pain medications were given and the nurse was aware. Review of the MAR for 1/10/11 reflected the resident received a Fleets enema x 1. The enema was not documented on the "Nurse's Medication Notes" or in the nurse's notes. Review of the "Bowel Record" for 1/10/11 noted "0" for the amount of bowel movements on 7-3, 3-11, and 11-7 shifts. Review of the nurse's notes, dated 1/10/11 revealed no indication of physician notification regarding the in-effective enema. The PT notes for 1/11/11 revealed the resident said "I can't do it." (in regards to therapy) Resident #1 had pain in her right lower extremity and rectum pain. Pain medications were received and the nurse was aware. The resident had 1 medium hard bowel movement during dayshift on 1/11/11. The nurse's note (done by nurse #2), dated 1/11/11 at 8:30PM revealed the resident would not attempt to walk and her appetite was poor. A moderate amount of soft stool was removed manually from the resident's rectum before inserting a Dulcolax suppository. Lactulose 30 cc was given by mouth. The resident was taking a "fair" amount of liquids. Another nurse's note from 1/11/11 reflected at 9:30PM the resident was assisted to the toilet. The note read in part, "will not try to expel (push out) stool." States, "I can't	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* needed basis on-going. Pain care plan is inclusive of: • Pain type, chronic, acute, breakthrough, phantom • Pain symptoms: crying / moaning, facial grimace, guarding, complaints of pain, decrease in functional level, inability to sleep, limiting activities, not eating a) Licensed Nursing Staff monitoring residents for pain each shift. Attending physicians when signs and symptoms of pain, worsening pain, reporting changes in pain location / type / frequency / intensity of pain to physician • Providing non-pharmacological comfort measures including relaxation techniques, deep breathing, repositioning, activities as appropriate • Monitoring for side effects including Licensed Nurses to monitor for signs and symptoms of constipation, Licensed Nurses and Certified Nursing Assistants monitoring and documenting bowel movements	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 157	Continued From page 6 get it to move." There was no indication of physician notification in regards to the resident's status. During an interview on 2/17/11 at 3:30PM nurse #2 indicated she believed she checked the resident's rectum once manually and did not feel any stool. Of course the resident was on a narcotic pain medication and that could be constipating. Review of the MAR revealed resident #1 received a Fleets enema on 1/12/11 at 8AM and 1:30PM. Both enemas were documented on the "Nurse's Medication Notes" as "not effective." There was no indication of physician notifcation in regards to the lack of effectiveness of the enemas. A nurse's note on 1/12/11 at 4PM revealed the resident received Anusol HC per rectum at 9AM and 2PM with minimal pain relief voiced per resident. The nurse noted before inserting the suppositories she felt "gummy pasty like fecal matter" and she removed a "fistful amt (amount) of stool." On 1/12/11 at 10PM the nurse noted the resident remained in bed and "continues not helping herself." Her appetite was poor and she was given Lortab for "discomfort." There was no evidence of physician notification. The "C.N.A. Flow Record" had a section for "Behaviors observed." It was noted on the 3-11 shift on 1/12/11 the resident had "Continuous yelling/screaming." No other behaviors were noted on the flow record. The "C.N.A. Flow Record" contained a narrative	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* • Administering and monitoring for effectiveness and for possible side effects from pain medication • Pain Assessment to be completed on admission, quarterly and with significant change in status • Education with resident and family members as needed about comfort measures, analgesic medications, fear and concerns regarding pain • Certified Nursing Assistants will verbally notify licensed nurse if resident has no bowel movement in three days • Certified Nursing Assistants will document notification on bowel record and licensed nurses will review the bowel record flow book the beginning of each shift. • Licensed Nurses administering stool softeners and laxatives per MD orders • Licensed Nurses encouraging fluid and fiber	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 157	Continued From page 7 note dated 1/12/11 (no time) that read in part, "Resident having problems with having BM (bowel movement) the nurse gave her something. She didn't eat much." An interview was conducted on 2/17/11 2:43PM with NA #2. The NA stated resident #1 complained about not being able to have a bowel movement and having pain (stomach) because she could not go to the bathroom. The nurse (#1) gave the resident an enema and a little bit of "mushy" stool came out. Another note dated 1/12/11 (11pm-7am) noted the resident had been removing stool from her rectum and had put it all over her bedding. The resident complained of pain in her rectum. The NA informed the nurse. During an interview, on 2/17/11 at 3:06PM, NA #4 indicated the resident was a very anxious about her care. The NA stated the resident was "always wanting laxatives" and trying to manually remove stool out of her rectum with her fingers. The nurse's were aware of the resident's behavior and it was something she did throughout her stay. The PT notes for 1/12/11 read in part, "I am hurting so bad (resident)." The resident complained of pain in her rectum. The nurse was aware and pain medications were received. Resident #1 had only 1 noted bowel movement on the 11-7 shift, a small soft one on 1/12/11. Review of the resident's "Bowel Record" for 7-3 shift revealed she had no noted bowel movements on 1/12/11 and 1/13/11.	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* • Certified Nursing Assistant encouraging resident to follow prescribed diet (B) On 3-01-11, Nurse Management team, consisting of Interim Director of Nursing Services (I-DNS), Staff Development Coordinator (SDC) and Minimum Data Set Coordinators (MDSC) implemented, evaluated and / or updated resident care plans related to constipation as needed. Constipation care plan is inclusive of: • Certified Nursing Assistants monitoring and documenting bowel movements every shift • Certified Nursing Assistants will verbally notify licensed nurse if resident has no bowel movement in three days • Certified Nursing Assistants will document notification on bowel record and licensed nurses will review the bowel record flow book the beginning of each shift. • Licensed Nurses administering stool softeners and laxatives per MD orders	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 157	Continued From page 8 The nurse's note dated 1/13/11 at 6:45AM noted the resident had been requesting the bed pan most of the night. She had a medium brown stool and continued to insert her fingers into her rectum to try to remove stool. Resident #1 told PT she was sick on 1/13/11. The daily PT note dated 1/13/11 revealed the resident had abdominal pain secondary to no bowel movement. A nurse's note for 1/13/11 at 12:30PM noted the resident was being sent to the emergency room for "altered mental status." The resident stated "I don't feel good." Her vital signs were; temperature 97.3 degrees Farenheit, pulse 69, respirations 12 and blood pressure was 58/32. The MAR revealed resident #1 had received 24 doses of the as needed Lortab from 1/3/11 to 1/13/11. She received one dose on 1/3/11. From 1/4/11 to 1/8/11 the resident received 2 doses daily of the Lortab. On 1/9/11 she had four doses of Lortab (4AM, 12PM, 4PM, and 8pm). The resident had two doses daily of the Lortab on 1/10/11 and 1/11/11. She received three doses of the Lortab on 1/12/11 (times not documented) and 2 doses on 1/13/11. Resident #1 was receiving the Ferrous Sulfate twice daily and the Colace twice daily. Record review of the hospital records dated, 1/13/11, noted the resident presented to the emergency department with complaint of abdominal pain, fatigue, poor oral intake, and hypotension. The resident was given several enemas and manual disimpaction of stool on 1/12/11. The facility and family member reported "Very poor oral intake for past 3-4 days." The	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* • Licensed Nurses encouraging fluid and fiber as appropriate • Certified Nursing Assistant encouraging resident to follow prescribed diet • Notification of Registered Dietician for evaluation of diet and fluid intake / offerings, resident likes and dislikes, and recommendations for food and /or fluids to promote regular bowel elimination 4. Education was initiated by: (a) Staff Development Coordinator inserviced current licensed nursing staff on 3-1-11 and will repeat in-service on-going for newly hired licensed nurses during orientation, licensed nurses returning from vacation and leave of absence with regard to pain policy to include: • Assessment of resident pain including location, duration, frequency, time of day pain generally occurs, feeling of pain (internal, external, acute, chronic), severity of pain verbal pain scale (if resident able to respond) and non-verbal pain scale, pain type / intensity, other	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 157	Continued From page 9 abdominal exam noted the abdomen was "distended, diffusely tender with hypoactive BS (bowel sounds), rectal with gross heme + stool (positive for blood)." The CT (computed tomography) of the abdomen and pelvis, done on 1/13/11, read in part, "A rather marked amount of retained stool is noted in the rectum and rectosigmoid (colon) compatible with clinical diagnosis of fecal impaction. Fluid filled dilated small bowel loops with scattered air fluid levels are present." Resident #1 expired on 1/13/11 at the hospital with final primary diagnoses of cardiopulmonary arrest, aspiration pneumonia, GI (gastrointestinal) bleed, hypotension, leukocytosis, metabolic acidosis and renal failure. The rehabilitation interim manager was interviewed on 2/17/11 at 12:05PM. She indicated she had worked with resident #1. She remembered the resident did "pretty good" the first time she worked with her. Then she was off for a few days, a weekend she thinks, and when she came back the resident was "different." The resident was complaining of trouble with her stomach. The rehab interim manager remembered assisting the resident to the toilet with nursing because they thought that might help her move her bowels. The resident stated she just could not do it, she couldn't push. She indicated as the resident's stay progressed she was significantly different. It was not the whole stay but like 3-4 days towards the end. An interview was conducted on 2/17/11 at 12:15PM with nurse #1. The nurse had cared for	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* non-verbal cues (facial expressions, vocalizations, body actions / observed behaviors), pain affecting resident's quality of life / activities of daily living, cause of pain, relief of pain • Initiation of pain care plan as needed • Implementation of pain care plan • Monitoring frequency of use of analgesic medication • Notifying the attending MD of pain requiring prn (as needed) medication for greater than three consecutive days • Notifying the attending MD of unrelieved pain of 3 or higher on a scale of 1(mild)-10 (continuous/severe) on the pain assessment form • Initiation and implementation of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 157	Continued From page 10 resident #1 frequently (8 out of 10 days) during her stay. Nurse #1 indicated the resident came in for rehab; she had a right hip fracture. She did complain of pain. She had a PRN pain medication and nurse #1 gave the medication as ordered. Nurse #1 indicated some of the side effects of a narcotic pain medication were constipation, lethargy and drowsiness. The nurse stated she did not have any conversations with the physician in regards to the pain med and possible/potential connection to the resident's constipation and abdominal pain. She noted the facility had a BM protocol. The protocol was like a standing order and the nurses would follow the protocol. The nurse would not contact the physician until they had gone all the way thru the protocol and had no results (bowel movements), but that hardly ever happened. Nurse #1 stated she last assessed the resident's abdomen on 1/13/11 and it was "soft, wasn't really hard" and her bowel sounds were hyperactive. During an interview on 2/17/11 at 2:37PM, NA #1 indicated she took care of the resident during her stay. The NA stated the resident was "total care" meaning the staff had to assist her with her activities of daily living. The resident did complain that she could not have a bowel movement. NA #1 reported the resident's concern to the nurse (#1). The NA indicated nurse #1 gave the resident an enema, but she could not recall the exact date. She stated the resident just had "a little watery type" of results from the enema. The resident did not express any relief from receiving the enema. The last time the NA worked with the resident was 1/12/11. The resident kept putting on the call light because she could not move her bowels. An interview was conducted on 2/17/11 at	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* constipation care plan b) Staff Development Coordinator inserviced current Certified Nursing Assistants on 3-1-11 and will repeat in-service on-going for newly hired Certified Nursing Assistants during orientation, Certified Nursing Assistants returning from vacation and leave of absence with regard to: • Pain policy to include reporting to Licensed Nurse when resident experiences pain • Implementation of pain care plan including Certified Nursing Assistants monitoring frequency and amount of bowel movement and documenting accordingly • Certified Nursing Assistants notifying licensed nurse if resident has no bowel movement in	

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
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 157	Continued From page 11 4:33PM with the DON, the administrator and facility consultant #1. The DON indicated when she assessed the resident on 1/12/11 she was in no apparent distress. The DON did not document the assessment in the resident's medical record. Facility consultant #1 stated the staff would not be expected to phone the physician until the bowel protocol was completely done. The reason they had the protocol was so the staff would not have to call the doctor. However, if the resident had severe abdominal pain then she would expect the nurse to phone the physician. During an interview on 2/17/11 at 5:45PM physician #1 (medical director) stated if the facility was having trouble contacting an attending physician then they could always contact him. He would then call the doctor himself. He stated it was a small community and he knew most of the physicians in the immediate area. If the facility had an acute issue/concern then he (as the medical director) would handle it immediately then get in touch with the attending physician. Physician #2 was interviewed on 3/1/11 at 11:28AM. Physician #2 was at the hospital during the time of the interview and referenced the resident's hospital records prior to her coming to the facility. He indicated she had a hip fracture. Physician #2 stated some residents might have been on pain medications all their lives. Sometimes a PRN pain medication becomes a routine medication. The physician indicated he expected the staff would call him or his PA if a resident was utilizing their PRN medication on a routine basis and they would do an evaluation. The physician and/or his PA would try to determine if the medication was effective at relieving the resident's pain. Physician #2	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* three days • Certified Nursing Assistants will document notification on bowel record and licensed nurses will review the bowel record flow book the beginning of each shift • Certified Nursing Assistants encouraging resident to follow prescribed diet. **Systemic Changes:** 1. Pain assessments will be completed by the licensed nurse for all newly admitted residents, all readmitted residents, residents admitted for rehabilitation therapy, and residents admitted with pain medications on admission. Pain assessments will also be initiated with the onset of new pain by the licensed nurse caring for the resident at the time the pain is identified. Pain assessments will be performed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 157	Continued From page 12 expected if a resident did not have a bowel movement after 2-3 days the staff would call and inform him or the PA. He does not remember receiving a call or a fax regarding this resident and her being constipated or having increased pain or a change in the location of her pain. During an interview on 3/1/11 at 11:43AM, physician's assistant (PA) #1 indicated if the staff did get in touch with him in regards to resident #1 (and orders for Anusol/Lactulose) it was probably via fax. He stated he really could not recall/remember anything off hand about the resident. A follow up interview was conducted with physician #2 on 3/3/11 at 10AM. Physician #2 indicated if a resident developed a new problem such as rash, fever, cough, or pain "of course" the physician would want to be notified. He also emphasized when a resident was new to the facility and the physician group did not know them well, they would want them sent to the emergency room for things new onset abdominal pain. If the physician had seen the resident then he would be able to give orders to treat at the facility if able. Physician #2 stated the facility staff should keep trying until they reached either him or the PA. He indicated the evidence of the facility contacting him or the PA would be a fax with a date, signature and instructions on it or if they called him a verbal order with instructions. Physician #2 stated three of the biggest concerns he saw were pain, constipation and dehydration. He indicated constipation was a problem especially with narcotic pain medication administration. The administrator was notified of the I.J. on 3/1/11 at 12:10PM. The facility provided an	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* quarterly and with significant change resulting in pain. 2. Pain monitoring added to the Medication Administration Records for all residents. Residents will be assessed for pain each shift by the licensed nurse and care planned interventions implemented as needed. If pain medication is indicated and the resident has no order for pain medication, the licensed nurse will notify the physician of the new onset of pain and request pain medication. If the resident is experiencing pain at a level 3 with no relief with current plan of care, the assessing nurse will notify the physician for a pain medication order or adjustment of current pain medication dosage as indicated. 3. Care plans will be initiated for all residents with pain. The care plan will include medication interventions as well as non-pharmacological interventions to be attempted prior to medication. Care plans will be revised and evaluated quarterly and with change of condition. 4. Nursing assistants will document	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 157	Continued From page 13 acceptable credible allegation of compliance on 3/3/11 at 12:08PM. The following interventions were put in place: Resident Specific Resident #1 was admitted to the facility on 1/3/2011. Her diagnoses included Comminuted Intertrochanteric right Hip fracture, Rhobdomylosis, HTN, Mild Cognitive Impairment, and Alzheimer's dementia. Her medications included Metoprolol Tartrate, Mirtazepine, Plavix, Prednisone, Lisinopril, Colace, Ferrous Sulfate, and Lortab. She received Lortab for right hip pain once on 1/3, twice on 1/4, 1/5, 1/6, 1/7, 1/8, 1/9, 1/10, 1/11, and 1/13/2011. She received Lortab three times on 1/12/2011. She also experienced hemorrhoid pain on 1/9/2011 and an order was received for Annusol suppositories three times per day as needed. Resident received Colace 100mg two times per day since admission. On 1/9/2011, Lactulose 30cc daily was added to her medication regimen for constipation. On 1/10/2011, Senokot was added one tablet daily for constipation. Resident received Fleets enemas on 1/10/2011 (one) and 1/12/2011 (two). On 1/13/2011, both the resident and her brother requested she be sent to the emergency room for evaluation. She stated, "I don't feel good." Attending physician was notified and order received for resident to be transported to the emergency room. Vital signs were: temperature 97.3, pulse 69, respirations 12, and blood pressure 58/32. Resident had documented bowel movements as follows: 1/5/2011-two soft, medium bowel movements 1/7/2011-one soft, medium bowel movement 1/8/2011-one soft, medium bowel movement	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* bowel movements on bowel monitoring flow sheet. At the end of each shift, the nursing assistants will report off to their supervising licensed nurse for validation the flow book documentation has been completed. Licensed nurses working 7a-3p will review the bowel monitoring flow books and identify residents with no bowel movement in 3 days. These residents will be added to the laxative list for a laxative to be administered on the 3p-11p shift. The laxative list will be passed on to the 11p-7a shift for laxative results to be documented. If results are not achieved within thirty minutes after Fleets enema is administered per bowel protocol, the attending physician or physician on call will be notified for further orders. Once the bowel protocol is implemented, the 24 hour report log will be updated to indicate the bowel protocol has been initiated. The resident will remain on the 24 hour report until the constipation is relieved. 5. Interim Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 157	Continued From page 14 1/9/2011-one soft, small bowel movement 1/10/2011-Senokot one tablet daily was added for constipation; one Fleet's enema 1/11/2011-one hard, medium bowel movement 1/12/2011-one soft, small bowel movement 1/12/2011-two Fleets enemas given with no results documented Resident passed away in the hospital on 1/13/2011. All Other Residents (A) On 3-01-11, Nurse Management team, consisting of Interim Director of Nursing Services (I-DNS), Staff Development Coordinator (SDC) and Minimum Data Set Coordinators (MDSC) performed pain assessments on all residents in house to identify residents with pain. (B) On 3-01-11, Nurse Management team, consisting of Interim Director of Nursing Services (I-DNS), Staff Development Coordinator (SDC) and Minimum Data Set Coordinators (MDSC) performed bowel record review for residents of the facility to also include the look back period to the last documented bowel movement to identify residents with no bowel movement in three days. (A) The resident's primary licensed nurse will be responsible for physician notification via telephone when a residents with a score of 3 or higher on a scale of 1(mild)-10 (continuous/severe) on the pain assessment form, with new orders implemented and care planned by MDSC and or primary licensed nurse, at the time of pain onset. The IDT (Interdisiplinary Team) will validate this process at least 5 times weekly in Clinical Morning Review. Responsible	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* Services (I-DNS), or SDC will review laxative lists daily ongoing to validate laxatives were administered as appropriate and results documented. In the absence of the Interim Director of Nursing Services (DNS) and SDC, the North Hall 7-3 Licensed Nurse will review laxative lists daily on weekends and holidays ongoing to validate laxatives were administered as appropriate and results documented. **Completion date of credible allegation is 3/3/2011.** **Quality Assurance:** The Interim Director of Nursing Services (I-DNS) or SDC will review medical records of newly admitted or readmitted residents daily for three days following admission to validate pain assessments are accurately completed, care plans for pain are implemented as necessary, and residents experiencing pain have pain medication prescribed either PRN or	

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
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 157	Continued From page 15 Party(s) will be notified of new medications or change in dosage of current medication as needed. (B) Bowel Protocol was initiated by the Nurse Management Team, consisting of the Interim Director of Nursing Services (I-DNS), Staff Development Coordinator (SDC) and Minimum Data Set Coordinators (MDSC) for residents noted with no bowel movement in three days. Bowel Protocol states: · On third day with no documented bowel movement give Lactulose 30 cc po (by mouth) or via tube (gastric or peg) prn (as needed) · On fourth day with no documented bowel movement and no results from Lactulose give Dulcolax supp (suppository) pr (per rectum) prn (as needed) · On fifth day with no documented bowel movement and no results from Lactulose or Dulcolax give Fleets Enema pr (per rectum) prn (as needed) · Notify attending physician if no results within 30 minutes of Fleets enema administration. (A) On 3-01-11, Nurse Management team, consisting of Interim Director of Nursing Services (I-DNS), Staff Development Coordinator (SDC) and Minimum Data Set Coordinators (MDSC) implemented, evaluated and / or updated resident care plans to reflect pain as needed concerning all residents in the facility. Careplans are made accessible through the resident's medical record for the licensed nurses and the nursing assistant will obtain any careplan updates in shift report from the licensed nurse on an as needed basis on-going. Pain care plan is inclusive of: · Pain type, chronic, acute, breakthrough, phantom	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* scheduled. These reviews will continue on an ongoing basis. Interim Director of Nursing Services (I-DNS), or SDC will review 24 hour report book daily ongoing to identify residents with new onset of pain. These residents' medical records will be reviewed as well to validate pain assessments are accurately completed, care plans for pain are implemented as necessary, and the physician was notified for pain medication order as needed. Interim Director of Nursing Services (I-DNS), or SDC will audit laxative lists each morning and validate laxatives were given as indicated and results were documented. In the absence of the Interim Director of Nursing Services (I-DNS) and SDC on the weekends and holidays, the 7-3 North Hall Licensed Nurse will review laxative lists daily ongoing to validate laxatives were administered as appropriate and results documented. Results of these audits and medical record reviews will be reported to the facility's Performance Improvement Committee monthly x 6 months for review, evaluation and further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 157	Continued From page 16 · Pain symptoms: crying / moaning, facial grimace, guarding, complaints of pain, decrease in functional level, inability to sleep, limiting activities, not eating · Licensed Nursing Staff monitoring residents for pain each shift. Attending physicians when signs and symptoms of pain, worsening pain, reporting changes in pain location / type / frequency / intensity of pain to physician · Providing non-pharmacological comfort measures including relaxation techniques, deep breathing, repositioning, activities as appropriate · Monitoring for side effects including Licensed Nurses to monitor for signs and symptoms of constipation, Licensed Nurses and Certified Nursing Assistants monitoring and documenting bowel movements · Administering and monitoring for effectiveness and for possible side effects from pain medication · Pain Assessment to be completed on admission, quarterly and with significant change in status · Education with resident and family members as needed about comfort measures, analgesic medications, fear and concerns regarding pain · Certified Nursing Assistants will verbally notify licensed nurse if resident has no bowel movement in three days · Certified Nursing Assistants will document notification on bowel record and licensed nurses will review the bowel record flow book the beginning of each shift. · Licensed Nurses administering stool softeners and laxatives per MD orders · Licensed Nurses encouraging fluid and fiber · Certified Nursing Assistant encouraging resident to follow prescribed diet	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* 3. DNS and interdisciplinary team (IDT) will review the 24 hour report book daily ongoing to identify residents with new onset of behaviors and change in condition. The medical records of these identified residents will be reviewed by the DNS and IDT to validate clinical assessment has been completed and documented by the staff nurse, physician notified of the behaviors and change in condition, and new orders implemented as appropriate. DNS will maintain a log of these identified residents and continue to follow-up daily until change in condition is resolved and behaviors have subsided. These identified residents will remain on the 24 hour report until stabilized. 4. Log of residents with new onset of behaviors while experiencing a change in condition will be reviewed by the facility's Performance Improvement Committee monthly x 3 months for further recommendation and to validate continued compliance. 1. Resident #11continues on Coumadin and has labs ordered as directed by physician. Unable to correct areas identified as they are past occurrences. 2. Residents requiring PT/INR testing to monitor the use of Coumadin	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 157	Continued From page 17 (B) On 3-01-11, Nurse Management team, consisting of Interim Director of Nursing Services (I-DNS), Staff Development Coordinator (SDC) and Minimum Data Set Coordinators (MDSC) implemented, evaluated and / or updated resident care plans related to constipation as needed. Constipation care plan is inclusive of: · Certified Nursing Assistants monitoring and documenting bowel movements every shift · Certified Nursing Assistants will verbally notify licensed nurse if resident has no bowel movement in three days · Certified Nursing Assistants will document notification on bowel record and licensed nurses will review the bowel record flow book the beginning of each shift. · Licensed Nurses administering stool softeners and laxatives per MD orders · Licensed Nurses encouraging fluid and fiber as appropriate · Certified Nursing Assistant encouraging resident to follow prescribed diet · Notification of Registered Dietician for evaluation of diet and fluid intake / offerings, resident likes and dislikes, and recommendations for food and /or fluids to promote regular bowel elimination Education was initiated by: Staff Development Coordinator inserviced current licensed nursing staff on 3-1-11 and will repeat in-service on-going for newly hired licensed nurses during orientation, licensed nurses returning from vacation and leave of absence with regard to pain policy to include: · Assessment of resident pain including	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* have the potential to be affected. Licensed nursing staff were in-serviced by the Staff Development Coordinator (SDC) on revised protocol for scheduling and obtaining laboratory tests. Newly hired licensed staff will receive this training upon hire. Residents receiving Coumadin were identified through medical record review. Medical records of these identified residents were also reviewed to validate a current PT/INR was available and a physician's order for PT/INR frequency was present. Residents with no current PT/INR results or no physician order for PT/INR frequency were identified, the attending physician notified, and orders implemented as received. Lab calendar was reviewed by the Director of Nursing Services (DNS) to validate PT/INRs were scheduled as per MD orders. 3. Residents requiring PT/INR testing to monitor the use of Coumadin have the potential to be affected. Licensed nursing staff were in-serviced by the Staff Development Coordinator (SDC) on revised	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 157	Continued From page 18 location, duration, frequency, time of day pain generally occurs, feeling of pain (internal, external, acute, chronic), severity of pain verbal pain scale (if resident able to respond) and non-verbal pain scale, pain type / intensity, other non-verbal cues (facial expressions, vocalizations, body actions / observed behaviors), pain affecting resident's quality of life / activities of daily living, cause of pain, relief of pain · Initiation of pain care plan as needed · Implementation of pain care plan · Monitoring frequency of use of analgesic medication · Notifying the attending MD of pain requiring prn (as needed) medication for greater than three consecutive days · Notifying the attending MD of unrelieved pain of 3 or higher on a scale of 1(mild)-10 (continuous/severe) on the pain assessment form · Initiation and implementation of constipation care plan Staff Development Coordinator inserviced current Certified Nursing Assistants on 3-1-11 and will repeat in-service on-going for newly hired Certified Nursing Assistants during orientation, Certified Nursing Assistants returning from vacation and leave of absence with regard to: · Pain policy to include reporting to Licensed Nurse when resident experiences pain · Implementation of pain care plan including Certified Nursing Assistants monitoring frequency and amount of bowel movement and documenting accordingly · Certified Nursing Assistants notifying licensed nurse if resident has no bowel movement in three days · Certified Nursing Assistants will document notification on bowel record and licensed nurses will review the bowel record flow book the	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* protocol for scheduling and obtaining laboratory tests. Newly hired licensed staff will receive this training upon hire. Residents receiving Coumadin were identified through medical record review. Medical records of these identified residents were also reviewed to validate a current PT/INR was available and a physician's order for PT/INR frequency was present. Residents with no current PT/INR results or no physician order for PT/INR frequency were identified, the attending physician notified, and orders implemented as received. Lab calendar was reviewed by the Director of Nursing Services (DNS) to validate PT/INRs were scheduled as per MD orders. 4. Individual Coumadin logs will be reviewed by the facility's Performance Improvement Committee monthly x 3 months for further recommendation and validation of continued compliance. .	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 157	Continued From page 19 beginning of each shift · Certified Nursing Assistants encouraging resident to follow prescribed diet. Systemic Changes: 1. Pain assessments will be completed by the licensed nurse for all newly admitted residents, all readmitted residents, residents admitted for rehabilitation therapy, and residents admitted with pain medications on admission and daily for three days following admission to ensure residents experiencing pain are identified. Pain assessments will also be initiated with the onset of new pain by the licensed nurse caring for the resident at the time the pain is identified. Pain assessments will be performed quarterly and with significant change resulting in pain. 2. Pain monitoring added to the Medication Administration Records for all residents. Residents will be assessed for pain each shift by the licensed nurse and care planned interventions implemented as needed. If pain medication is indicated and the resident has no order for pain medication, the licensed nurse will notify the physician of the new onset of pain and request pain medication. If the resident is experiencing pain at a level 3 with no relief with current plan of care, the assessing nurse will notify the physician for a pain medication order or adjustment of current pain medication dosage as indicated. The nurse initiating the physician notification will document the resident ' s pain and pending physician notification on the 24 hour report log. The resident will remain on the 24 hour report book until physician has responded. 3. Care plans will be initiated for all residents with pain. The care plan will include medication interventions as well as non-pharmacological	F 157	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* 1.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 157	Continued From page 20 interventions to be attempted prior to medication. Care plans will be revised and evaluated quarterly and with change of condition. 4. Nursing assistants will document bowel movements on bowel monitoring flow sheet. At the end of each shift, the nursing assistants will report off to their supervising licensed nurse for validation the flow book documentation has been completed. Licensed nurses working 7a-3p will review the bowel monitoring flow books and identify residents with no bowel movement in 3 days. These residents will be added to the laxative list for a laxative to be administered on the 3p-11p shift. The laxative list will be passed on to the 11p-7a shift for laxative results to be documented. If results are not achieved within thirty minutes after Fleets enema is administered per bowel protocol, the attending physician or physician on call will be notified for further orders. Once the bowel protocol is implemented, the 24 hour report log will be updated to indicate the bowel protocol has been initiated. The resident will remain on the 24 hour report until the constipation is relieved. 5. Interim Director of Nursing Services (I-DNS), or SDC will review laxative lists daily ongoing to validate laxatives were administered as appropriate and results documented. In the absence of the Interim Director of Nursing Services (DNS) and SDC, the 3-11 West Hall Licensed Nurse will review laxative lists daily ongoing to validate laxatives were administered as appropriate and results documented. Completion date of credible allegation is 3/3/2011.	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 157	Continued From page 21 Quality Assurance: The Interim Director of Nursing Services (I-DNS) or SDC will review medical records of newly admitted or readmitted residents daily for three days following admission to validate pain assessments are accurately completed, care plans for pain are implemented as necessary, and residents experiencing pain have pain medication prescribed either PRN or scheduled. These reviews will continue on an ongoing basis. Interim Director of Nursing Services (I-DNS), or SDC will review 24 hour report book daily ongoing to identify residents with new onset of pain. These residents ' medical records will be reviewed as well to validate pain assessments are accurately completed, care plans for pain are implemented as necessary, and the physician was notified for pain medication order as needed. Interim Director of Nursing Services (I-DNS), or SDC will audit laxative lists each morning and validate laxatives were given as indicated and results were documented. In the absence of the Interim Director of Nursing Services (I-DNS) and SDC on the weekends and holidays, the 7-3 North Hall Licensed Nurse will review laxative lists daily ongoing to validate laxatives were administered as appropriate and results documented. Results of these audits and medical record reviews will be reported to the facility ' s Performance Improvement Committee monthly x 6 months for review, evaluation and further recommendation. Verification of the credible allegation was evidenced by interviews of direct care staff relating to training and in-services received regarding pain assessment, bowel management	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 157	Continued From page 22	F 157		

and physician notification. All direct care staff interviewed on 3/3/11 were knowledgeable about the facility's bowel protocol, how resident changes are to be communicated and reported (to each other and the physician). The monitoring tools included a skills validation form which included pain management and the bowel protocol and a form to document audits and corrective measures taken when negative findings are noted during facility audits.

2. Resident #11 was admitted to the facility on 9/28/10. Her diagnoses included cerebrovascular accident, hypertension, atrial fibrillation, and dementia.

Review of the physician order for January 2011 revealed the following orders, "Check PT/INR Q (every) Monday" and "PT/INR Q Monday and Thursday." Resident #11 was also receiving Coumadin 2mg (milligrams) PO (by mouth) QD (every day).

On 1/12/11 a PT/INR was drawn on resident #11. The results were reported to the facility on 1/13/11. The PT was 16.4 (range 11.6-15.2) the INR was 1.33 (therapeutic range was generally 2.0 to 3.0). Nurse #3 signed, initialled and dated the results on 1/13/11. She noted physician #2 was faxed and called. There was no notation from the physician on the form.

The February 2011 physician orders revealed the following orders, "Check PT/INR Q Monday." Resident #11 was also receiving Coumadin 2 mg PO QD.

A nurse's note (written by nurse #3) dated 2/4/11 read in part, "(name of physician #2) called

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 157	Continued From page 23 regarding PT/INR drawn 1-12-11- no response to fax or call made on 1-13-11. (name of physician #2) ordered stat PT/INR and will regulate times PT to be drawn." During an interview on 2/17/11 at 5:45PM physician #1 (medical director) stated if the facility was having trouble contacting an attending physician then they could always contact him. He would then call the doctor himself. He stated it was a small community and he knew most of the physicians in the immediate area. If the facility had an acute issue/concern then he (as the medical director) would handle it immediately then get in touch with the attending physician. During an interview, on 3/3/11 at 10AM, physician #2 indicated he wanted resident #11's PT and INR closely because it was not at a therapeutic level. He stated he wanted the INR to be between 2-3 and he would monitor the PT/INR either once a week or twice a week. Once the resident started reaching therapeutic levels, he would monitor every other week. The longest stretch would be 4 weeks and that would only be once the resident was in the therapeutic range of 2-3 (for the INR). Physician #2 stated whenever a resident had a change in Coumadin dosing they would require close monitoring as well until the resident was within what the physician considered a therapeutic range. The physician indicated if the facility staff could not reach him by fax or phone, they should try again. The facility staff could also attempt to reach his physician assistant (PA). Physician #2 stated the facility staff should keep trying until they reached either him or the PA. He indicated the evidence of the facility contacting him or the PA would be a fax with a date, signature and instructions on it or if they called	F 157		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 157	Continued From page 24 him a verbal order with instructions. The interim Director of Nursing (DON) was interviewed on 3/3/11 at 11:09AM. She indicated she just became responsible for monitoring lab results about 1 week ago. The former assistant DON and former DON were responsible before and she could not answer for their actions. The interim DON's understanding of lab monitoring at this point was, the labs were written on a calendar. The lab company came usually on Tuesday, Wednesday, and Thursday. When verbal orders were written the interim, DON would receive the green carbon copy. Once the labs were back from the lab company, the interim DON would pass them out to the floor nurses. The nurses were responsible for contacting the physicians. Many of the physicians prefer faxes instead of phone calls. If the labs were, critical levels the interim DON indicated the nurse should keep trying to reach the physician. The nurse should then inform the DON if they cannot reach the physician. The administrator would then get involved if the DON could not reach the physician. During an interview, on 3/3/11 at 11:12AM, nurse #3 indicated once she calls the physician or the PA the first time she usually waits a day then tries again. She stated she usually notified the DON if she could not get in touch with a physician. The DON in January 2011 was not available for comment. Nurse #3 could not provide a clear explanation for why the PT/INR from 1/12/11 was not re-addressed with the physician until 2/4/11. She stated when/if she catches "it", she calls/faxes the physician again.	F 157		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES	F 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 242	Continued From page 25 The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to offer showers to 2 of 2 residents (#7 and #12) on their scheduled shower days. Findings include: 1. Resident #7 was admitted to the facility on 7/26/10 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD). The quarterly Minimum Data Set (MDS) dated 12/27/10 Brief Interview of Mental Status (BIMS) revealed Resident #7's cognition was intact. The MDS also revealed Resident #7 needed total assistance with transfers and physical help in part of bathing activity with one person assistance. The Care Plan dated 12/29/10 revealed "Self-Care Deficit bathing/showers," "will continue to Bathe self with extensive assistance," "shampoo, shower/bath daily " and "set up bathing supplies encourage to complete task and assist as needed with extensive assist." A review of the Activity Daily Living (ADL) sheet from October-February revealed Resident#7 had received a "Bed Bath" (BB). There was no Showers (S) documented on the ADL sheet. The back section of the ADL sheet where comments would be documented revealed there were no	F 242	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* 1. Residents #7 and #12 bathing preferences identified through resident and family interviews. Bathing preferences added to the resident care cards and care plans. Primary nursing assistants for Resident's #7 and #12 were in-serviced on resident's choices with specific focus to resident's bathing preference and on facility bathing schedule. 2. Residents residing in the facility have the potential to be affected. Certified nursing assistants and licensed nurses in-serviced on resident choices with specific focus to resident bathing preference. Newly hired nursing assistants and licensed nurses will be in-serviced on resident choices in new employee orientation with specific focus to resident bathing preference upon hire. Shower/bath schedule also in-serviced to assure residents are offered baths/showers as scheduled. Resident care cards updated to reflect residents' bathing preferences. 3. Certified nursing assistants to review care cards daily for any changes to resident's method of care and are encouraged to collaborate with primary nurse of resident when changes to the resident care card is needed. Resident	F 242 4/04/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 242	Continued From page 26 comments about showers. A review of the nurse's note from January through February revealed Resident #7 had not refused showers. On 2/27/11 at 7:08 pm an interview was conducted with Resident #7. Resident #7 stated staff gives her a bed bath. Resident #7 revealed she would like to receive a shower, but she could not walk. Resident #7 revealed staff never offered her a shower. On 3/1/11 at 11:04 am Resident #7 was observed in the door way of her room. The resident was exiting her room. Resident #7 hair appeared to be damp. The resident stated she had a bed bathe. 2. Resident #12 was admitted to the facility on 6/18/2008 with a diagnosis of Hypertension. The quarterly Minimum Data Set (MDS) dated 2/8/11 revealed resident # 12 Brief interview for Mental Status (BIMS) revealed the resident was cognitively intact. The MDS also revealed Resident #12 was "totally dependent" for transfers, needed extensive assistance for getting dressed and personal hygiene. The Care plan dated 2/23/11 revealed "Self-Care Deficit: Hygiene/Bathing/Showers," "Extensive Assistance with Grooming/Hygiene/Bathing " and "Shampoo, Shower/Bath daily." A review of the nurse's note from January through February revealed Resident #12 had not refused showers. A review of the Activity Daily Living (ADL) sheet from October-February reviewed Resident#12	F 242	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* care cards will be updated as needed in clinical morning review at least 5x weekly by Nursing Administration Team (Director of Nursing, Staff Development Coordinator, Unit Managers, MDS Coordinator [DNS,UMs, SDC, MDSC]). Additional review of resident care cards will occur monthly at end of month medication order re-capitulation. DNS, and or SDC, and or UMs will audit certified nursing assistant flow records to assure that baths or showers are being given as scheduled and residents are offered desired bathing preference. Audits will occur 5x weekly x 2 weeks, 2x weekly x 3 weeks, once weekly x 3 months. 4. These audits will be reviewed in facility's monthly Performance Improvement (PI) meeting and subsequent plans and interventions will be developed as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 242	Continued From page 27 had received a "Bed Bath" (BB). There was no Showers (S) documented on ADL sheet. The back section of the ADL sheet (where comments would be documented) revealed there were no comments about showers. A review of the Shower schedule for Resident #7 revealed showers was giving on Tuesday and Friday. The resident's shower days were scheduled Monday-Saturday. There were no showers provided on Sundays. On 3/1/11 at 8:31 am an interview was conducted with NA#11. The NA discussed how non-ambulatory residents were provided with showers. The NA stated the residents were provided with "shower chairs" and "shower beds" where the water can run down on the resident. The NA revealed "showers should be offered" on shower days. The NA stated if resident refused shower, she would offer shower later on that day. On 3/1/11 at 9:00am an interview was conducted with Nurse#3. The nurse discussed refusing showers. The nurse revealed NA would inform the nurse, another staff would attempt encourage resident to take a shower; if resident continued to refuse shower, and NA would document it on ADL flow sheet. The nurse revealed NA needed to continue to offer showers "cause residents might change their minds." On 3/3/11 at 8:45am an interview was conducted with Interim Director of Nursing (IDON). IDON revealed her expectations would be to provide showers according to facilities policy. IDON stated if it was not resident's shower day, then a bed bath should be provided to them.	F 242	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.*	

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
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observations, resident interviews, family interviews, staff interviews and record review the facility failed to maintain an environment free from lingering odors on 3 of 4 halls. Findings include: Review of the resident council minutes from 10/11/10 revealed under the new business section, the majority of residents attending meeting request that hallways be sprayed (deodorize) more after a resident was changed. Strong odors of bowel movements were left behind. Review of the resident council minutes from 11/5/10 revealed under the old business section, listed as "resolved", was the odor concern from the 10/11/10 meeting. The note reflected the housekeeping manager met with staff and an extra supply of deodorizers were purchased and used. The deodorizers were to be used in resident rooms and the hallways after incontinent care was done. Upon entering the facility on 2/27/11 at 6PM a strong lingering odor of stool was noted on the	F 252	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* 1. Administrator and Housekeeping Supervisor met with Resident Council and responsible party of resident #11 to discuss interventions to prevent and minimize odors in facility. 2. Housekeeping and nursing staff in-serviced on proper barrel identification to assure disposal of trash and or resident soiled briefs/material(s) is placed in proper receptacle and the importance of emptying these receptacles when full and or odorous. Maintenance Director installed deodorizers through out facility to assist with odor neutralization. Maintenance Director has also identified and replaced odorous tile in resident areas to assist with reduction of odors. Housekeeping Supervisor devised schedule to disinfect the facility barrels to assist with odor elimination. Housekeeping staff in-serviced on this schedule. 3. Facility rounds to be conducted by Administrator and facility department head members at least twice per shift for 7-3 and 3-11 shifts when odors are most concentrated. Facility audits will continue twice daily for 3 months. 4. Facility audits to be reviewed in	F 252 4/04/2011

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
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 252	Continued From page 29 400 and 300 halls. The evening meal was being served. During the initial tour on 2/27/11 at 6:30PM resident # 12 indicated she noticed a "smell" when she would go up and down the hall. She described the "smell" as being like a "bowel movement." She wished the facility would give the resident air fresheners to use in their rooms. On 2/27/11 at 6:42PM a yellow barrel labeled "trash" and a gray barrel labeled "linen" were present on the 400 hall. There was a strong urine and feces odor present. The 400 hall has a lingering odor of urine and feces at 7:30PM on 2/27/11. The yellow and gray barrels are present on the hallway. On 2/27/11 at 10:21PM the far end of the 400 hallway, by the west solarium had a lingering odor of feces. Upon entering the facility on 2/28/11 at 2PM a faint orange smell was noted over a foul odor in the lobby area. Traveling down the 400 hallway was a lingering strong feces odor. On 2/28/11 at 4:34PM a strong lingering feces odor on the far end of the 400 hall by the west solarium. During an interview on 2/28/11 at 5:04PM, nursing assistant (NA) #10 indicated the yellow and gray barrels can be on the halls if the lids were closed. After doing incontinent care tied up bags should be brought out of the resident rooms. One would have soiled linens and be placed in the gray barrel and the other would have a soiled	F 252	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* monthly Performance Improvement (PI) x 3 months. Subsequent plans and interventions will be developed and implemented as needed to assure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 252	Continued From page 30 During an interview on 2/28/11 at 5:04PM, nursing assistant (NA) #10 indicated the yellow and gray barrels can be on the halls if the lids were closed. After doing incontinent care tied up bags should be brought out of the resident rooms. One would have soiled linens and be placed in the gray barrel and the other would have a soiled brief and be placed in the yellow barrel. For the evening shift the barrels are emptied at 3PM and 6PM. To her knowledge they were not emptied after 6PM on the evening shift. NA #10 indicated she noticed odors if a resident had certain health conditions like moving their bowels after eating certain types of foods. The NA had no knowledge of the resident council resolution regarding the use of deodorizers after incontinent care in resident rooms and hallways. A foul smell was noted at the central nurse's station on 2/28/11 at 5:30PM. A strong urine odor was noted at the end of the 400 hall by the west solarium on 2/28/11 at 6:30PM. During an interview, on 3/1/11 at 9:35AM the administrator indicated she would like the facility to be free from odors. She stated the nursing assistants have access to deodorizing spray they can use and the nursing assistants would usually keep the spray in an area not accessible by the residents for safety purposes. An interview was conducted with housekeeper (HK) #1 on 3/1/11 at 8:20AM. HK #1 stated one housekeeper was assigned to each of the four halls during the day shift. The HK duties included going into the resident rooms and cleaning/wiping down the furniture and fixtures. She stated the HK	F 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 252	Continued From page 31 also emptied the trash in the resident rooms. HK #1 indicated she also worked in the laundry department. The laundry department was responsible for maintaining and emptying the gray linen barrels on the halls. She stated the laundry department probably emptied the linen barrels about "10 to 15" times during the day shift. She indicated the linen barrels were not emptied again until 2AM when the morning laundry shift arrived. HK #1 stated the floor technician was responsible for emptying the yellow trash barrels. She was not sure how many times per shift the trash barrels were emptied. Each hall had two linen barrels and two trash barrels. When the barrels were on the hall, the lids were supposed to be on. There was a lingering urine and stool odor on the 400 hall on 3/1/11 at 8:35AM. During an interview, on 3/1/11 at 8:59AM, the housekeeping supervisor stated he also performed the duties of the floor technician at times. He was performing the dual role that day. The floor technician's job duties included, buffing and moping the floors, sweeping the floors and emptying the trash. He indicated the trash was pulled multiple times during the day and whenever necessary. The housekeeping manager stated his staff used an odor neutralizer as well as bleach to control odors in the facility. The housekeeping staff would come and spray rooms if the nursing assistants would call them. He was not aware of the resident council concerns from 10/11/10 or the resolution to the council concerns on 11/5/10. He indicated the facility did have time released air fresheners in the hallways but they were taken down before he began employment.	F 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 252	Continued From page 32 A family member for resident #11 was interviewed on 3/2/11 at 8:59AM. The family member stated the facility had a "terrible smell." Once the family member hit the nurse's station, it smelled like urine. When the family member walked down the hallway, it smelled like stool and urine (300 hall). When the family member brings the concern to the attention of the facility staff, they indicate they will "take care of it" but the odor continues. Upon entrance to the facility on 3/3/11 at 5:35AM, a strong urine odor was noted at the central nurse's station. On 3/3/11 at 5:40AM, a gray linen barrel was observed on the 400 hall. The lid was closed. Tied to the handle of the gray barrel was a large clear open trash bag. Inside the trash bag were soiled briefs. There were soiled briefs loose in the clear open trash bag and there were a few soiled briefs in separate smaller clear trash bags. There was a heavy strong lingering urine odor surrounding the gray barrel, open clear trash bag and extending down the 400 hallway. The 100 hall had a strong urine odor on 3/3/11 at 5:50AM. A gray barrel was observed on the 300 hall on 3/3/11 at 6:15AM. The lid was closed. Tied to the handle was a clear open trash bag. Most of the soiled briefs in the bag were in separate clear trash bags. There was a strong heavy urine odor surrounding the gray barrel and traveling down the hall. During an interview on 3/3/11 at 6:35AM, NA #6 indicated she had run out of the small clear trash bags and that was why she could not individually	F 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 252	Continued From page 33 bag the soiled briefs. However, she stated she could obtain the small clear trash bags from the laundry staff who came in at 2AM and could not provide any further explanation why she did not. NA #6 indicated the night shift always tied the clear bag to the gray linen barrel and disposed of the soiled briefs in the clear bag. A follow up interview was conducted with the housekeeping manager on 3/3/11 at 9:44AM. The housekeeping manager indicated the staff should be using the yellow barrel to dispose of soiled briefs and the gray barrels to dispose of soiled linens. The lids should be closed.	F 252	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.*	
F 309 SS=J	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on staff interviews, family interviews, physician interviews and record review the facility failed to assess new onset abdominal pain with associated constipation and failed to assess the resident's pain management program for 1 of 4 sampled residents (Resident #1) resulting in hospitalization. Furthermore, the facility failed to monitor the bowel movements and implement their bowel protocol as written to prevent constipation for 1 of 4 sampled residents (Residents #8). The facility failed to assess and	F 309	Resident Specific Resident #1 was admitted to the facility on 1/3/2011. Her diagnoses included Comminuted Intertrochanteric right Hip fracture, Rhobdomylosis, HTN, Mild Cognitive Impairment, and Alzheimer's dementia. Her medications included Metoprolol Tartrate, Mirtazepine, Plavix, Prednisone, Lisinopril, Colace, Ferrous Sulfate, and Lortab. She received Lortab for right hip pain once on 1/3, twice on 1/4, 1/5, 1/6, 1/7, 1/8, 1/9, 1/10, 1/11, and 1/13/2011. She received Lortab three times on 1/12/2011. She also experienced hemorrhoid pain on 1/9/2011 and an order was received for Annusol suppositories three times per day as needed. Resident received Colace 100mg two times per day since admission. On 1/9/2011, Lactulose 30cc daily was added to her medication regimen for constipation. On 1/10/2011, Senokot was added one tablet daily for constipation. Resident received Fleets enemas on 1/10/2011 (one) and 1/12/2011 (two). On 1/13/2011, both the resident and her brother requested she be sent to the emergency room for evaluation. She stated, "I don't feel good." Attending physician was notified and order received for resident to be transported to the emergency room. Vital	F 309 4/04/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 34 recognize the relationship between a new onset of behaviors and clinical change in condition for 1 of 1 sampled resident (resident #3). Immediate Jeopardy (IJ) began on 1/3/11 for resident #1. The immediate jeopardy for resident #1 was identified on 3/1/11 and was removed on 3/3/11, when the facility demonstrated it had implemented their credible allegation of compliance. The facility was left out of compliance at no actual harm with potential for more than minimal harm that is not immediate jeopardy (D) so that completion of staff in-services and incorporation of monitoring systems could be accomplished and included in the Quality Assurance Program. Findings include: The facility "Bowel Protocol" dated 8/09 read in part, "1. Lactulose 30cc (cubic centimeters) on 3rd day with no BM (bowel movement). 2. Dulcolax Suppository PR (per rectum) on 4th day with no BM and no results from Milk of Magnesia. 3. Fleets enema PR on 5th day with no BM and no results from Milk of Magnesia or Dulcolax Suppository." 1.Resident #1 was admitted to the facility on 1/3/11 with diagnoses including a right hip fracture, rhabdomyolysis (rapid breakdown of skeletal muscle due to damage to muscle tissue), hypertension, and mild cognitive dysfunction. The undated, unsigned "Pain Assessment" had the following handwritten in the "location" section, "No c/o (complaint) pain - on admission soreness R (right) hip." The "severity" section was not completed. Further review revealed the "pain	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* signs were: temperature 97.3, pulse 69, respirations 12, and blood pressure 58/32. Resident had documented bowel movements as follows: 1/5/2011-two soft, medium bowel movements 1/7/2011-one soft, medium bowel movement 1/8/2011-one soft, medium bowel movement 1/9/2011-one soft, small bowel movement 1/10/2011-Senokot one tablet daily was added for constipation; one Fleet's enema 1/11/2011-one hard, medium bowel movement 1/12/2011-one soft, small bowel movement 1/12/2011-two Fleets enemas given with no results documented Resident passed away in the hospital on 1/13/2011. All Other Residents 1. (A) On 3-01-11, Nurse Management team, consisting of Interim Director of Nursing Services (I-DNS), Staff Development Coordinator (SDC) and Minimum Data Set Coordinators (MDSC) performed	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 35 type/intensity" , "other non-verbal", "quality of life/activities of daily living", "cause of pain", "relief of pain" and "conclusion" sections were not completed. Nurse #2 was interviewed on 2/17/11 at 3:30PM. Nurse #2 admitted the resident to the facility on 1/3/11. She indicated the resident wasn't having a whole lot of pain in the first day. Then around the second or third day she would just scream when you touched her. The staff was not sure if maybe the resident did not want to go to therapy and that was the reason for her behavior. Therapy would come to work with the resident and she would just scream. The nurse stated she was responsible for the initial pain assessment and could not provide a reason for the incomplete pain assessment. Review of the undated care plans found no plan of care for pain or potential side effects from narcotic pain medication (constipation). Review of her hospital records prior to her admission to the facility found no noted issues with constipation. Resident #1's physician orders for January 2011 revealed the resident was ordered to receive Ferrous Sulfate 325 mg (milligrams) twice daily and Colace (a stool softener) 100mg twice daily. The resident was also ordered Lortab (Hydrocodone/Acetaminophen) 5mg/325mg 1 tab every 4 hours as needed. Lexi-Comp's Geriatric Dosage Handbook, 15th edition, revealed Lortab was an Opioid narcotic for treatment of moderate to severe pain. Under the "Adverse Reactions - Gastrointestinal (GI)" section the following were noted, abdominal pain and constipation. The section "Special Geriatric	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* pain assessments on all residents in house to identify residents with pain. (B) On 3-01-11, Nurse Management team, consisting of Interim Director of Nursing Services (I-DNS), Staff Development Coordinator (SDC) and Minimum Data Set Coordinators (MDSC) performed bowel record review for residents of the facility to also include the look back period to the last documented bowel movement to identify residents with no bowel movement in three days. 2. (A) The resident's primary licensed nurse will be responsible for physician notification via telephone when a residents with a score of 3 or higher on a scale of 1(mild)-10 (continuous/severe) on the pain assessment form, with new orders implemented and care planned by MDSC and or primary licensed nurse, at the time of pain onset. The IDT (Interdisiplinary Team) will validate this process at least 5 times weekly in Clinical Morning Review. Responsible	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 36 Considerations" it was noted the elderly might be particularly susceptible to the CNS (central nervous system) depressant action (sedation, confusion) and the constipating effects of narcotics. Ferrous Sulfate was used to prevent iron-deficiency anemia. Under the "Adverse Reactions - Gastrointestinal" section the following were noted, constipation, dark stools, epigastric pain, GI irritation, nausea and stomach cramping, Review of the nurse's notes, dated 1/3/11, revealed at 3PM the resident was "alert and oriented." Her abdomen was soft with bowel sounds in all four quadrants. Later on 1/3/11 at 9:30PM the resident requested a Lortab for pain in her right hip. The effectiveness of the pain medication was not evaluated. Review of the resident's "Bowel Record" for 7-3 shift revealed she had no noted bowel movements on 1/3/11 and 1/4/11. On 1/4/11 at 6AM it was noted the resident was awake, alert and voiced no complaints. A note on the same day at 4:20PM noted the resident had requested a Lortab with "effective" results. The nurse's note at 10PM that day revealed the resident rested in bed and was able to make her needs known. She requested a Lortab at bedtime for right hip discomfort. The effectiveness of the pain medication was not evaluated. The resident had 2 medium soft bowel movements on dayshift of 1/5/11. Resident #1 received a dose of Lortab on 1/5/11 during the dayshift. The reason for the dose, the time of the dose, and the effectiveness of the medication were not noted.	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* Party(s) will be notified of new medications or change in dosage of current medication as needed. (B) Bowel Protocol was initiated by the Nurse Management Team, consisting of the Interim Director of Nursing Services (I-DNS), Staff Development Coordinator (SDC) and Minimum Data Set Coordinators (MDSC) for residents noted with no bowel movement in three days. Bowel Protocol states: • On third day with no documented bowel movement give Lactulose 30 cc po (by mouth) or via tube (gastric or peg) prn (as needed) • On fourth day with no documented bowel movement and no results from Lactulose give Dulcolax supp (suppository) pr (per rectum) prn (as needed) • On fifth day with no documented bowel movement and no results from Lactulose or Dulcolax give Fleets Enema pr (per rectum) prn (as needed) • Notify attending physician if no results within 30 minutes of Fleets enema administration	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 37 A nurse's note dated 1/5/11 at 10PM noted the resident remained, alert, able to make needs known, pleasant and cooperative. She requested a Lortab at bedtime. The effectiveness of the pain medication was not evaluated. The reason for the medication was not noted. The nurse's notes, dated 1/6/11 revealed no concerns with pain or discomfort. However, the medication administration record (MAR) revealed on 1/6/11 the resident received two doses of her pain medication. One was on dayshift at an unknown time for an unknown reason. The effectiveness was not evaluated. At 8:30PM resident #1 was medicated with Lortab for right hip pain. The effectiveness was not evaluated. Review of the resident's "Bowel Record" for 7-3 shift revealed she had no noted bowel movements on 1/6/11. On 1/7/11 at 12:40AM the resident had bleeding from a tiny pinpoint area on her right upper arm. The resident indicated she had pulled of a scab. She voiced no complaints with pain or discomfort. A nurse's note dated 1/7/11 at 4PM reflected a family member informed the staff the resident was "hurting" and could not tolerate sitting in her wheelchair. The medication administration record (MAR) did reflect the resident received a Lortab on dayshift. The dose and time were not noted on the back of the MAR. The effectiveness was not evaluated. The MAR reflected the resident received a dose	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* 3. (A) On 3-01-11, Nurse Management team, consisting of Interim Director of Nursing Services (I-DNS), Staff Development Coordinator (SDC) and Minimum Data Set Coordinators (MDSC) implemented, evaluated and / or updated resident care plans to reflect pain as needed concerning all residents in the facility. Careplans are made accessible through the resident's medical record for the licensed nurses and the nursing assistant will obtain any careplan updates in shift report from the licensed nurse on an as needed basis on-going. Pain care plan is inclusive of: • Pain type, chronic, acute, breakthrough, phantom • Pain symptoms: crying / moaning, facial grimace, guarding, complaints of pain, decrease in functional level, inability to sleep, limiting activities, not eating a) Licensed Nursing Staff monitoring residents for pain each shift. Attending physicians when signs and symptoms of pain, worsening pain, reporting changes	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 38 of Lortab at 8:30PM on 1/7/11 for right hip pain. The effectiveness of the medication was not evaluated. The resident had one medium soft bowel movement on 1/7/11 and 1/8/11 during dayshift. Resident #1 received a Lortab at 4:55AM on 1/8/11 for complaint "pain." There was no follow up to evaluate the effectiveness of the medication. On 1/8/11 at 1:30PM the resident was alert and responsive, with no distress noted, per the nurse's note. The MAR reflected the resident received a Lortab for rectal pain at 9PM on 1/8/11. The effectiveness of the medication was not evaluated. The "C.N.A. Flow Record" noted on 1/8/11 (11pm-7am shift) the resident was on and off the bedpan and voided yellow urine. The nursing assistant (NA) noted the resident seemed "happy and resting well." The MAR noted the resident received Lortab at 4AM for complaint of rectal pain. It was noted as being "effective." On 1/9/11 at 12:50PM the nurse's notes reflected the resident was complaining of hemorrhoids hurting. A verbal order was received from the physician assistant for "Anusol HC (Hydrocortisone Cream) suppository 1 to 2 pr (per rectum) TID (three times daily) for hemorrhoidal pain prn (as needed)." The resident received a Lortab and Anusol HC for "rectal" pain at 12PM.	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* in pain location / type / frequency / intensity of pain to physician • Providing non-pharmacological comfort measures including relaxation techniques, deep breathing, repositioning, activities as appropriate • Monitoring for side effects including Licensed Nurses to monitor for signs and symptoms of constipation, Licensed Nurses and Certified Nursing Assistants monitoring and documenting bowel movements • Administering and monitoring for effectiveness and for possible side effects from pain medication • Pain Assessment to be completed on admission, quarterly and with significant change in status • Education with resident and family members as needed about comfort measures, analgesic medications, fear and concerns regarding pain • Certified Nursing Assistants will verbally notify licensed nurse if resident has no bowel movement in three days • Certified Nursing Assistants will document notification on bowel record and licensed nurses will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 39 There was no evaluation on the effectiveness of either medication. Resident #1 had a small soft bowel movement on 1/9/11. The MAR reflected resident #1 received a Lortab and Anusol HC for "rectal" pain at 4PM. There was no evaluation on the effectiveness of either medication. The nurse's note dated ,1/9/11 at 6:50PM noted the resident had received an Anusol HC suppository per rectum and Lortab for hemorrhoidal pain. There was no mention of whether or not there was stool present in the rectum when the Anusol suppositories were inserted. No assessment of the hemorrhoids or the abdomen was noted. The MAR noted resident #1 received Lortab at 8PM on 1/9/11 for "pain across top buttock." The effectiveness of the medication was not evaluated. A verbal order dated 1/9/11 at 11PM read in part, "Lactulose 30cc (cubic centimeter) po (by mouth) daily, Senokot 1 po daily." The five day medicare minimum data set (MDS) dated 1/10/11 revealed the resident was moderately impaired cognitively. She required extensive assistance of one person for bed mobility, transfers, dressing, toilet use, personal hygiene and bathing. She was continent of bowel and bladder. Resident #1 was noted to have frequent pain in the five days prior to the MDS. The pain was noted to have limited her day to day activities. The numeric rating the resident gave	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* review the bowel record flow book the beginning of each shift. • Licensed Nurses administering stool softeners and laxatives per MD orders • Licensed Nurses encouraging fluid and fiber • Certified Nursing Assistant encouraging resident to follow prescribed diet (B) On 3-01-11, Nurse Management team, consisting of Interim Director of Nursing Services (I-DNS), Staff Development Coordinator (SDC) and Minimum Data Set Coordinators (MDSC) implemented, evaluated and / or updated resident care plans related to constipation as needed. Constipation care plan is inclusive of: • Certified Nursing Assistants monitoring and documenting bowel movements every shift • Certified Nursing Assistants will verbally notify licensed nurse if resident has no bowel movement in three days • Certified Nursing Assistants will document notification on bowel record and licensed nurses will review the bowel record flow book the beginning of each shift.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 40 was "7" on a scale of 1-10 with 10 being the worst pain you can imagine. The pain was noted as "moderate." Review of the medication administration record (MAR) revealed the resident was started on the Senokot on 1/10/11. On 1/10/11 at 6:15AM the nurse's note reflected the resident had been medicated with Anusol HC per rectum (at 5:30AM) and Lortab for complaint hemorrhoidal pain (at 3:35AM). The effectiveness of the medication was not evaluated. The physical therapy (PT) notes for 1/10/11 noted the resident stated she could not participate in therapy. The therapist noted the resident had "decreased motivation." The PT noted the resident had pain in her abdomen and right hip. Pain medications were given and the nurse was aware. The 10PM nurse's note from 1/10/11 revealed the resident rested in bed and was medicated with Lortab for right hip pain (at 8PM).The effectiveness was not evaluated. Review of the MAR for 1/10/11 reflected the resident received a Fleets enema x 1. The enema was not documented on the "Nurse's Medication Notes" or in the nurse's notes. Review of the "Bowel Record" for 1/10/11 noted "0" for the amount of bowel movements on 7-3, 3-11, and 11-7 shifts. The PT notes for 1/11/11 revealed the resident said "I can't do it." (in regards to therapy) Resident #1 had pain in her right lower extremity and rectum pain. Pain medications were received	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* • Licensed Nurses administering stool softeners and laxatives per MD orders • Licensed Nurses encouraging fluid and fiber as appropriate • Certified Nursing Assistant encouraging resident to follow prescribed diet • Notification of Registered Dietician for evaluation of diet and fluid intake / offerings, resident likes and dislikes, and recommendations for food and /or fluids to promote regular bowel elimination 4. Education was initiated by: (a) Staff Development Coordinator inserviced current licensed nursing staff on 3-1-11 and will repeat in-service on-going for newly hired licensed nurses during orientation, licensed nurses returning from vacation and leave of absence with regard to pain policy to include: • Assessment of resident pain including location, duration, frequency, time	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 41 and the nurse was aware. The resident had 1 medium hard bowel movement during dayshift on 1/11/11. The nurse's note (done by nurse #2), dated 1/11/11 at 8:30PM revealed the resident would not attempt to walk and her appetite was poor. A moderate amount of soft stool was removed manually from the resident's rectum before inserting a Dulcolax suppository. Lactulose 30 cc was given by mouth. The resident was taking a "fair" amount of liquids. Another nurse's note from 1/11/11 reflected at 9:30PM the resident was assisted to the toilet. The note read in part, "will not try to expel (push out) stool." States, "I can't get it to move." During an interview on 2/17/11 at 3:30PM nurse #2 indicated she believed she checked the resident's rectum once manually and did not feel any stool. Of course the resident was on a narcotic pain medication and that could be constipating. Review of the MAR revealed resident #1 received a Fleets enema on 1/12/11 at 8AM and 1:30PM. Both enemas were documented on the "Nurse's Medication Notes" as "not effective." A nurse's note on 1/12/11 at 4PM revealed the resident received Anusol HC per rectum at 9AM and 2PM with minimal pain relief voiced per resident. The nurse noted before inserting the suppositories she felt "gummy pasty like fecal matter" and she removed a "fistful amt (amount) of stool." The resident continued to refuse to ambulate with PT. She was encouraged to drink water.	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* of day pain generally occurs, feeling of pain (internal, external, acute, chronic), severity of pain verbal pain scale (if resident able to respond) and non-verbal pain scale, pain type / intensity, other non-verbal cues (facial expressions, vocalizations, body actions / observed behaviors), pain affecting resident's quality of life / activities of daily living, cause of pain, relief of pain • Initiation of pain care plan as needed • Implementation of pain care plan • Monitoring frequency of use of analgesic medication • Notifying the attending MD of pain requiring prn (as needed) medication for greater than three consecutive days • Notifying the attending MD of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 42 On 1/12/11 at 10PM the nurse noted the resident remained in bed and "continues not helping herself." Her appetite was poor and she was given Lortab for "discomfort." There was no follow up to evaluate the effectiveness of the pain medication. The "C.N.A. Flow Record" had a section for "Behaviors observed." It was noted on the 3-11 shift on 1/12/11 the resident had "Continuous yelling/screaming." No other behaviors were noted on the flow record. The "C.N.A. Flow Record" contained a narrative note dated 1/12/11 (no time) that read in part, "Resident having problems with having BM (bowel movement) the nurse gave her something. She didn't eat much." An interview was conducted on 2/17/11 2:43PM with NA #2. The NA stated resident #1 complained about not being able to have a bowel movement and having pain because she could not go to the bathroom. The nurse (#1) gave the resident an enema and a little bit of "mushy" stool came out. Another note dated 1/12/11 (11pm-7am) noted the resident had been removing stool from her rectum and had put it all over her bedding. The resident complained of pain in her rectum. The NA informed the nurse. During an interview, on 2/17/11 at 3:06PM, NA #4 indicated the resident was a very anxious about her care. The NA stated the resident was "always wanting laxatives" and trying to manually remove stool out of her rectum with her fingers. The	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* unrelieved pain of 3 or higher on a scale of 1(mild)-10 (continuous/severe) on the pain assessment form • Initiation and implementation of constipation care plan b) Staff Development Coordinator inserviced current Certified Nursing Assistants on 3-1-11 and will repeat in-service on-going for newly hired Certified Nursing Assistants during orientation, Certified Nursing Assistants returning from vacation and leave of absence with regard to: • Pain policy to include reporting to Licensed Nurse when resident experiences pain • Implementation of pain care plan including Certified Nursing Assistants monitoring frequency and amount of bowel	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 43 nurse's were aware of the resident's behavior and it was something she did throughout her stay. The PT notes for 1/12/11 read in part, "I am hurting so bad (resident)." The resident complained of pain in her rectum. The nurse was aware and pain medications were received. Resident #1 had only 1 noted bowel movement on the 11-7 shift, a small soft one on 1/12/11. Review of the resident's "Bowel Record" for 7-3 shift revealed she had no noted bowel movements on 1/12/11 and 1/13/11. The nurse's note dated 1/13/11 at 6:45AM noted the resident had been requesting the bed pan most of the night. She had a medium brown stool and continued to insert her fingers into her rectum to try to remove stool. Resident #1 told PT she was sick on 1/13/11. The daily PT note dated 1/13/11 revealed the resident had abdominal pain secondary to no bowel movement. A nurse's note for 1/13/11 at 12:30PM noted the resident was being sent to the emergency room for "altered mental status." The resident stated "I don't feel good." Her vital signs were; temperature 97.3 degrees Fahrenheit, pulse 69, respirations 12 and blood pressure was 58/32. The MAR revealed resident #1 had received 24 doses of the as needed Lortab from 1/3/11 to 1/13/11. She received one dose on 1/3/11. From 1/4/11 to 1/8/11 the resident received 2 doses daily of the Lortab. On 1/9/11 she had four doses of Lortab (4AM, 12PM, 4PM, and 8pm). The	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* movement and documenting accordingly • Certified Nursing Assistants notifying licensed nurse if resident has no bowel movement in three days • Certified Nursing Assistants will document notification on bowel record and licensed nurses will review the bowel record flow book the beginning of each shift • Certified Nursing Assistants encouraging resident to follow prescribed diet. **Systemic Changes:** 1. Pain assessments will be completed by the licensed nurse for all newly admitted residents, all readmitted residents, residents admitted for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 44 resident had two doses daily of the Lortab on 1/10/11 and 1/11/11. She received three doses of the Lortab on 1/12/11 (times not documented) and 2 doses on 1/13/11. Resident #1 was receiving the Ferrous Sulfate twice daily and the Colace twice daily. Resident #1 had no noted bowel movements on the 3-11 shift from 1/3/11 to 1/13/11. Record review of the hospital records dated, 1/13/11, noted the resident presented to the emergency department with complaint of abdominal pain, fatigue, poor oral intake, and hypotension. The resident was given several enemas and manual disimpaction of stool on 1/12/11. The facility and family member reported "Very poor oral intake for past 3-4 days." The abdominal exam noted the abdomen was "distended, diffusely tender with hypoactive BS (bowel sounds), rectal with gross heme + stool (positive for blood)." The CT (computed tomography) of the abdomen and pelvis, done on 1/13/11, read in part, "A rather marked amount of retained stool is noted in the rectum and rectosigmoid (colon) compatible with clinical diagnosis of fecal impaction. Fluid filled dilated small bowel loops with scattered air fluid levels are present." Resident #1 expired on 1/13/11 at the hospital with final primary diagnoses of cardiopulmonary arrest, aspiration pneumonia, GI (gastrointestinal) bleed, hypotension, leukocytosis, metabolic acidosis and renal failure. During an interview, on 2/16/11 at 10:26AM, the Director of Nursing (DON) indicated she had	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* rehabilitation therapy, and residents admitted with pain medications on admission. Pain assessments will also be initiated with the onset of new pain by the licensed nurse caring for the resident at the time the pain is identified. Pain assessments will be performed quarterly and with significant change resulting in pain. 2. Pain monitoring added to the Medication Administration Records for all residents. Residents will be assessed for pain each shift by the licensed nurse and care planned interventions implemented as needed. If pain medication is indicated and the resident has no order for pain medication, the licensed nurse will notify the physician of the new onset of pain and request pain medication. If the resident is experiencing pain at a level 3 with no relief with current plan of care, the assessing nurse will notify the physician for a pain medication order or adjustment of current pain medication dosage as indicated. 3. Care plans will be initiated for all residents with pain. The care plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 45 assessed resident #1 either the day she went out to the hospital or the day before, she was not quite sure. She stated the resident's abdomen was slightly distended but soft. She indicated she did hear bowel sounds. The primary nurse informed the DON the resident was having issues with constipation. The primary care nurse had informed the DON that an enema had been given. The resident expressed to the DON she felt she had to go to the bathroom. The DON stated the pain assessment form should be completed in its entirety on admission. She reviewed the form completed for the resident and indicated once the resident started using pain medicine on a routine basis someone should have completed a new pain assessment form. The DON indicated a side effect of taking narcotic pain medication was constipation. The rehabilitation interim manager was interviewed on 2/17/11 at 12:05PM. She indicated she had worked with resident #1. The rehab interim manager stated the resident had lived alone prior to her fall and right hip fracture. She remembered the resident did "pretty good" the first time she worked with her. Then she was off for a few days, a weekend she thinks, and when she came back the resident was "different." The resident was complaining of trouble with her stomach. The rehab interim manager remembered assisting the resident to the toilet with nursing because they thought that might help her move her bowels. The resident stated she just could not do it, she couldn't push. She indicated as the resident's stay progressed she was significantly different. It was not the whole stay but like 3-4 days towards the end. An interview was conducted on 2/17/11 at	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* will include medication interventions as well as non-pharmacological interventions to be attempted prior to medication. Care plans will be revised and evaluated quarterly and with change of condition. 4. Nursing assistants will document bowel movements on bowel monitoring flow sheet. At the end of each shift, the nursing assistants will report off to their supervising licensed nurse for validation the flow book documentation has been completed. Licensed nurses working 7a-3p will review the bowel monitoring flow books and identify residents with no bowel movement in 3 days. These residents will be added to the laxative list for a laxative to be administered on the 3p-11p shift. The laxative list will be passed on to the 11p-7a shift for laxative results to be documented. If results are not achieved within thirty minutes after Fleets enema is administered per bowel protocol, the attending physician or physician on call will be notified for further orders. Once the bowel protocol is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 46 12:15PM with nurse #1. The nurse had cared for resident #1 frequently (8 out of 10 days) during her stay. Nurse #1 indicated the resident came in for rehab; she had a right hip fracture. She did complain of pain. She had a PRN pain medication and nurse #1 gave the medication as ordered. The nurse was not sure why the pain assessment form was not completely filled out on admission. She did not do the assessment. The nurse indicated she was not sure if she was allowed to go back and complete the pain assessment or start a new one once she determined the resident had pain on a daily basis. The nurse stated some residents have a pain scale chart on their MARs and some do not (this resident did not). She was not sure what determined who got the pain scale and who did not. It just came that way from the pharmacy. She stated an RN (registered nurse) had to complete/initiate the care plan. Nurse #1 indicated some of the side effects of a narcotic pain medication were constipation, lethargy and drowsiness. The nurse stated she did not have any conversations with the physician in regards to the pain med and possible/potential connection to the resident's constipation and abdominal pain. She noted the facility had a BM protocol. The protocol was like a standing order and the nurses would follow the protocol. The nurse would not contact the physician until they had gone all the way through the protocol and had no results (bowel movements), but that hardly ever happened. Nurse #1 stated she last assessed the resident's abdomen on 1/13/11 and it was "soft, wasn't really hard" and her bowel sounds were hyperactive. The nurse was trying to encourage water intake. She pointed to a clear cup and indicated she would fill it to the 8 ounce line and offer the resident two 8 ounce cups of water during her shift.	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* implemented, the 24 hour report log will be updated to indicate the bowel protocol has been initiated. The resident will remain on the 24 hour report until the constipation is relieved. **5.** Interim Director of Nursing Services (I-DNS), or SDC will review laxative lists daily ongoing to validate laxatives were administered as appropriate and results documented. In the absence of the Interim Director of Nursing Services (DNS) and SDC, the North Hall 7-3 Licensed Nurse will review laxative lists daily on weekends and holidays ongoing to validate laxatives were administered as appropriate and results documented. **Completion date of credible allegation is 3/3/2011.** **Quality Assurance:** The Interim Director of Nursing Services (I-DNS) or SDC will review medical records of newly admitted or readmitted residents daily for three days	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 47 During an interview on 2/17/11 at 2:37PM, NA #1 indicated she took care of the resident during her stay. The NA stated the resident was "total care" meaning the staff had to assist her with her activities of daily living. The resident did complain that she could not have a bowel movement. NA #1 reported the resident's concern to the nurse (#1). The NA indicated nurse #1 gave the resident an enema, but she could not recall the exact date. She stated the resident just had "a little watery type" of results from the enema. The resident did not express any relief from receiving the enema. The last time the NA worked with the resident was 1/12/11. The resident kept putting on the call light because she could not move her bowels. An interview was conducted on 2/17/11 at 4:33PM with the DON, the administrator and facility consultant #1. The DON indicated when she assessed the resident on 1/12/11 she was in no apparent distress. The DON did not document the assessment in the resident's medical record. The DON did not recall discussing resident #1's pain or constipation during daily rounds. Facility consultant #1 stated the staff would not be expected to phone the physician until the bowel protocol was completely done. The reason they had the protocol was so the staff would not have to call the doctor. However, if the resident had severe abdominal pain then she would expect the nurse to phone the physician. During an interview on 2/28/11 at 5:40PM, nurse #1 indicated she gave the resident the enemas because she was "at that step" on the bowel protocol. The nurse stated she did assess the resident's abdomen each time she gave the enemas she just forgot to chart it. Each time	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* following admission to validate pain assessments are accurately completed, care plans for pain are implemented as necessary, and residents experiencing pain have pain medication prescribed either PRN or scheduled. These reviews will continue on an ongoing basis. Interim Director of Nursing Services (I-DNS), or SDC will review 24 hour report book daily ongoing to identify residents with new onset of pain. These residents' medical records will be reviewed as well to validate pain assessments are accurately completed, care plans for pain are implemented as necessary, and the physician was notified for pain medication order as needed. Interim Director of Nursing Services (I-DNS), or SDC will audit laxative lists each morning and validate laxatives were given as indicated and results were documented. In the absence of the Interim Director of Nursing Services (I-DNS) and SDC on the weekends and holidays, the 7-3 North Hall Licensed Nurse will review laxative lists daily ongoing to validate laxatives were administered as appropriate and results documented. Results of these audits and medical record reviews will be reported to the facility's Performance Improvement Committee monthly x 6 months for review, evaluation and further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 48 resident #1's stomach was soft and flat with good bowel sounds. She did check the resident's hemorrhoids and did not notice any bleeding. She stated she did not correlate the hemorrhoids and the constipation. Resident #1's decreased appetite had not been reported to her. The nurse stated the ward clerk was responsible for reviewing the BM books. Nurse #1 indicated she did not look at the BM books. Usually the NAs would come and inform her if a resident had not moved their bowels in a couple of days. During an interview on 3/1/11 at 8:30AM, ward clerk #1 indicated she would review the BM (bowel movement) books. She would give a copy of the BM sheets to the (former) DON and she would write on a sticky note who had not had a bowel movement in 3 days. She would then give the sticky notes to the hall nurses responsible for the residents. Once the (former) DON and nurse's got the list of the resident's needing laxatives they were supposed to document on the BM sheets who received a laxative. Ward clerk #1 was not informed she needed to do any type of follow up. She indicated she did not keep any copies of the sticky notes she gave to the nursing staff. The interim DON was interviewed on 3/1/11 at 9:15AM. She stated the NA were supposed to be keeping tract of the bowel movements a resident had and the nurses should be looking at the BM book. The interim DON's goal would be for the NAs to improve their communication with the nurse's and for the nurse's to follow up on concerns brought forth by the NAs in regards to the residents. Physician #2 was interviewed on 3/1/11 at	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* For Resident #8: 1. Laxatives orders for resident #8 clarified for use of bowel protocol. 2. See credible allegation section "for other residents". 3. See credible allegation section "systemic changes". 4. See credible allrgation section "quality assurance". For Resident #3: 1. Resident #3 evaluated by psychiatrist on 2/22/2011 and medications adjusted to address exhibited behaviors. 2. Residents exhibiting a new onset of behaviors while experiencing a change in condition have the potential to be affected. Licensed staff were in-serviced by the SDC on indicators of change in condition and the need for assessment of clinical condition when new onset of behaviors is identified. Newly hired licensed staff will receive this training upon hire.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 49 11:28AM. Physician #2 was at the hospital during the time of the interview and referenced the resident's hospital records prior to her coming to the facility. He indicated she had a hip fracture. Physician #2 stated some residents might have been on pain medications all their lives. Sometimes a PRN pain medication becomes a routine medication. The physician indicated he expected the staff would call him or his PA if a resident was utilizing their PRN medication on a routine basis and they would do an evaluation. The physician and/or his PA would try to determine if the medication was effective at relieving the resident's pain. Physician #2 expected if a resident did not have a bowel movement after 2-3 days the staff would call and inform him or the PA. He does not remember receiving a call or a fax regarding this resident and her being constipated or having increased pain or a change in the location of her pain. During an interview on 3/1/11 at 11:43AM, physician's assistant (PA) #1 indicated if the staff did get in touch with him in regards to resident #1 (and orders for Anusol/Lactulose) it was probably via fax. He stated he really could not recall/remember anything off hand about the resident. A follow up interview was conducted with physician #2 on 3/3/11 at 10AM. Physician #2 indicated if a resident developed a new problem such as rash, fever, cough, or pain "of course" the physician would want to be notified. He also emphasized when a resident was new to the facility and the physician group did not know them well, they would want them sent to the emergency room for things new onset abdominal pain. If the physician had seen the resident then he would be	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* 3. DNS and interdisciplinary team (IDT) will review the 24 hour report book daily ongoing to identify residents with new onset of behaviors and change in condition. The medical records of these identified residents with new onset of behaviors will be reviewed by the DNS and IDT to validate clinical assessment has been completed and documented by the staff nurse, physician notified of the behaviors and change in condition, and new orders implemented as appropriate. DNS will maintain a log of these identified residents and continue to follow-up daily until change in condition is resolved and behaviors have subsided. These identified residents will remain on the 24 hour report until stabilized. 4. Log of residents with new onset of behaviors while experiencing a change in condition will be reviewed by the facility's Performance Improvement Committee monthly x 3 months for further recommendation and to validate continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 50 able to give orders to treat at the facility if able. Physician #2 stated the facility staff should keep trying until they reached either him or the PA. He indicated the evidence of the facility contacting him or the PA would be a fax with a date, signature and instructions on it or if they called him a verbal order with instructions. Physician #2 stated three of the biggest concerns he saw were pain, constipation and dehydration. He indicated constipation was a problem especially with narcotic pain medication administration. The administrator was notified of the I.J. on 3/1/11 at 12:10PM. The facility provided an acceptable credible allegation of compliance on 3/3/11 at 12:08PM. The following interventions were put in place: Resident Specific Resident #1 was admitted to the facility on 1/3/2011. Her diagnoses included Comminuted Intertrochanteric right Hip fracture, Rhobdomylosis, HTN, Mild Cognitive Impairment, and Alzheimer's dementia. Her medications included Metoprolol Tartrate, Mirtazepine, Plavix, Prednisone, Lisinopril, Colace, Ferrous Sulfate, and Lortab. She received Lortab for right hip pain once on 1/3, twice on 1/4, 1/5, 1/6, 1/7, 1/8, 1/9, 1/10, 1/11, and 1/13/2011. She received Lortab three times on 1/12/2011. She also experienced hemorrhoid pain on 1/9/2011 and an order was received for Anusol suppositories three times per day as needed. Resident received Colace 100mg two times per day since admission. On 1/9/2011, Lactulose 30cc daily was added to her medication regimen for constipation. On 1/10/2011, Senokot was added one tablet daily for constipation. Resident received Fleets enemas on 1/10/2011	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 51 (one) and 1/12/2011 (two). On 1/13/2011, both the resident and her brother requested she be sent to the emergency room for evaluation. She stated, "I don't feel good." Attending physician was notified and order received for resident to be transported to the emergency room. Vital signs were: temperature 97.3, pulse 69, respirations 12, and blood pressure 58/32. Resident had documented bowel movements as follows: 1/5/2011-two soft, medium bowel movements 1/7/2011-one soft, medium bowel movement 1/8/2011-one soft, medium bowel movement 1/9/2011-one soft, small bowel movement 1/10/2011-Senokot one tablet daily was added for constipation; one Fleet's enema 1/11/2011-one hard, medium bowel movement 1/12/2011-one soft, small bowel movement 1/12/2011-two Fleets enemas given with no results documented Resident passed away in the hospital on 1/13/2011. All Other Residents (A) On 3-01-11, Nurse Management team, consisting of Interim Director of Nursing Services (I-DNS), Staff Development Coordinator (SDC) and Minimum Data Set Coordinators (MDSC) performed pain assessments on all residents in house to identify residents with pain. (B) On 3-01-11, Nurse Management team, consisting of Interim Director of Nursing Services (I-DNS), Staff Development Coordinator (SDC) and Minimum Data Set Coordinators (MDSC) performed bowel record review for residents of the facility to also include the look back period to	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 52 the last documented bowel movement to identify residents with no bowel movement in three days. (A) The resident's primary licensed nurse will be responsible for physician notification via telephone when a residents with a score of 3 or higher on a scale of 1(mild)-10 (continuous/severe) on the pain assessment form, with new orders implemented and care planned by MDSC and or primary licensed nurse, at the time of pain onset. The IDT (Interdisciplinary Team) will validate this process at least 5 times weekly in Clinical Morning Review. Responsible Party(s) will be notified of new medications or change in dosage of current medication as needed. (B) Bowel Protocol was initiated by the Nurse Management Team, consisting of the Interim Director of Nursing Services (I-DNS), Staff Development Coordinator (SDC) and Minimum Data Set Coordinators (MDSC) for residents noted with no bowel movement in three days. Bowel Protocol states: · On third day with no documented bowel movement give Lactulose 30 cc po (by mouth) or via tube (gastric or peg) prn (as needed) · On fourth day with no documented bowel movement and no results from Lactulose give Dulcolax supp (suppository) pr (per rectum) prn (as needed) · On fifth day with no documented bowel movement and no results from Lactulose or Dulcolax give Fleets Enema pr (per rectum) prn (as needed) · Notify attending physician if no results within 30 minutes of Fleets enema administration. (A) On 3-01-11, Nurse Management team,	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 53 consisting of Interim Director of Nursing Services (I-DNS), Staff Development Coordinator (SDC) and Minimum Data Set Coordinators (MDSC) implemented, evaluated and / or updated resident care plans to reflect pain as needed concerning all residents in the facility. Careplans are made accessible through the resident's medical record for the licensed nurses and the nursing assistant will obtain any careplan updates in shift report from the licensed nurse on an as needed basis on-going. Pain care plan is inclusive of: · Pain type, chronic, acute, breakthrough, phantom · Pain symptoms: crying / moaning, facial grimace, guarding, complaints of pain, decrease in functional level, inability to sleep, limiting activities, not eating · Licensed Nursing Staff monitoring residents for pain each shift. Attending physicians when signs and symptoms of pain, worsening pain, reporting changes in pain location / type / frequency / intensity of pain to physician · Providing non-pharmacological comfort measures including relaxation techniques, deep breathing, repositioning, activities as appropriate · Monitoring for side effects including Licensed Nurses to monitor for signs and symptoms of constipation, Licensed Nurses and Certified Nursing Assistants monitoring and documenting bowel movements · Administering and monitoring for effectiveness and for possible side effects from pain medication · Pain Assessment to be completed on admission, quarterly and with significant change in status · Education with resident and family members as needed about comfort measures, analgesic medications, fear and concerns regarding pain	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 54 · Certified Nursing Assistants will verbally notify licensed nurse if resident has no bowel movement in three days · Certified Nursing Assistants will document notification on bowel record and licensed nurses will review the bowel record flow book the beginning of each shift. · Licensed Nurses administering stool softeners and laxatives per MD orders · Licensed Nurses encouraging fluid and fiber · Certified Nursing Assistant encouraging resident to follow prescribed diet (B) On 3-01-11, Nurse Management team, consisting of Interim Director of Nursing Services (I-DNS), Staff Development Coordinator (SDC) and Minimum Data Set Coordinators (MDSC) implemented, evaluated and / or updated resident care plans related to constipation as needed. Constipation care plan is inclusive of: · Certified Nursing Assistants monitoring and documenting bowel movements every shift · Certified Nursing Assistants will verbally notify licensed nurse if resident has no bowel movement in three days · Certified Nursing Assistants will document notification on bowel record and licensed nurses will review the bowel record flow book the beginning of each shift. · Licensed Nurses administering stool softeners and laxatives per MD orders · Licensed Nurses encouraging fluid and fiber as appropriate · Certified Nursing Assistant encouraging resident to follow prescribed diet · Notification of Registered Dietician for evaluation of diet and fluid intake / offerings, resident likes and dislikes, and recommendations for food and /or fluids to promote regular bowel	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 55 elimination Education was initiated by: Staff Development Coordinator inserviced current licensed nursing staff on 3-1-11 and will repeat in-service on-going for newly hired licensed nurses during orientation, licensed nurses returning from vacation and leave of absence with regard to pain policy to include: · Assessment of resident pain including location, duration, frequency, time of day pain generally occurs, feeling of pain (internal, external, acute, chronic), severity of pain verbal pain scale (if resident able to respond) and non-verbal pain scale, pain type / intensity, other non-verbal cues (facial expressions, vocalizations, body actions / observed behaviors), pain affecting resident's quality of life / activities of daily living, cause of pain, relief of pain · Initiation of pain care plan as needed · Implementation of pain care plan · Monitoring frequency of use of analgesic medication · Notifying the attending MD of pain requiring prn (as needed) medication for greater than three consecutive days · Notifying the attending MD of unrelieved pain of 3 or higher on a scale of 1(mild)-10 (continuous/severe) on the pain assessment form · Initiation and implementation of constipation care plan Staff Development Coordinator inserviced current Certified Nursing Assistants on 3-1-11 and will repeat in-service on-going for newly hired Certified Nursing Assistants during orientation, Certified Nursing Assistants returning from	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 56 vacation and leave of absence with regard to: · Pain policy to include reporting to Licensed Nurse when resident experiences pain · Implementation of pain care plan including Certified Nursing Assistants monitoring frequency and amount of bowel movement and documenting accordingly · Certified Nursing Assistants notifying licensed nurse if resident has no bowel movement in three days · Certified Nursing Assistants will document notification on bowel record and licensed nurses will review the bowel record flow book the beginning of each shift · Certified Nursing Assistants encouraging resident to follow prescribed diet. Systemic Changes: 1. Pain assessments will be completed by the licensed nurse for all newly admitted residents, all readmitted residents, residents admitted for rehabilitation therapy, and residents admitted with pain medications on admission and daily for three days following admission to ensure residents experiencing pain are identified. Pain assessments will also be initiated with the onset of new pain by the licensed nurse caring for the resident at the time the pain is identified. Pain assessments will be performed quarterly and with significant change resulting in pain. 2. Pain monitoring added to the Medication Administration Records for all residents. Residents will be assessed for pain each shift by the licensed nurse and care planned interventions implemented as needed. If pain medication is indicated and the resident has no order for pain medication, the licensed nurse will notify the physician of the new onset of pain and request	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 57 pain medication. If the resident is experiencing pain at a level 3 with no relief with current plan of care, the assessing nurse will notify the physician for a pain medication order or adjustment of current pain medication dosage as indicated. The nurse initiating the physician notification will document the resident's pain and pending physician notification on the 24 hour report log. The resident will remain on the 24 hour report book until physician has responded. 3. Care plans will be initiated for all residents with pain. The care plan will include medication interventions as well as non-pharmacological interventions to be attempted prior to medication. Care plans will be revised and evaluated quarterly and with change of condition. 4. Nursing assistants will document bowel movements on bowel monitoring flow sheet. At the end of each shift, the nursing assistants will report off to their supervising licensed nurse for validation the flow book documentation has been completed. Licensed nurses working 7a-3p will review the bowel monitoring flow books and identify residents with no bowel movement in 3 days. These residents will be added to the laxative list for a laxative to be administered on the 3p-11p shift. The laxative list will be passed on to the 11p-7a shift for laxative results to be documented. If results are not achieved within thirty minutes after Fleets enema is administered per bowel protocol, the attending physician or physician on call will be notified for further orders. Once the bowel protocol is implemented, the 24 hour report log will be updated to indicate the bowel protocol has been initiated. The resident will remain on the 24 hour report until the constipation is relieved. 5. Interim Director of Nursing Services (I-DNS),	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 58 or SDC will review laxative lists daily ongoing to validate laxatives were administered as appropriate and results documented. In the absence of the Interim Director of Nursing Services (DNS) and SDC, the 3-11 West Hall Licensed Nurse will review laxative lists daily ongoing to validate laxatives were administered as appropriate and results documented. Completion date of credible allegation is 3/3/2011. Quality Assurance: The Interim Director of Nursing Services (I-DNS) or SDC will review medical records of newly admitted or readmitted residents daily for three days following admission to validate pain assessments are accurately completed, care plans for pain are implemented as necessary, and residents experiencing pain have pain medication prescribed either PRN or scheduled. These reviews will continue on an ongoing basis. Interim Director of Nursing Services (I-DNS), or SDC will review 24 hour report book daily ongoing to identify residents with new onset of pain. These residents' medical records will be reviewed as well to validate pain assessments are accurately completed, care plans for pain are implemented as necessary, and the physician was notified for pain medication order as needed. Interim Director of Nursing Services (I-DNS), or SDC will audit laxative lists each morning and validate laxatives were given as indicated and results were documented. In the absence of the Interim Director of Nursing Services (I-DNS) and SDC on the weekends and holidays, the 7-3 North Hall Licensed Nurse will review laxative lists	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 59	F 309		

daily ongoing to validate laxatives were administered as appropriate and results documented. Results of these audits and medical record reviews will be reported to the facility's Performance Improvement Committee monthly x 6 months for review, evaluation and further recommendation.

Verification of the credible allegation was evidenced by interviews of direct care staff relating to training and in-services received regarding pain assessment, bowel management and physician notification. All direct care staff interviewed on 3/3/11 were knowledgeable about the facility's bowel protocol, how resident changes are to be communicated and reported (to each other and the physician). The monitoring tools included a skills validation form which included pain management and the bowel protocol and a form to document audits and corrective measures taken when negative findings are noted during facility audits.

2. Resident #8 was admitted to the facility on 11/2/10. Her diagnoses included cerebrovascular accident, hypertension, diabetes, a history of irritable bowel syndrome and diverticulosis.

The facility "Bowel Protocol" dated 8/09 read in part, "1. Lactulose 30cc (cubic centimeters) on 3rd day with no BM (bowel movement). 2. Dulcolax Suppository PR (per rectum) on 4th day with no BM and no results from Milk of Magnesia. 3. Fleets enema PR on 5th day with no BM and no results from Milk of Magnesia or Dulcolax Suppository."

Review of the resident's care plans, last reviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 60 on 2/2/11 yielded no concerns related to constipation or pain. The most recent minimum data set (MDS), dated 2/7/11, revealed the resident had modified independence for cognitive skills. The resident required extensive assistance for bed mobility, transfers, dressings, toileting, personal hygiene and bathing. She was incontinent of bowel and bladder. The resident was noted as receiving as needed (PRN) pain medication. The physician order's for February 2011 revealed the resident was receiving Tylenol 650mg (milligrams) by mouth (PO) three times a day (TID). She could also have Norco (Hydrocodone-Acetaminophen) 5/325mg 1 to 2 tablets by mouth every 6 hours as needed for pain. Resident #8 could have Mobic 7.5mg tablet by mouth twice daily as needed for pain. She was receiving Colace (stool softener) 100mg by mouth once daily at bedtime. Lexi-Comp's Geriatric Dosage Handbook, 15th edition, revealed Norco (Hydrocodone-Acetaminophen) was an Opioid narcotic for treatment of moderate to severe pain. Under the "Adverse Reactions - Gastrointestinal (GI)" section the following were noted, abdominal pain and constipation. The section "Special Geriatric Considerations" it was noted the elderly might be particularly susceptible to the CNS (central nervous system) depressant action (sedation, confusion) and the constipating effects of narcotics. Percocet (oxycodone and acetaminophen) was an Opioid narcotic used to treat moderate to severe pain. Under the "Adverse Reactions" section constipation, nausea and vomiting were listed. The section "Special	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 61 Geriatric Considerations" it was noted the elderly might be particularly susceptible to the CNS (central nervous system) depressant action (sedation, confusion) and the constipating effects of narcotics. Review of the "Bowel Record" for February 2011 reflected the resident had no noted bowel movements from 2/8/11 to 2/11/11 (4 days). Prior to this time, she had BMs daily with the exception of 2/6/11 when none was noted. The resident had a large soft BM and a large loose BM on 2/12/11. The nurse's note dated 2/15/11 at 3:30PM revealed the resident had vomited one time. The resident indicated she felt better afterwards. According to the "Bowel Record" for February 2011, the resident had no noted bowel movements from 2/13/11 to 2/16/11 (4 days). The February 2011 MAR revealed the resident was receiving her Colace daily. She had received MOM (Milk of Magnesia) on 2/16/11 (4th day with no noted bowel movement).Resident #8 had a Dulcolax Suppository per rectum for no BM in 4 days given on 2/17/11 (which was the 5th day with no bowel movement). The resident then moved her bowels two times on 2/17/11 (small/soft). A family member of the resident was interviewed on 2/17/11 7:35PM. The family member indicated the resident had vomited that day. The nursing staff had given her a shot for nausea (Phenergan). The nursing staff informed the family member the resident was "constipated" and had not had a bowel movement in a couple of days. The family member indicated before the resident's stroke she used to take Metamucil on a daily basis to keep her bowel movements regular.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 62 The resident moved her bowels again on 2/18/11 and 2/19/11, per the bowel record. The physician's progress notes revealed a visit from the physician on 2/18/11. The resident was noted as being "sick this week (with) several bouts of emesis, (increased) fever." The assessment noted the resident had a recent urinary tract infection, fever and emesis (vomiting). She was on an antiemetic (relief of nausea) and Pepcid (relieves heartburn). A verbal order was noted on 2/19/11 for Percocet 5/325mg 1 to 2 tablets by mouth as needed for pain. Per the bowel, record resident #8 did not have any noted BM on 2/20/11. The resident received Lactulose 30cc (cubic centimeters) by mouth for no BM in 3 days on 2/21/11 (she had a BM on 2/19/11). The resident had a large loose BM on 2/21/11, per the bowel record. A fax was re- sent to the physician on 2/23/11 (the date listed on the fax was "2/17/11- 2/23/11." The nursing staff communicated the following to the physician, "Resident takes pain med daily- having difficulty (with) BM's- Resident current takes Colace - May we have order for something else also daily such as lactulose or prune juice?" The physician responded on 2/23/11 and noted the facility could give the resident prune juice daily - hold for diarrhea and Lactulose 15cc's twice daily as needed. According to the bowel record resident #8 had no	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 63 noted bowel movements from 2/22/11 to 2/25/11 (4 days). According to the MAR the resident received MOM on 2/27/11 (she had a bowel movement on 2/26/11 and two on 2/27/11, per the bowel record). During an interview on 2/28/11 at 4:56PM, NA #3 indicated she regularly took care of the resident. The resident was able to communicate her needs through non verbal means. NA #3 stated the resident did not have many bowel movements on the 3-11 shift. If the NAs noticed a resident had not had a BM in 2-3 days then they should notify the nurse responsible for the resident. An interview was conducted on 2/28/11 at 5:32PM with nurse #5. The nurse indicated the nursing assistants (NAs) should be monitoring the frequency of bowel movements the resident had. If a resident does not have a bowel movement in 3 days then they should receive a laxative or whatever their physician has ordered. Nurse #5 stated if the laxative doesn't work the first time then the nurse's would give another laxative on the next shift. If 24 to 48 hours later the resident has not moved their bowels then the physician should be called. Nurse #5 stated she had not received any reports from the NAs that resident #8 was not moving her bowels. She was aware the resident had vomiting about a week ago. The nurse indicated the resident did not have any abdominal pain or fever during her shifts. If the resident complained of pain it was usually in her legs and relieved by the pain medication ordered by the physician. The nurse stated she thought the assistant director of nursing (ADON) checked the BM books everyday, she was not sure who	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 64 was doing this since they did not currently have an ADON. If the nurse noticed the resident had not had a BM in 3-4 days then she would ask the NAs to verify. She would then proceed to the MAR and follow the bowel protocol. Nurse #5 stated she should be checking the bowel books every shift but honestly she did not. The nurse was not able to provide a reason why the bowel protocol implemented differently than it was written. During a follow up interview on 2/28/11 at 6:03PM, physician #1 indicated he expected the facility staff to follow the bowel protocol but also evaluate each resident on an individual basis. If a resident had abdominal pain or distension then he would expect them to call the physician. If a resident was still having difficulty with bowel movements even with the bowel protocol then he expected the nurse's to notify the physician. The nurse's must assess and evaluate each resident on an individual basis. During an interview on 3/1/11 at 8:30AM, ward clerk #1 indicated she would review the BM (bowel movement) books. She would give a copy of the BM sheets to the (former) DON and she would write on a sticky note who had not had a bowel movement in 3 days. She would then give the sticky notes to the hall nurses responsible for the residents. Once the (former) DON and nurse's got the list of the resident's needing laxatives they were supposed to document on the BM sheets who received a laxative. Ward clerk #1 was not informed she needed to do any type of follow up. She indicated she did not keep any copies of the sticky notes she gave to the nursing staff.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 65 The interim DON was interviewed on 3/1/11 at 9:15AM. She stated the NA were supposed to be keeping tract of the bowel movements a resident had and the nurses should be looking at the BM book. The interim DON's goal would be for the NAs to improve their communication with the nurse's and for the nurse's to follow up on concerns brought forth by the NAs in regards to the residents. The administrator was interviewed on 3/1/11 at 9:35AM. The administrator expected the NAs to report to the nurse if a resident did not have a bowel movement in 3 days. The nurse's should be implementing the bowel protocol for any resident who doesn't have a specific order for a laxative and not just utilizing it for every resident. 3. Resident #3 was admitted to the facility on 5/22/08. Diagnoses included cerebrovascular accident, (CVA) hypertension, neurogenic bladder, dyslipidemia, hemiplegia, and benign prostatic hyperplasia with urinary obstruction. Review of the quarterly Minimum Data Set (MDS) dated 10/13/10 revealed that the Resident #3 had no short- or long-term memory problems and that his cognition was intact. The MDS dated 10/13/10 also coded Resident # 3 as always continent of bladder and bowel. The assessments further indicated that the Resident needed limited assistance with 1-person assist with transfers, in-room walking, dressing, toileting, and personal hygiene. He fed himself after tray set-up. The assessment noted that the Resident was moderately depressed, and he resisted care. Review of the nurse's notes dated 10/27/10 revealed that the "Resident was in the room with	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 66 his roommate, and the roommate's visitor. He [Resident #3] continued to get out of bed with difficulty to go to the bathroom. The Resident continually entered the bathroom, pulled down his pants [Depends] without asking for assistance. The Resident did not close the bathroom door. These behaviors occurred during the roommate's family visit. " Review of the nurse's notes dated 10/29/10 revealed that Resident #3 was having difficulty urinating. The attending physician's office was called. An order was given for a urologist consult. Review of the nurse's notes dated 10/29/10 revealed that "the Resident was in his room, lying in bed, alert and verbal. His roommate had company. The Resident went in and out of bed with difficulty. He went to the bathroom in his room many times from 4:55 to 5:20 p.m. while his roommate's family member was present. The Resident did not close the door to the bathroom or ask for assistance to close the door, when his roommate's family member was present." Review of the urology consult dated 11/18/10 read in part, "He [Resident #3] is in a wheelchair although can ambulate a small distance .... Since August of this year, he had lower urinary tract symptoms (LUTS). He has difficulty starting his stream. He has frequency and double voiding. Denies retention. Denies incontinence, gross hematuria, or dysuria. No documented infection. He is on Flomax {Flomax is a medication used to improve urination in men with enlarged prostate}. Review of his record revealed he has been on it for over 2 years. He was on the medication upon his admission to (name of the hospital) in 2008	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 67 for a CVA. No routine urological care. Unable to perform a GU (genitourinary) examination today. Add Avodart [Avodart medication used to treat enlarged prostate] daily. Follow up in eight weeks. If fails, will consider cystoscopy and adding an anti-cholinergic for potential neurogenic bladder." Review of Resident #3 mental health notes dated 12/7/10 read in part, "Psychiatric Diagnostic Interview: Chief complaint: refusing therapy; not getting out of bed; using bathroom on self. History of present illness revealed: depressed mood, anxiety per staff-Recommendations, Zoloft 25milligrams (mg) po [by mouth] daily for depressed mood; Ativan 0.5 mg po [by mouth] tid [three times per day] prn [as needed] for anxiety and agitation." Review of nurse's notes dated 12/11/10 revealed that "The Resident removed his underwear, got out of bed and placed his underwear in the wheelchair. The Resident then got back into his bed, voided in the bed and asked for an entire bath. The aide gave the Resident a complete bath and changed his bed linen." Review of the nurse's notes dated 12/15/10, read in part, "Resident had bowel movement in bed on himself. He stated that he needed someone to clean him up. Resident also stated he cannot tell when he wants to urinate." Review of Physician's telephone orders dated 12/15/10 read, "Mental Health consult. " Review of Evaluation and Management Psychiatry interview dated 12/29/10 read in part, "History: seen for mood and behavior; depressed mood moderate; energy decreased; staff upset	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 68 that resident has behavior urinates and defecates on self. Urology consults and test has been normal. Findings: depression, moderate symptoms of insomnia and decreased appetite. Recommendations: Zoloft 25mg po, Ativan 0.5mg tid. " Review of nurse's notes dated 12/30/10 read in part, "Resident stated, ' I need to see the nurse or I am going to call the police to take me to the hospital [per aide]. ' " The Resident was assessed by the nurse; he told the nurse, "I cannot pee. " The last time he had urinated was " 4 hours ago. The Resident stated that he was hurting in his lower abdomen. The Resident's family member was present. The Resident was sent to the hospital for evaluation per Resident's and family member's requests. " Review of nurse's notes dated 12/30/10 revealed that the resident returned to the facility from the hospital with an indwelling catheter intact and a diagnosis of urinary tract infection. Bactrim was prescribed by mouth 2 times per day. Review of the emergency room record dated 12/30/10 read in part, "COMPLAINT: Abdominal pain w/o (without) n/v (nausea and vomiting); ASSESSMENT: Triage assessment performed. "Pt [patient] presents via EMS (emergency medical service) from [name of facility] with complaint of abdominal pain for the past 3 days and inability to urinate since this morning. PAIN: PT complained of pain. On scale of 0-10 patient rates pain as 6, abdomen. Resident chief complaint was ' I cannot pee. ' TEXT: (Name of catheter) placed and draining urine. Will get UA (urinalysis) to assess for UTI (urinary tract infection). Pt to be d/c (discharged) back to	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 69 facility with leg bag and will f/u (follow up) with urology. PATIENT PLAN: The patient will be discharged; the patient will follow up with primary care physician. Laboratory (lab) results WBC (white blood ce1ls) 30-50/hpf, and bacteria 1+. " The 2 lab results mentioned were above the normal range which indicated infection. " Review of the nurse's notes dated 1/3/11 read in part "Resident went to the bathroom several times. The Resident stated that he was not able to have a bowel movement. The nurse offered meds [medication]. Resident refused. Pain meds were offered. Resident stated that ' his stomach was hurting. ' Resident refused medication stating, ' I want to go to the hospital. ' The DON was aware of the Resident's behaviors. The Attending Physician's office was called concerning the Resident's status. Spoke with the Physician's Assistant; re-fax mental health evaluation orders. Resident was sent to emergency room. " Review of emergency room visit dated 1/3/11 revealed that Resident #3 was treated for constipation. Review of nurse's notes dated 1/5/11 revealed that "the resident was alert and verbal. " He had taken his indwelling catheter and drainage bag apart. The Resident was advised not to tamper with his indwelling catheter 2 times during the shift. " Review of the nurse's notes dated 1/6/11 at 1:15 p.m. revealed that the "resident had his call light on 12 times, disconnected his indwelling catheter bag, and wet the whole bed with urine. His gown was adjusted around his neck. The Resident	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 70	F 309		

requested water 4 times, so that he could void. Each time he was given water, he stated that he could not void [there was an indwelling catheter in directly to bladder removing 500cc of urine in to the catheter.] The Resident stated, ' I cannot move my bowels ' ; Lactulose 30cc was given. "

Review of nurse's notes dated 1/6/11 at 1:30 p.m. revealed that "[the Physician's Office] was called, the Resident continued to turn the call light on and off, stating that he needs help with going to the bathroom because he couldn ' t urinate or have bowel movements. " The Director of Nursing (DON) was instructed to call the Physician's Office and give a verbal report of the Resident's behaviors.

Review of nurse's notes dated 1/6/11 at 5:55 p.m. revealed that the "the Resident had taken his pants off and he was lying nude in the bed in the presence of his roommate, 2 times this shift. "

Review of nurse's notes dated 1/7/11 at 6:00 p.m. revealed that "the Resident's call light was on a total of 22 times this shift. The Resident asked to put his indwelling catheter bag from one side of the bed to the other side. The Resident was seen out in the hallway, and then he got back in the bed and started to ring the call light several times. Then the bag from the catheter was disconnected and was running in the bed. "

Review of the social worker's notes dated 1/7/11 indicated: "spoke with Resident and responsible party about Resident's moods and behaviors. Resident to respect roommate's rights, other residents and staff. Resident will be moved to a private room until mood behaviors have declined. "

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 71 Review of Physician's telephone order dated 1/8/11 read in part, "Zoloft 25mg po [by mouth] daily and Ativan 0.5mg po [by mouth] tid [3 times per day] prn [as needed] were prescribed for anxiety and agitation. " Review of nurse's notes dated 1/8/11 revealed that "the Resident took his clothes off, and he was sitting in the chair naked. When asked, he stated that nothing was wrong. The aide gave him a complete bath, and then the Resident had a bowel movement and smeared the feces on his bed 38 minutes later. The Resident disconnected the indwelling catheter bag from the catheter several times. The Resident continued to the turn lights on stating he forgot what he needed. " Review of the aide's notes dated 1/8/11 revealed "the Resident continuously ringing the light, he also made several trips to the bathroom. " Review of the aide's notes dated 1/10/11 revealed that the "Resident continued to make several trips to the bathroom. He was continually ringing the light for someone to come in because he does not know what is wrong with him. " The latest quarterly Minimum Data Set (MDS) dated 1/11/11 revealed that Resident #3 had no short- or long-term memory problems and that his cognition was intact. The MDS also coded Resident #3 as having an indwelling catheter and stated Resident is always continent of bowel. The assessment further indicated that the Resident needs limited assistance with 1-person assist with transfers, in-room walking, dressing, toileting and personal hygiene. He can feed himself after tray set-up. The assessment noted that the Resident	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 72 was moderately depressed, and he resisted care. Review of the urologist consult dated 1/13/11 read in part, "patient know to my practice with lower urinary tract symptoms (LUTS). I saw him on 11/18/10. At that time, he had obstructive and irritative symptoms. He also has a history of stroke with right hemi paresis. His internal history is remarkable for 2 trips to emergency room for lower urinary tract symptoms. His catheter was placed in 12/30/10 for a presumed inability to void. Catheterized post void residual was 80cc. He is obviously not in retention. He was reevaluated 1/3/11 for penile irritation and constipation in the emergency room. Labs were reviewed from that date and are benign. He was given bactrim prophylactically. CT scan 1/3/11 was performed without contrast. No pathology noted. I am recommending continuing his combination therapy. I have added oxybutynin 10-mg daily. I recommend a cytoscopy. Assessment & Plan: Neurogenic Bladder; Problem Story: H/O [history of] CVA with persistent irritative S x S (signs and symptoms) failure to store. PVR (post void residual) <100 consistently on dual agent therapy. Start Oxybutynin ER [Extended Release] (Oxybutynin medication prescribed to treat overactive bladder,) 10 mg (milligrams) & (and) reassessed next week. Plan: Hypertrophy Prostate Benign w/Urinary (with urinary) OBST (obstruction) /LUTS. PROBLEM STORY; persistent LUTS on flomax PVR 70. Unable to stand for examine prostate .... (Indwelling catheter) placed in Ed [emergency department] 12/30/10 .... pvr 80cc. No retention. d/c (discontinue) Foley 1/13/11. cipro500mg ..... follow up in a week. " Review of the urologist follow-up visit dated	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 73 1/18/11 read in part, "I believe his symptoms are a combination of neurogenic bladder and bladder outlet obstruction secondary to mild to moderate Benign Prostatic Hyperplasia. He is currently on Tramsulosin (flomax) , Avodart and Oxybutynin as of 1/13/11. Overall I think his symptoms have modestly improved in a week. His cystospy today confirmed mild to moderate BPH and no additional pathology. Continue present triple agent pharmacotherapy. Follow-up in ninety days. Current plan the patient diagnosis of LUTS was review; his urological medications were reviewed. irritative systems (nocturia, urgency & frequency) remain his primary concerns. A recent scanned PVR was < 150cc and patient denies a previous history of urinary retention. I have recommended the addition of an anticholinergic medication. Dosing possible side effect, and expect outcomes were reviewed in detail. The patient understands and agrees to proceed. " Review of aide's notes dated 1/23/11 revealed that Resident continued to ring the call light every 5 minutes. Nurses are aware of his behaviors. Review of the aide's notes dated 1/31/11 revealed that "the Resident went to the bathroom every 15 minutes. The matter was reported to the nurse but no one knows what to do. " Review of aide's notes dated 2/4/11 revealed that "the Resident was put in a diaper because he had several incontinent episodes. The Director of Nursing [DON] was notified. " Review of aide's notes dated 2/5/11 revealed that "the Resident had another bladder incontinent episode. The Resident had been taken to the bathroom 4 times with no result. The Resident	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 74 kept saying he thought he had to go. " Resident was observed on 2/16/11 at 10:30 a.m. "He was lying in his bed; the room was dark and the television was off. The Resident appeared as if he was sleeping. " Review of aide's notes dated 2/17/11 revealed that the "Resident refused care. He was taken to the bathroom numerous times and before I could exit the room the Resident had the call light on again. I went to DON for advice for some solution and I did not get a direct answer or solution. " During an interview with the social worker on 2/17/11, at 12:15 p.m., she stated that the Resident had been displaying several behaviors since October 2010. A visiting PA[Physician's Assistant] wrote Mental Health consult The social worker further stated "I have moved the Resident to another room for his dignity and the dignity of the other residents in the facility. The Resident was seen on 12/29/10, and the mental health doctor recommended Zoloft and Ativan for the Resident. On 1/8/11, the Medical Director signed the order for Zoloft and Ativan. " The social worker stated that as of 2/15/11 the Resident will have new psychiatric services. During an interview on 2/17/11 at 3:10 p.m. with NA #3, who was assigned to the resident on 2/16/11, she indicated that she knew the resident well. She stated that the Resident has been displaying the same behaviors since last year. But the behaviors of going to the bathroom and using the call light have increased.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 309	Continued From page 75 During an interview on 2/17/11 at 3:19 p.m. with NA #11, she stated, "I normally work 7-3 [7 a.m. to 3 p.m.). Some days [name of Resident] is very hostile; he will hit the call light every 15 minutes to tell us he cannot urinate. I went to the DON and asked what can be done about his behavior. I just cannot get any direct solutions on how to handle the problem. " During an interview on 2/17 /11 at 4:30 p.m. with the administrator, she stated that she was not aware that the Resident was moved to another room because of his behaviors. Review of the attending physician's assessment of Resident #3 dated 2/19/11 read in part: "staff had been concerned regarding some behavioral issues in the past few months. He has been seeing psychiatry consultants with some adjustments in his regimen .... [Resident] denies pain and is doing better. Bladder issues still problematic. Followed by the Urologist. Medication not helpful. " During an interview on 2/28/11 at 2:30 p.m. w	F 309	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.*	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, record review and policy review the facility failed to	F 312	1. Primary nursing assistants caring for resident #9 were in-serviced on peri-care and competency validated with return demonstration. 2. Staff Development Coordinator (SDC) to in-service current nursing staff (RNs/LPNs/ and certified nursing assistants) on proper peri-care technique. 3. When identified, peri-care technique re-training will be provided as needed. SDC to incorporate peri-care technique education in new employee orientation to include return demonstration. 4. The SDC and or UMs, and or DNS will monitor through direct observation of nursing assistants performing peri-care. The SDC and or UMs, and or DNS will audit nursing assistant performing peri-care 5x wkly x 2 weeks, 2x wkly x 2 weeks, then 1x wkly x 3 months and reviewed in Performance Improvement (PI) meeting for 3 months. A subsequent plan will be developed and implemented as needed.	F 312 4/04/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 312	Continued From page 76 provide thorough incontinent care for 1 of 3 residents dependent on staff for activities of daily living. (Resident #9) Findings include: Review of the facility policy titled "Perineal Care for the Female Resident" dated 04/28/07, read in part; "Gently cleanses the pubic area: a. Uses one gloved hand to stabilize and separate the labia and use the other hand to wash from front to back. b. Cleanses from front to back. c. Uses only one side of cloth for each swipe." Resident #9 was re-admitted to the facility on 11/17/10. The resident's cumulative diagnoses included, hypertension, cerebrovascular accident and dementia. The minimum data set (MDS) dated 12/10/10, revealed the resident had severe cognitive impairment. Resident #9 was always incontinent of bowel and bladder. The resident was totally dependent upon staff for all activities of daily living including toileting and personal hygiene. The resident's care plan, last reviewed on 1/26/11, included incontinence of bowel and bladder related to the disease process and short term memory loss. The goal was for the resident to be clean and free from odor daily. The interventions included, perineal care in the AM and PM as well as after each incontinent episode, per policy and procedure. On 2/27/11 at 6:58PM an observation of incontinent care being done for resident #9 was	F 312	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 312	Continued From page 76 provide thorough incontinent care for 1 of 3 residents dependent on staff for activities of daily living. (Resident #9) Findings include: Review of the facility policy titled "Perineal Care for the Female Resident" dated 04/28/07, read in part; "Gently cleanses the pubic area: a. Uses one gloved hand to stabilize and separate the labia and use the other hand to wash from front to back. b. Cleanses from front to back. c. Uses only one side of cloth for each swipe." Resident #9 was re-admitted to the facility on 11/17/10. The resident's cumulative diagnoses included, hypertension, cerebrovascular accident and dementia. The minimum data set (MDS) dated 12/10/10, revealed the resident had severe cognitive impairment. Resident #9 was always incontinent of bowel and bladder. The resident was totally dependent upon staff for all activities of daily living including toileting and personal hygiene. The resident's care plan, last reviewed on 1/26/11, included incontinence of bowel and bladder related to the disease process and short term memory loss. The goal was for the resident to be clean and free from odor daily. The interventions included, perineal care in the AM and PM as well as after each incontinent episode, per policy and procedure. On 2/27/11 at 6:58PM an observation of incontinent care being done for resident #9 was	F 312	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 312	Continued From page 77 done. Nursing Assistants (NA) #8 and #9 were present. NA #8 turned the resident on her left side. NA #9 proceeded to cleanse the resident from front to back, starting in the vaginal area. The NA then wiped the resident's rectal area which had a small amount of soft stool. NA #9 then took the same rag, same spot on the rag, which now had stool on it, went back and wiped the vaginal area again from front to back. The NAs then placed a new incontinence brief on the resident. During an interview, on 2/27/11 at 7:07PM, NA #9 stated she should have folded the towel to a clean area or obtained a new towel after cleansing the stool from the resident. She indicated she should not have went back and cleansed the vaginal area with the towel once it was soiled with stool and could not provide a reason why she did. The interim Director of Nursing (DON) was interviewed on 3/1/11 at 9:15AM. The interim DON indicated the nursing assistants had been receiving training on peri-care. If their skills were still weak then the administrative team needed to go back and work with the staff member/members. The interim DON stated she would not want stool in the vaginal area as it could lead to a urinary tract infection. During an interview, on 3/1/11 at 9:35AM, the administrator indicated her expectations were for the staff to follow the policies and procedures they were taught in regards to peri-care.	F 312		
F 315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 315	Continued From page 78 assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to provide catheter care as ordered by the physician, failed to assess the urinary drainage system and failed to detect blockage of the urinary drainage system for 1 of 4 sampled residents. (Resident #2) Findings include: 1.Resident #2 was last re- admitted to the facility on 8/10/10 with diagnoses including, Parkinson's disease, end stage dementia, hypertension, anemia, cerebrovascular accident, quadriplegia and anxiety. The Resident Assessment Protocol (RAPS), dated 7/21/10, revealed a concern with urinary incontinence. The resident was not able to voice her needs and was incontinent of bowel and bladder. An undated care plan revealed a problem with urinary output related to the need for an indwelling catheter due to persistent overflow incontinence with symptomatic infections. The goal was for the resident to not develop any	F 315	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* 1. Unable to correct for resident #2. Resident discharges from facility on 1/30/2011. 2. Residents with indwelling catheters have the potential to be affected. Licensed nursing staff were in-serviced by the Staff Development Coordinator (SDC) on the facility's policy and procedure for catheter care and signs and symptoms of indwelling catheter blockage. Nursing assistants were in-serviced by the SDC on the facility's policy and procedure for catheter care and use of leg strap to secure the catheter. Skills competency validated with return demonstration for both licensed nursing staff and nursing assistants. Newly hired licensed and unlicensed nursing staff will receive above stated training and skills competency validation upon hire. 3. Director of Nursing Services (DNS) or SDC to observe staff performance of catheter care 5 x week x 2 months, then weekly x 1 month to validate continued competency. DNS or SDC will validate documentation of catheter care and urine output on the Treatment Administration Records daily ongoing during morning clinical rounds. Residents with noted decrease in urine	F 315 4/04/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 315	Continued From page 79 symptomatic urinary tract infections (UTI) and/or catheter related complications. The interventions included, provide catheter care per facility protocol to prevent infection and/or reduce irritation. Observe and report signs and symptoms of UTI (including cloudy urine, sediment in urine, discolored tubing or drainage bag, complaints of burning and/or suprapubic tenderness, dark concentrated urine, hematuria, fever, cognitive changes and foul smelling urine.). Observe and report any signs/symptoms of catheter related complications (including blocked catheter). Resident #2's monthly physician orders for January 2011 included an order for catheter care every shift. The indwelling catheter was to be changed every month and as needed for leakage or occlusion. Resident #2 had labs collected on 1/3/11. Her BUN (blood urea nitrogen- a test that revealed important information about how well her kidneys and liver were working) was 40 (range was 6-23) and her creatinine (a test used to diagnose impaired kidney function and to determine kidney damage) was 1.36 (range was 0.40-1.20). Review of the " C.N.A. Flow Record " revealed on 1/9/11 the resident had 200 cc (cubic centimeters) of yellow urine documented on the 11-7 shift. No other shifts had documented the resident's urine ouput.Review of the " C.N.A. Flow Record " revealed on 1/12/11 she had 400cc of yellow urine documented on the 11-7 shift. No other shifts had documented the resident's output. There were no other urinary outputs documented until 1/21/11.	F 315	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* output amount will be assessed for potential catheter blockage and the attending physician notified of the decrease in urine output and the assessment findings. DNS will maintain log of these identified residents and document validation of nursing assessment, physician notification, and new order implementation as appropriate. 4. Results of catheter care observations and the log for residents identified with decreased urine output will be reviewed by the facility's Performance Improvement Committee monthly x 3 months for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 315	Continued From page 80 Resident #2 was seen by the physician on 1/13/11. The physician noted her respirations were between 16-24 and irregular. She had a neurogenic bladder and end stage Alzheimer's disease. A nurse's note dated 1/15/11 revealed the urine in the resident's drainage bag was "turbid & amber colored." The on call physician was contacted and gave no orders because the resident was not running a fever and was "probably colonized" due to having the indwelling catheter. The nurse's note for 1/16/11 revealed the catheter was found lying between the resident's legs with the balloon fully inflated. A moderate amount of bleeding was noted. A new indwelling catheter was inserted and was draining blood tinged urine. A basic metabolic panel (BMP/lab) was drawn on 1/19/11. Resident #2's BUN was 56 (range was 6-23) and her creatinine was 1.49 (range was 0.40-1.20). The potassium level was 4.1 (range 3.5-5.3). A note from a nurse was left for the physician on 1/19/11. The resident was noted to have blood in indwelling catheter. The physician responded the same day to obtain a UA (urinalysis) and a PT (Prothrombin Time) with INR (International Normalized Ratio). The resident was taking Coumadin 4mg (milligrams) everyday. A verbal order was written to obtain the UA and PT/INR on 1/20/11. The results of the PT/INR on 1/20/11 were as follows, PT= 26.4 seconds (range 11.6 - 15.2) and INR= 3.47 (therapeutic range normally between 2-3).	F 315	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 315	Continued From page 81 Review of the " C.N.A. Flow Record " reflected an output of 400cc on 1/21/11 with no description of the urine and no details to indicate if it was for one shift or the entire day. The physician visited the resident on 1/21/11 noted questionable hematuria (bloody urine) versus amber colored urine. He noted the urine drainage bag was clear at the time of his assessment with no signs of blood. The physician wanted the UA results faxed to him when available. On 1/25/11 the resident was started on Macrobid 100 mg twice daily for 7 days. Review of the " C.N.A. Flow Record " reflected an output of 450cc for 2nd shift and 300cc for 3rd on 1/25/11 with no description of the urine. Review of the " C.N.A. Flow Record " reflected an output of 250cc for 2nd shift on 1/26/11 with no description of the urine. The nurse's note dated , 1/27/11 at 11:30AM revealed the catheter was draining yellow urine. No amount listed. Review of the " C.N.A. Flow Record " reflected an output of 450cc for 2nd shift on 1/27/11 with no description of the urine. A nurse's note dated 1/29/11 at 7:30AM, noted her indwelling catheter was intact with clear amber urine. No amount of output was noted. On 1/30/11 at 11:30AM nurse #6 was called to the resident's room by the NA (nursing assistant).	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 315	Continued From page 82 The resident was breathing heavily and grimacing. She was medicated for pain due to the facial grimacing. The resident was suctioned with no results, her lungs were clear to auscultation bilaterally. Review of the nurse's notes, dated 1/30/11 at 2:35PM revealed the resident continued to have labored breathing. Her vitals were, temperature 98.2 Fahrenheit, pulse 68, respirations 20, and blood pressure was 85/62. She was on 1.5 liter of nasal cannula oxygen and her oxygen saturation was 95%. A " scant " amount of amber colored urine was noted as output since 7AM. An assessment of the resident's abdomen was not noted. Review of the medication administration record (MAR) for the month of January 2011 revealed an order for " Catheter Care Q (every) Shift. " Handwritten on the MAR was " 7-3 " (shift). No other shifts were noted on the MAR. Catheter care was documented as being done on the 7-3 shift seventeen times.No other shifts were noted catheter care as being done. Catheter care was not noted as being done on 1/29/11,1/30/11 or 1/31/11. The resident was sent to the emergency department (ED) for evaluation and treatment on 1/30/11 per the nurse's notes (2:35PM). Review of the hospital records revealed, resident #2 was sent to the hospital on 1/30/2011. The chief complaint was " abnormal breathing. " Review of the ED notes revealed the resident was also sent to the ED for evaluation of low blood pressure. The resident had been grimacing more and appeared in pain. The resident was currently	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 315	Continued From page 83	F 315		

being treated for a UTI. Examination of the resident's abdomen noted, " abdomen is tender to RLQ/LLQ (right lower quadrant/left lower quadrant). " The nurse's note reflected the resident arrived with an indwelling catheter in place. The " tubing noted to be dry, no urine in tubing, sediment noted along entire tubing, less than 100 ml (milliliters) dark urine noted in bag. " The indwelling catheter was replaced and an " immediate return of 600ml bloody urine with clots noted. " The history and physical read in part, " she was found to have a very dirty and clogged up Foley catheter. Her basic lab work showed acute renal failure from serum creatinine jumping from 1 to about 5 and she was also hyperkalemic (elevated potassium of 6.9). She had a CT (computed tomography) scan of the abdomen and pelvis, which showed hydronephrosis (swelling of a kidney due to back up of urine), bilateral dilated ureters and distended bladder even though the Foley is in place. Obviously, this is a Foley catheter that was clogged. " Resident #2's admitting diagnoses were, acute renal failure, hyperkalemia, pyelonephritis (A UTI that starts in the urethra or bladder and travels up to the kidney), and hydronephrosis.

During an interview on 2/17/11 at 11:47AM nurse #3 indicated indwelling catheter care should be done every shift. The NA's should report things like bloody urine to the nurse and the nurse should then inform the physician.

An interview was conducted on 2/17/11 at 11:53AM with nurse #4. The nurse stated resident's with indwelling catheters should have catheter care every shift. The staff (nurses and NAs) should be monitoring intake and output and changes in the urine (color consistency).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 315	Continued From page 84 NA #2 was interviewed on 2/17/11 at 2:43PM. The NA indicated catheter care should be done " everyday " and sometimes it was done more than once a day. NA #2 worked regularly with resident #2. The resident was usually " neat and clean " in regards to her personal hygiene. She was totally dependent on staff for personal hygiene and toileting. The NA did not recall the resident having any problems (bloody urine, decreased output) with her indwelling catheter. During an interview on 2/17/11 at 3:06PM, NA #3 indicated the resident was totally dependent on the facility staff for her activities of daily living (personal hygiene, toileting). NA #3 stated catheter care should be done everyday. She did not recall the resident having bloody urine (hematuria) when she took care of her. An interview was conducted with the DON on 2/17/11 at 4:33PM. The DON indicated the facility recently switched documenting catheter care from the treatment record to the medication administration record. The DON stated this could be a reason the staff was not keeping track of the times they did catheter care. The DON expected the facility staff to do catheter care every shift. It should be documented as being done. The DON expected staff to report changes in the urine such as blood or decreased output. The resident's physician was interviewed on 2/17/11 at 5:45PM. The physician indicated the resident did have periods of hematuria, but not consistent hematuria. The staff did report a change in the color of the urine from yellow to bloody. The physician expected the facility staff to be caring for the indwelling catheter per their	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 315	Continued From page 85 policy and procedure.	F 315	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.*	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to conduct laboratory tests as ordered by the physician for Pro-Time (PT) and (INR) International Normalization Ratio to monitor the use of anticoagulant (Coumadin) therapy for 1 of 2 sampled residents resulting in a sub therapeutic (low) INR . (Resident #11)	F 329	1. Unable to correct missed PT/INR testing for resident #11. PT/INR obtained on 2/22/2011. The PT was 20.6 and the INR was 1.79. The attending physician was notified and a verbal order received to continue Coumadin dosage at 2.5mg PO daily. 2. Residents requiring PT/INR testing to monitor the use of Coumadin have the potential to be affected. Licensed nursing staff were in-serviced by the Staff Development Coordinator (SDC) on revised protocol for scheduling and obtaining laboratory tests. Newly hired licensed staff will receive this training upon hire. Residents receiving Coumadin were identified through medical record review. Medical records of these identified residents were also reviewed to validate a current PT/INR was available and a physician's order for PT/INR frequency was present. Residents with no current PT/INR results or no physician order for PT/INR frequency were identified, the attending physician notified, and orders implemented as received. Lab calendar was reviewed by the Director of Nursing Services (DNS) to validate PT/INRs were scheduled as per MD orders.	F 329 4/04/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 329	Continued From page 86 Findings include: Resident #11 was admitted to the facility on 9/28/10. Her diagnoses included cerebrovascular accident, hypertension, atrial fibrillation, and dementia. The most recent minimum data set (MDS), dated 2/14/11, revealed the resident had severely impaired cognitive skills. The resident was totally dependent on staff for bed mobility, transfers, dressings, toileting, personal hygiene and bathing. The care plan was last reviewed on 12/22/10 and included a concern for the risk for adverse bleeding related to administration of Coumadin. The goal was no adverse bleeding through the next review. Interventions included, monitor resident for abnormal bleeding and bruising, monitor PT/INR per physician orders, administer Coumadin per physician orders and limit consumption of foods high in Vit K. Review of the physician order for January 2011 revealed the following orders, "Check PT/INR Q (every) Monday" and another order read "PT/INR Q Monday and Thursday." Resident #11 was also receiving Coumadin 2mg (milligrams) PO (by mouth) QD (every day). On 1/12/11 a PT/INR was drawn on resident #11. The results were reported to the facility on 1/13/11. The PT was 16.4 (range 11.6-15.2) the INR was 1.33 (therapeutic range was generally 2.0 to 3.0). Nurse #3 signed, initialed and dated the results on 1/13/11. She noted physician #2 was faxed and called. There was no notation from	F 329	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* 3. Nursing Supervisor to maintain ongoing individual Coumadin logs for residents receiving Coumadin. These logs will include the date and result of the latest PT/INR, current Coumadin order, Coumadin dosage changes, and the date of the next scheduled PT/INR. Nursing supervisor will review these logs weekly on Mondays ongoing to validate upcoming PT/INRs for the week are scheduled on the lab calendar. Once PT/INR results are received, the nursing supervisor will notify the attending physician of the results and update the individual Coumadin logs with the test results, any Coumadin dosage changes, and the date of the next scheduled PT/INR. If no response is received from the attending physician regarding PT/INR results that are sub therapeutic or elevated, the nursing supervisor will attempt a second notification. If still no response by the close of business on the day the PT/INR result is received, the nursing supervisor will contact the facility's medical director for intervention. 4. Individual Coumadin logs will be reviewed by the facility's Performance Improvement Committee monthly x 3 months for further recommendation and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 329	Continued From page 87 the physician on the form. No other PT/INR labs were drawn in the month of January 2011. The February 2011 physician orders revealed the following orders, "Check PT/INR Q Monday." Resident #11 was also receiving Coumadin 2 mg PO QD. A nurse's note (written by nurse #3) dated 2/4/11 read in part, " (name of physician #2) called regarding PT/INR drawn 1-12-11- no response to fax or call made on 1-13-11. (name of physician #2) ordered stat PT/INR and will regulate times PT to be drawn." During an interview, on 3/3/11 at 11:12AM, nurse #3 indicated once she calls the physician or the PA the first time she usually waits a day then tries again. She stated she usually notified the DON if she could not get in touch with a physician. The DON in January 2011 was not available for comment. Nurse #3 could not provide a clear explanation for why the PT/INR from 1/12/11 was not re-addressed with the physician until 2/4/11. She stated when/if she catches "it", she calls/faxes the physician again. A verbal order, dated 2/4/11 read in part, "PT/INR now- call results." Further review of the nurse's notes revealed the lab stated they did not receive the initial specimen from 2/4/11. A verbal order dated 2/4/11 read in part, "Draw PT/INR Sat 2-5-11; call results to on call physician." A review of the nurse's notes revealed the	F 329	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* validation of continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 329	Continued From page 88 PT/INR was redrawn on 2/7/11. There was no explanation given why the labs needed redrawn from 2/5/11. PT/INR results dated 2/7/11 were 19.0/1.64 respectfully. A verbal order was received on 2/8/11 and read in part, "Increase Coumadin 2.5mg po qd recheck PT/INR in 2 weeks." On 2/22/11 a PT/INR was collected. The result were reported to the facility on 2/23/11. The PT was 20.6 and the INR was 1.79. A verbal order was received on 2/25/11 and read in part, "No change continue Coumadin 2.5mg po daily." During an interview, on 3/3/11 at 10AM, physician #2 indicated he wanted resident #11's PT and INR monitored closely because it was not at a therapeutic level. He stated he wanted the INR to be between 2-3 and he would monitor the PT/INR either once a week or twice a week. Once the resident started reaching therapeutic levels, he would monitor every other week. The longest stretch would be 4 weeks and that would only be once the resident was in the therapeutic range of 2-3 (for the INR). Physician #2 stated whenever a resident had a change in Coumadin dosing they would require close monitoring as well until the resident was within what the physician considered a therapeutic range. The physician indicated if the facility staff could not reach him by fax or phone, they should try again. The facility staff could also attempt to reach his physician assistant (PA). Physician #2 stated the facility staff should keep trying until they reached either him or the PA. He	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 329	Continued From page 89 indicated the evidence of the facility contacting him or the PA would be a fax with a date, signature and instructions on it or if they called him a verbal order with instructions. The interim Director of Nursing (DON) was interviewed on 3/3/11 at 11:09AM. She indicated she just became responsible for monitoring lab results about 1 week ago. The former assistant DON and former DON were responsible before and she could not answer for their actions. The interim DON's understanding of lab monitoring at this point was, the labs were written on a calendar. The lab company came usually on Tuesday, Wednesday, and Thursday. When verbal orders were written the interim, DON would receive the green carbon copy. Once the labs were back from the lab company, the interim DON would pass them out to the floor nurses. The nurses were responsible for contacting the physicians. Many of the physicians prefer faxes instead of phone calls. If the labs were critical levels the interim DON indicated the nurse should keep trying to reach the physician. The nurse should then inform the DON if they cannot reach the physician. The administrator would then get involved if the DON could not reach the physician.	F 329	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.*	
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.	F 387	1. Attending physician for resident #3 notified of need for physician visit and of non-compliance with federal regulations. Federal regulation regarding physician visits was reviewed with the attending physician by the administrator on 2/16/2011. 2. Residents residing in the facility have the potential to be affected. Current residents' medical records were reviewed to determine compliance with federal regulations regarding frequency of physician visits. Residents needing a physician visit were identified and the attending physicians notified as appropriate. Medical records clerk in-serviced on federal regulation regarding frequency of physician visits, scheduling physician visits, and the use of Physician's Assistants and Nurse Practitioners as medical providers. 3. Medical Records Clerk will maintain an ongoing master physician visit list for residents to track physician visits and ensure regulatory requirements are met. Medical records clerk will notify the attending physician on an ongoing basis when a visit is needed to maintain compliance. Administrator will review the master visit list monthly ongoing to validate continued compliance with	F 387 4/04/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 387	Continued From page 90 This REQUIREMENT is not met as evidenced by: Based on staff interviews, physician interview, and record review, the facility failed to ensure physician visits for 1 of 3 sampled residents. (Resident #3) Findings include: 1. Resident # 3 was admitted to the facility on 5/22/08. The resident's diagnoses included, but were not limited to, cerebrovascular accident, hypertension, dyslipidemia, and hemiplegia. Record review revealed that Resident #3 was last seen by Physician #3 on 5/15/10. There were no more documented physician visits in the medical record for Resident #3 . During an interview with the social worker on 2/17/11, at 12:15 p.m., she stated "that (Resident #3) had been displaying several behaviors since October 2010. " A visiting PA (Physician Assistant) wrote an order for a Mental Health consult but the resident was not seen by mental health until 12/7/10, because the facility was waiting for the Attending Physician to sign the order and although the resident was seen by Mental Health on 12/7/10, the order was still not signed. The social worker further stated that "the facility called the attending physician's office and faxed a new consult order but the physician did not reply." On 12/15/2010, the Medical Director signed for the Mental Health consult. The Resident was then seen on 12/29/2010. New medications were recommended during the mental health consult. The social worker indicated that the Attending Physician could not	F 387	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* regulatory requirements for physician visit frequency. 4. Results of the Administrator's monthly review of the physician visit master list will be reported to the facility's Performance Improvement Committee monthly x 3 months for further recommendation and validation of continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 387	Continued From page 91 be contacted to sign off for the medications. The Medical Director signed the orders for the new medications on 1/8/2011. During an interview, on 2/17/11, at 3:05 p.m., the administrator indicated that "I expected the physician to visit the residents according to the regulatory requirement once every 30 days for the first 3 months for new admissions, then every 60 days thereafter." She further added that "the physicians visits are documented in the Resident Care System (RCS is a system that tracks electronically PAs and physicians visits.) and I will have to revisit the system so that I can differentiate between the physician assistants (PAs) visits and the physicians visits." During an interview, on 2/17/11, at 5:35 p.m., Physician #3 stated that it was an oversight on his part that the residents were not seen in a timely manner. He further stated that "my (PA) switched the November visit and that threw the schedule off." He also added that "I did not make frequent visits, because my office has a new computerized system that was being implemented, and my office is behind in putting the patients' notes in the computer."	F 387		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 514	Continued From page 92 resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record reviews and staff interviews, the facility failed to document medication provided to 1 of 3 sampled residents with medication orders. (Resident #3) Furthermore, the facility had duplicate medication orders of the same medication (Plavix) on 1 of 3 sampled residents physician orders and medication administration records. (Resident #1) The findings included: 1. Resident #3 was admitted to the facility on 5/22/08. Diagnoses included cerebrovascular accident, hypertension, dyslipidemia, and hemiplegia. Review of the resident's Psychiatric Diagnostic Interview on 12/7/10 read in part " Findings; depression: Recommendation; Zoloft 25 milligrams (mg) po [by mouth] daily; depressed mood. " Review of physician telephone order dated 1/8/11 read in part " Zoloft 25 mg po [by mouth] daily; depressed mood. " Review of resident #3 medication administration record (MAR) from 1/9/11 through 2/16/11 revealed that Zoloft was not documented as given to the resident as ordered Record review revealed 2 instances of Zoloft not	F 514	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* 1. Unable to correct deficient practice as medication occurrence is in the past for Resident #3. Primary nurses for Resident #3 were in-serviced to assure that resident is medicated at scheduled medication time. Medication Error Report was completed for omissions for 1/15/11 and 1/16/11. Resident #1 was discharged from the facility on 1/13/11 and unable to correct area identified as deficient practice. 2. Residents residing in the facility have the potential to be affected. Licensed nursing staff in-serviced on the 5 Rights of Medication with specific focus to reviewing the MAR explicitly to assure that each medication is given as ordered. 3. In-service training completed and the audit tool entitled *Licensed Nurse Shift-to-Shift Sign Off Report* implemented to assist licensed nurses in reviewing residents' MAR to assure that omissions are prevented for each shift. This tool will be utilized on-going and will be included in new employee orientation for licensed nurses. Medication Errors observed will be handled following the facility's policy. Physician Orders to be reviewed each month at month-end medication re-capitulation by Nursing Administration (DNS, SDC, UMs,	F 514 4/04/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 514	Continued From page 93 marked as given on the resident MAR for the month of January (1/15/11 and 1/16/11) and 15 instances of Zoloft not marked as given for the month of February (2/1/11 through 2/15/11). During a staff interview on 2/16/11 at 10:30 a.m., nurse #3 indicated that " I gave Resident #3 Zoloft this morning and every morning for the month of February whenever I worked [nurse #3 works Monday through Friday, 7-3] but because Zoloft was not highlighted on the MAR, I did not mark Zoloft on the MAR as given. " When asked by the surveyor if the resident was given Zoloft on 1/15 and 1/16/11 she stated " I do not know, those days are weekends, and I do not work on weekends and the weekend nurse is not here. " During an interview with the director of nursing (DON) on 2/16/11 at 11:00 a.m., she stated that her expectations are that " if the medications are not marked as given on the MAR by the nurse, as a rule they are not given. " Record review of the pharmacy reconciliation chart on 2/16/11 indicated that 16 tablets were dispersed to Resident #3, and observation revealed that 16 tablets were administered. 2. Resident #1 was admitted to the facility on 1/3/11. The facility policy titled "Physician Orders", dated 10/31/09, read in part under the medication orders section, "Verify dosages and/or orders that appear inappropriate, illegible, or presents any other concerns, prior to administering the	F 514	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.* MDS) to assure no duplication of medication and or treatment orders. Errors to be corrected at the time of observation. Data entry personnel in-serviced on data system to further prevent errors printing on monthly Physician Order Sheets. 4. The audit tool entitled *Licensed Nurse Shift-to-Shift Sign Off Report* and monthly physician orders and any subsequent medication errors will be reviewed monthly in facility Performance Improvement (PI) meeting x 3 months to assure that omissions in medication administration are resolved and Physician Orders are accurate. Subsequent plan of action will be devised as needed for areas of continued non-compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 514	Continued From page 94 medication. Clarify any orders observed to be incomplete, illegible or presents any other concerns, prior to administering the medication." Review of the admission orders dated 1/3/11 revealed an order for Plavix 75 mg (milligrams) by mouth daily at 9AM. Three boxes down on the admission orders was a duplication of the Plavix order that read the same. The medication administration record (MAR) for January 2011 reflected two separate entries for Plavix. Both entries were for Plavix 75mg by mouth daily at 9AM. Nurses starting on 1/4/11 signed off both entries. The second entry continued to be signed off as given up until 1/11/11, when it was then noted as a "duplicate." During an interview, on 2/16/11 at 10:26AM, the Director of Nursing (DON) indicated the nurse's should have caught on to the fact the Plavix was written twice. A transcription error form should have been completed. An interview with nurse #1 was conducted on 2/17/11 at 12:15PM. Nurse #1 cared for the resident for 8 of the 10 days she was present in the facility. The nurse verified her signature was present on all but 2 of the days the duplicate order was signed as given. Nurse #1 stated she was the nurse who caught on to the duplicate order on 1/11/11. She indicated she wrote the word "duplicate" on the MAR. The nurse stated she did not give the medication twice. She indicated it was just hard when passing medications and sometimes you just get caught up and just sign it. Nurse #1 stated she should have clarified and checked the order once she	F 514	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the 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.*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 03/03/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 514	Continued From page 95 noticed the duplicate and "obviously" it was (a duplicate). The nurse could not provide any further explanation for why a transcription error report was not done.	F 514		