STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	03/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to determine the ability to self administer a breathing medication for 1 of 1 sampled resident (Resident #17. Resident #17 was admitted on 2/1/11 with the cumulative diagnoses of expressive aphasia, pulmonary edema, and chronic obstructive pulmonary disease (COPD). Record review of an undated facility policy titled " Bedside Medications " revealed " No medications or supplies shall be left at the bedside, unless there is a specific written order by the physician. The most recent Admission Minimum Data Set (MDS) assessment dated 2/1/11 revealed Resident #17 was cognitively intact. Record review of the Physician ' s Orders dated 3/1/11 - 3/31/11 for Resident #17 did not reveal a written order for self medication. Record of the medical record on 3/9/11 did not reveal an assessment / form indicating Resident #17 was able to self administer medication(s). Record review of Physician ' s Orders dated	F 176	Medication was removed from resident #17's room the day of the survey. All rooms have been checked by the staff developer and there are no medications at the bedside. The D.O.N. will watch one Med pass, once a week for 60 days to ensure nurses do not leave medications in the resident room. Any negative findings will be sent to the next quarterly QA meeting for resolution.	4-6-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Wendy Davis — TITLE: Administrator — (X6) DATE: 4-1-11

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.

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F 176	Continued From page 1 3/1/11 -3/31/11 for Resident #17 revealed AdvAIR Diskus 250-50 microgram (mcg) Disk inhale 1 puff by mouth twice daily at 9:00 AM and 5:00 PM. During an observation on 3/8/11 at 4:30 PM Nurse #3 gave Resident #17 the AdvAIR Diskus to inhale 1 puff followed by some ice chips. Nurse #1 placed the AdvAIR Diskus on Resident #17 ' s over bed table. Nurse #1 left the room at 4:40 PM. During an observation on 3/8/11 at 5:15 PM the Administrator went into Resident #17 ' s room and observed the AdvAIR Diskus on the over bed table. The Administrator indicated he did not know if Resident #17 could keep the medication in his room. The Administrator indicated he would check to see if Resident #17 was able to keep the medication in his room. During an observation on 3/8/11 at 5:17 PM the Administrator asked Nurse #1 if Resident #17 could keep the AdvAIR Diskus in his room. The Administrator also asked Nurse #1 if she had left the AdvAIR Diskus in Resident #17 ' s room. Nurse #1 indicated she must have left the AdvAIR Diskus in Resident #17 ' s room. Nurse #1 went into Resident #17 ' s room and removed the AdvAIR Diskus from the over bed table. An interview was held on 3/9/11 at 7:30 PM with the Director of Nursing. She indicated her expectation was medications were left at the bedside of a Resident after an assessment and form were completed to determine if the resident was alert and oriented enough to give themselves medication(s).	F 176		
F 242	483.15(b) SELF-DETERMINATION - RIGHT TO	F 242		

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	345316	A. BUILDING _____ B. WING _____ APR 13 2011	03/09/2011

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F 242 SS=D	Continued From page 2 MAKE CHOICES 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 observations, staff interviews and record reviews, the facility failed to assist a resident to attend and participate in a chosen activity for 1 of 1 sampled residents. (Resident #13). The findings included: Resident #13 was admitted to the facility on 4/30/2010. Resident #13's cumulative diagnoses included sepsis, respiratory failure, diabetes, general muscle weakness, osteoarthritis, and dysphagia. The quarterly Minimum Data Set (MDS) dated 2/7/2011, indicated the resident had intact short and long term memory and had no cognitive impairments. The MDS revealed the resident required extensive and total assistance with all activities of daily living, required two person assistance with transfers, and his mode of locomotion was by wheelchair. An admission activity assessment was conducted on 5/1/2010. The assessment indicated the resident had interest in spiritual / religious activities. On 2/22/2011 the Activity Assessment / Participation for Resident #13 listed religious,	F 242	All interviewable residents have been interviewed by the Activity Director to make sure they are able to attend the facility activities of their choice. On a weekly basis, for 60 days, the activity Director will talk to 2 interviewable residents to ensure they are attending the facility activity of their choice. The Activity Director will also ask the residents in resident council. Any negative findings from monitoring will be sent to the next quarterly QA meeting for follow up. Each resident has a facility activity calendar on their closet door. The activities they like to attend are highlighted so any staff member in the room will know which activities the resident prefers.	4-6-11

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F 242	Continued From page 3 musical, and social events as areas of interest and attendance for this resident. On 3/8/2011 at 10:30 AM Resident #13 was observed to be in his bed with his gown on. The resident stated he asked staff to get him up each morning at 9:30 AM. He stated he wanted to go to church. He indicated staff never assisted him up as requested. Resident #13 revealed he asked to be gotten up early two days a week and dressed because church services were held in the facility. Resident stated he only got to attend about half the time. Resident #13 revealed it made him mad when staff did not get him up. On 3/8/2100 at 10:40 a church service was observed in progress in the facility living room. An interview was conducted with Nursing Assistant # 3 (NA) on 3/9/2011 at 8:20 AM. She stated Resident #13 loved to go to church. She revealed she got him up at 9:00 AM on church days so he would be able to go. The resident's assigned Nursing Assistant (NA) #5 on 3/8/2011 was interviewed on 3/14/2011 at 12:41 PM. She reported the resident asked her to get him up to go to church the first time she entered his room to give morning care. NA #5 stated she informed the resident it was too late for her to be able to get the resident ready for church. NA#5 indicated she was not familiar with the resident"s activity schedule because she was a float nurse in the facility. An interview was conducted with the Activity Coordinator on 3/9/2011 at 2:45 PM. It was her expectation staff would assist residents to attend their activities of choice. She indicated she was	F 242		

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F 242	Continued From page 4 not aware Resident #13 had not been able to attend some of his chosen activities because staff did not get him up and dressed An interview with the Director of Nurses on 3/9/2011 at 5:10 PM revealed she was not aware staff were not getting Resident #13 up in time to attend church services. She stated it was her expectation staff would accommodate residents' requests for earlier morning care to allow them to attend chosen activities.	F 242		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility did not provide a sanitary environment by failing to clean a feeding pump, the pole, the floor area around the pump, the wall behind the pump, and the resident's bed for 1of 3 sampled residents with feeding tubes. (Resident #4). The findings include: During the initial tour of the facility on 3/7/2011 at 7:30 PM the feeding pump for Resident # 4 was observed. Numerous small droplets of dried brown matter were observed on the pump walls. Dried brown matter was observed on the feeding pole and on the pole legs. Two areas of dried droplets of brown matter were observed on the lower bed frame. One area was noted to be the size of a fifty cent coin and the other was the size	F 253	Resident #4's feeding pole wall, and floor have been cleaned by the housekeeper. All feeding poles in resident rooms have been cleaned along with the floor and wall. On a weekly basis, for 60 days, the Housekeeping Supervisor will check resident rooms that have a feeding tube to ensure the feeding pole, floor and wall have been cleaned. Any negative findings will be sent to the next quarterly QA meeting. After hours the laundry staff performs housekeeping duties as needed. If there is a spill after hours, nursing staff contacts laundry to clean.	4/6/11

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F 253	Continued From page 5 of a dime. A 2inch by 2 inch area of dried brown matter was detected on the left upper corner of the resident ' s bottom sheet. Three areas of dried brown matter in a drip pattern were observed on the wall directly behind the feeding pump. Eight areas of dime sized dried brown matter were noted on the floor around the feeding pole. An observation was conducted of Resident # 4's feeding pump on 3/8/2011 at 9:00 AM. The feeding pump, pump pole, bed frame, resident ' s sheet, wall, and floor were noted to be unchanged in appearance. On 3/8/2011 at 9:10 AM Nursing Assistant (NA) #4 was asked who was responsible for cleaning resident care equipment. She stated she was not sure but thought housekeeping did. During an interview on 3/8/2011 at 3:50 PM the Maintenance Supervisor indicated housekeeping staff were responsible for cleaning resident equipment during their daily cleaning of each resident's room. The Supervisor stated it was his expectation that all resident care equipment would be cleaned daily. Observation on 3/9/2011 at 8:15 AM revealed three dime sized dried areas of brown matter on the floor under the electrical cord for the feeding pump. The pump, pole, bed frame, and wall were unchanged in appearance. Nurse # 4 revealed on 3/9/2011 at 4:10 PM that she was not sure whether nursing or housekeeping were responsible for cleaning resident equipment. The nurse indicated she thought housekeeping was responsible.	F 253		

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F 253	Continued From page 6 During an interview on 3/14/2011 at 12:24 PM the first shift housekeeping staff assigned to Resident # 4's room indicated her department was suppose to clean all resident care equipment daily during their rounds. She stated she would clean the pump, wipe down the pole, and mop each day. She revealed when nursing staff changed the pump feeding bags the " stuff " got back on the pump, pole, and floor. An interview was conducted with the Director of Nursing on 3/9/2011 at 5:10 PM. When informed of the observations in Resident #4's room she stated it was her expectation that resident care equipment would be cleaned daily and as needed. She indicated housekeeping was responsible but nursing should follow up if the equipment needed cleaning.	F 253		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interviews with facility staff, the facility failed to draw laboratory tests that had been ordered by the physician for 2 of 14 sampled residents, (Residents #7 and #8), and failed to apply TED hose and Jobst stockings as ordered by the physician for 1 of 1 sampled resident (Resident #7). The findings include:	F 281		

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F 281	Continued From page 7 1. Resident #7 was admitted to the facility on 1/24/11 with the cumulative diagnoses of Stage 4 chronic kidney and volume depletion. The most recent Admission Minimum Data Set (MDS) assessment dated 1/31/11 revealed Resident #7 was cognitively intact. Record review of Physician ' s Telephone Orders dated 2/24/11 for Resident #7 revealed to do an albumin laboratory test on 3/1/11. Record review of Resident #7 ' s medical record did not reveal a laboratory report for an albumin on 3/1/11. An interview was held on 3/9/11 at 4:30 PM with the Director of Nursing (DON) who indicated they had forgotten to draw the albumin lab for Resident #7. An interview was held on 3/9/11 at 7:20 with the DON who indicated her expectation was lab orders were completed when ordered. 2. Resident #8 was admitted to the facility on 7/8/09 with the cumulative diagnosis of diabetes mellitus. The most recent Quarterly Minimum Data Set (MDS) assessment dated 12/31/10 revealed Resident #8 had short and long term memory loss and severely impaired daily decision making skills. Record review of a Physician ' s Telephone Orders dated 2/1/11-2/28/11 for Resident #8 revealed to do an A1C (blood test that reflects the	F 281	Resident #8's A1C has been performed. Resident #7 has been discharged. A list with all residents with A1C labs has been created as well as a list of residents with albumin labs. The DON will check, on a weekly basis, to ensure A1C and Albumin labs have been performed. This monitoring will last 60 days. Any negative findings from monitoring will be forwarded to the next quarterly QA meeting. A list of residents with Ted hose has been created. On a weekly basis the DON will check the residents on the list and the treatment sheet to ensure they are wearing them. This monitoring will last 60 days. Any negative findings will be forwarded to the next quarterly QA meeting.	4-6-11

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F 281	Continued From page 8 average blood sugar for the past 2-3 months) every 3 months (May, August, November, February). Record review of Resident #8 ' s medical record did not reveal a laboratory report for an A1C completed in February 2011. An interview was held with the DON on 3/9/11 at 9:50 AM who indicated they do not look at the Physician ' s Orders for the laboratory orders. She reported they have a list of all the labs that are done on a routine basis and the A1C for February 2011 was not on the list to do for Resident #8. An interview was held on 3/9/11 at 7:20 with the DON who indicated her expectation was lab orders were completed when ordered. 3. (A.) Resident #7 was admitted to the facility on 1/24/11 with the cumulative diagnoses of Stage 4 chronic kidney and congestive heart failure (CHF). The most recent Admission Minimum Data Set (MDS) assessment dated 1/31/11 revealed Resident #7 was cognitively intact. Record review of a Physician ' s Order dated 2/2/11 for Resident #7 revealed to use knee high Jobst stocking during the during the day. Review of the Treatment Record dated 2/1/11 - 2/28/11 for Resident #7 revealed an order to apply knee high Jobst stocking during the during the day. The Treatment Record dated 2/1/11 - 2/28/11 for Resident #7 revealed Jobst hose were signed as applied from 2/4/11 - 2/21/11, and on	F 281		

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F 281	Continued From page 9 2/24/11, 2/25/11 and 2/28/11. The Treatment Record dated 2/1/11 - 2/28/11 for Resident #7 revealed Jobst hose were signed as applied, with a circle around the initials, on 2/22/11, 2/23/11, and 2/26/11. The Treatment Record dated 2/1/11 - 2/28/11 for Resident #7 revealed Jobst hose was not signed as applied on 2/27/11. Review of the Treatment Record dated 3/1/11 - 3/31/11 for Resident #7 revealed knee high Jobst knee high stockings were signed as applied, with a circle around the initials, from 3/1/11 - 3/8/11. During an observation on 3/8/11 at 3:00 PM Resident #7 was laying in bed without Jobst knee high stockings / any stockings on either leg. An interview was held on 3/9/11 at 3:50 PM with the Treatment Nurse who indicated the circle around the initials on the Treatment Record for Resident #7 indicated the treatment was not done. She indicated if there was not a circle around the initials on the Treatment Record then the treatment had been done. The Treatment Nurse indicated the Jobst knee high stockings had not been applied because of the following: medication Resident #7 was taking, multiple bruising on the both legs, and the resident had indicated the stockings were too tight. She indicated it was a nursing decision not to use the Jobst knee high stockings for Resident #7. The Treatment Nurse indicated she thought the physician knew Resident #7 was not wearing the Jobst knee high stockings since he was in to see the resident multiple times. An interview was held on 3/9/11 at 4:00 PM with the RN Supervisor. She indicated if a treatment was not going to be done the Treatment Nurse	F 281		

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F 281	Continued From page 10 should obtain a clarification order / discontinuation order from the physician. The RN Supervisor indicated a clarification / discontinuation order should have been written for Jobst hose. The RN Supervisor reported the Communication Book was used to notify physicians about resident(s). She reported usually the staff would tell her about a (concern /change) or write them in the communication book. The RN Supervisor indicated she followed up on anything put in the communication book. During an observation and interview on 3/9/11 at 5:20 PM Resident #7 was laying in bed without Jobst knee high stockings / any stockings on either leg. Resident #7 indicated she had only worn the hose (stockings) when her legs were swollen. An interview was held on 3/9/11 at 7:20 PM with the DON who indicated her expectation was physician orders were followed or discontinued if not done. She indicated if Resident #7 refused to wear the hose / stockings it should be documented and the physician called for an order to discontinue the treatment. 3. (B.) Record review of Care Plan dated 2/10/11 for Resident #7 revealed to use Ted hose as ordered. Record review of a Physician ' s Order dated 2/14/11 for Resident #7 revealed to use Ted Hose during the day. Review of the Treatment Record dated 2/1/11 - 2/28/11 for Resident #7 did not reveal an order to apply Ted hose.	F 281		

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F 281	Continued From page 11 Review of the Treatment Record dated 3/1/11 - 3/31/11 for Resident #7 revealed an order for Ted hose stocking during the day with the start date of 2/14/11. The Treatment Record dated 3/1/11 - 3/31/11 for Resident #7 revealed Ted hose were signed as applied, with a circle around the initials, on 3/1/11, 3/2/11, 3/3/11, 3/5/11, 3/6/11, 3/7/11, and 3/8/11. The Treatment Record dated 3/1/11 - 3/31/11 for Resident #7 revealed Ted hose was not signed as applied on 3/4/11. During an observation on 3/8/11 at 3:00 PM Resident #7 was laying in bed without Ted hose / any hose on either leg. An interview was held on 3/9/11 at 3:50 PM with the Treatment Nurse who indicated the circle around the initials on the Treatment Record for Resident #7 indicated the treatment was not done. She indicated if there was not a circle around the initials on the Treatment Record then the treatment had been done. The Treatment Nurse indicated the Ted hose had not been applied because of the following: medication Resident #7 was taking, multiple bruising on the both legs, and the resident had indicated the hose were too tight. She indicated it was a nursing decision not to use the Ted hose for Resident #7. The Treatment Nurse indicated she thought the physician knew Resident #7 was not wearing the Ted hose since he was in to see the resident multiple times. An interview was held on 3/9/11 at 4:00 PM with the RN Supervisor. The RN Supervisor indicated the Treatment Nurse should have discontinued the Jobst stockings before the Ted hose were started. The RN Supervisor indicated a	F 281		

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F 281	Continued From page 12 clarification / discontinuation order should have been written for Jobst hose. She indicated if the Treatment Nurse did not put the Ted hose on Resident #7 then she should have written it in the Communication Book. The RN Supervisor reported the Communication Book was used to notify physicians about resident(s). She reported usually the staff would tell her about a (concern /change) or write them in the communication book. The RN Supervisor indicated she followed up on anything put in the communication book. During an observation and interview on 3/9/11 at 5:20 PM Resident #7 was lying in bed without Ted hose / any hose on either leg. Resident #7 indicated she had only worn the hose (stockings) when her legs were swollen. An interview was held on 3/9/11 at 7:20 PM with the DON who indicated her expectation was physician orders were followed or discontinued if not done. She indicated if Resident #7 refused to wear the hose / stockings it should be documented and the physician called for an order to discontinue the treatment.	F 281		
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, and record review, the facility failed to provide proper	F 312	Staff has been inserviced on incontinent care to ensure all resident are getting proper care. The staff Developer will watch incontinent care on one resident a week to ensure staff is performing correct technique. Each week the Staff Developer will watch a different shift. Findings will be sent to the next quarterly QA meeting.	4-6-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345316	A. BUILDING _____ B. WING _____	03/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 312	Continued From page 13 incontinent care for 1 of 4 sampled residents (Resident #8) that were dependent on staff for care. Findings included: Resident #8 was admitted to the facility on 7/8/09 with the cumulative diagnoses of multiple sclerosis (MS), renal insufficiency with neurogenic bladder, and urinary tract infection. Record review of an undated facility policy for " Incontinence Care " revealed under #6 to clean resident for female front to back. The most recent Quarterly Minimum Data Set (MDS) assessment dated 12/31/10 revealed Resident #8 had short and long term memory loss and severely impaired daily decision making skills. The MDS also revealed Resident #8 was frequently incontinent of bowel and bladder and was totally dependent for personal hygiene, bathing, and toileting. Record review of the Care Plan updated 1/5/11 revealed Resident #8 had a self care deficit related to impaired physical status and a diagnosis of MS. The goals for Resident #8 included to be kept clean and have all self care needs met by staff. The approach section revealed Resident #8 was to have incontinent care every 2 hours and as needed (p.r.n.) and personal hygiene needs provided daily which included the peri-area. During an observation on 3/8/11 at 10:10 AM Nursing Assistant #3 covered Resident #8, who was lying on her back in bed, with a bath blanket. Nursing Assistant #3 washed and dried Resident #8 ' s chest and back and applied deodorant under both arms. Nursing Assistant #3 removed	F 312		

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F 312	Continued From page 14 Resident #8 ' s brief and indicated the resident was wet. Nursing Assistant #3 used a wet wash cloth and washed Resident #8 ' s perineal area in a circular motion several times. Nursing Assistant #3 then washed Resident #8 ' s perineal area front to back and then back to front. She dried Resident #8 ' s perineal area and changed the water in the basin. Nursing Assistant #3 was not observed to separate the labia and wash Resident #8 ' s perineal area from front to back. Nursing Assistant #3 turned Resident #8 on her side. Nursing Assistant #3 used a wet wash cloth and washed Resident #8 ' s buttocks in a circular motion several times. Nursing Assistant #3 washed Resident #8 ' s rectal area from front to back and then back to front. She dried the buttocks and rectal area, turned Resident #8 onto her back and covered her with a bath blanket. Nursing Assistant #3 left the room and returned with supplies. Nursing Assistant #3 turned Resident #8 onto her side and applied cream to the buttocks. Nursing Assistant #3 turned and placed a brief on Resident #8. Nursing Assistant #3 completed care and dressed Resident #8. An interview was held on 3/8/11 at 10:30 AM with Nursing Assistant #3 who indicated she knew to wash the (perineal) area by starting at the top, washing the middle, and then the back. She reported she had been trained to wash from front to back when washing the bottom. Nursing Assistant #3 indicated she knew not to wash back to front because of infection. An interview was held on 3/9/11 at 4:20 PM with the Staff Developer. She indicated the staff members were trained yearly on incontinent care for males and females. She indicated for a female the staff members were trained to clean	F 312		

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F 312	Continued From page 15 the outside, separate the labia, clean front to back and clean the rectal area front to back. An interview was held on 3/9/11 at 7:20 PM with the Director of Nursing who indicated her expectation was incontinent care would be done correctly.	F 312		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record reviews: (1) the facility failed to ensure dented cans were separated from ready to use cans of food items, (2) the facility failed to prevent cross contamination by not separating ready to eat foods from thawing meats and (3) by dietary staff touching clean dishes with dirty gloves in the dishwashing area, (4) the facility failed to maintain quaternary solution in the 3-compartment sink at the recommended concentration of 200 parts per million (ppm) and (5) failed to maintain sanitizer solution in the kitchen for surface cleaning. Findings include: 1. During the initial tour of the kitchen on 3/7/11	F 371	On 3-24-11, the Dietitian conducted an inservice with the dietary staff on the sanitizer sink, sanitizer spray bottles, and proper handling of dirty and clean dishes. On a weekly basis, the Dietary Manager will check the freezer to ensure meats are stored properly. The Dietary Manager has also addressed the storage of meats with the dietary staff. The Dietary Manager, on a weekly basis, will observe the dietary aide in the dishwashing area to ensure staff is properly using gloves. On a weekly basis, the Dietary Manager will observe staff at the 3 compartment sink to ensure the correct amount of sanitizer is being used. On a weekly basis, the Dietary Manager will ensure the kitchen has enough sanitizer solution. All of the kitchen monitoring will last 90 days. Any negative findings will be forwarded to the next quarterly QA meeting for follow up.	4-6-11

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F 371	Continued From page 16 beginning at 7:00 PM, a dented can of corn was in the can rack, ready for preparation for residents. There was no separate area noted in the storage room for dented cans. On 3/9/11 at 8:56 AM, Dietary Aide #3 stated that dented cans were not to be used. Corn had been on the menu the day before and she had not checked the can to ensure it was not dented. The Food Service Director (FSD) stated on 3/9/11 8:58 AM that dented cans were not to be used for residents and were to be separated from cans those in the can rack. The FSD stated that dented cans are usually returned to the vendor for a credit. She stated that she had noticed the dented can of corn on the rack and had discarded the can in the trash. A review of the Program 8 of Educational Planning Services Corporation which the FSD stated was used for training stated that staff should "always be on the lookout for food spoilage. This includes dented cans." 2. During the initial tour of the kitchen on 3/7/11 beginning at 7:00 PM, the reach in cooler contained one opened box of 90 count individual packages of ready to serve margarine which was placed on top of a pan containing two (2) thawing, raw packages of beef. One 64 ounce bottle of juice and a one gallon jar of mustard were stored on the shelf beside a pan of raw, thawing turkeys. On 3/9/11 at 4:35 PM, an opened 64 ounce jar of juice and an opened one gallon jar of mustard were stored on the bottom shelf of the reach in cooler beside raw meats.	F 371		

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F 371	Continued From page 17 In an interview with the FSD on 3/9/11 at 4:35 PM, she stated that staff have been trained to only store meats on the bottom shelf. She said that all other foods should be stored above the raw meats. 3. During an observation of staff utilizing the dishwasher on 3/9/11 at 8:31 AM, Dietary Aide #2 was rinsing dirty dishes and placing them in racks to be washed. She was observed using a rack of dirty dishes to push a rack of clean dishes out of the dishwasher and then proceed to wash the dirty dishes. Dietary Aide #1 removed the dishes from the rack and placed them to dry. One rack of bowls and cups were observed to have 3 cups and 2 bowls turned upright, filled with water from the dish machine. Dietary Aide #1 turned the cups and bowls over and placed them to dry. Dietary Aide #2 was observed to use her dirty gloved hand to push a rack of clean trays out of the dishwasher. The gloves which had been used to remove food items from dirty dishes were observed to touch the clean trays which had been washed. In an interview with Dietary Aide #1 on 3/9/11 at 8:39 AM, she stated that bowls and cups are tossed around in the dishwasher. When that happened, she stated she poured the water out and then let them dry. She stated that the water could have food or other items and probably should rewash. Dietary Aide #2 was interviewed on 3/9/11 at 8:45 AM. She stated that she did sometimes use her dirty gloved hand to push clean dishes out of the dishwasher. She stated she had been told not to use her dirty gloves to touch the clean dishes.	F 371		

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F 371	Continued From page 18 The FSD stated in an interview at 8:50 AM on 3/9/11, that dishes should be rewashed if touched by staff with dirty hands or gloves or if dishes are filled with water from the dishwasher. She stated staff had been trained to keep clean dishes separate from dirty dishes. 4. During a kitchen observation on 3/8/11 at 10:54 AM, Dietary Aide #4 was asked to test the dilution of the quaternary solution in the 3 compartment sink. When the strip was placed in the water, it indicated that the solution was 400 ppm. Dietary Aide #4 stated that the solution should only be 200 ppm. In an interview with the FSD on 3/9/11 at 4:25 PM, she stated that staff had probably not tested the solution after it was made. A review of the manufacturer's instructions revealed that the solution should be prepared to 200 ppm. 5. On 3/9/11 at 4:25 PM, wet cloths were observed on the dirty side of the 3-compartment sink and the FSD was asked to test strength of the sanitizer bottles which were to be used for cleaning food preparation surfaces. She stated that bottles were kept in the office in an unlocked cabinet. Upon opening the cabinet, it was found that 5 bottles were on the shelf. Each of the 5 bottles contained only a minimal amount of sanitizer. Each 32-ounce bottle contained less than one-half inch of solution. The FSD stated that they needed to get more from the laundry area. When asked how the surfaces would be cleaned, she stated that staff would probably just use water on the towels to clean the surfaces.	F 371		

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F 371	Continued From page 19 A review of the Program 8 of Educational Planning Services Corporation which the FSD stated was used for training stated "Always wipe down a work area after you have used it with a clean cloth and warm water and sanitizing solution." "Sanitizing a counter means spraying it with a germ-killing (sanitizing) solution to kill bacteria that soap will not destroy. Wiping a counter with an old wet rag is doing more harm than good, by spreading the dirt and bacteria."	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review and	F 425	The calcium with Vitamin D for resident #15 has been delivered to the facility. Resident # 16 has passed away. To ensure all residents have their medications, nurses will complete a medication sheet at the end of their shift and write down any medications that were not available If a med is not available , the nurse will write on the sheet what they did to follow up and ensure the medication will be ordered. The DON will watch on e Med Pass, once a week to ensure medications are available. This monitoring will last 90 days. Any findings will be sent to the next quarterly QA meeting.	4/11

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F 425	Continued From page 20 interviews with facility staff, the facility did not follow their policy and procedure, to request and obtain medications, as the medications became depleted for 2 of 11 sampled residents. As a result, the residents did not receive their medications as ordered. (Residents #15 and #16). The findings include: 1. Record review of the policy and procedure titled "Ordering of Drugs", undated revealed the following procedure: 3. Existing Patient: Refill prescription: A. Rapid order procedure (Same day delivery required) 1. Fax to the pharmacy with the following information: a. Specify that this is a refill order that must have same day delivery on your order sheet. b. Patient name c. Rx (prescription) number d. Name of medication B. Method of ordering routing refills: 1. Take "Drug Order Sheet" form with you during your pass. 2. As you pass your meds and you discover a med of any kind (topical, liquid, etc.) which has only a 5-day supply left, peel the top portion of the label off the medication container (card, bottle, etc.) and stick it on the "Drug Order Sheet." 3. When the pass is completed, take the "Drug Order Sheet" into the med room to check the following: a. Is there an additional supply (e.g. bottle, card, etc.) of any of the medications you re-ordered?	F 425		

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F 425	Continued From page 21 If so, put a big "X" through the label on the re-order form for those items(s). 4. If for some reason, the peel-off label can't be removed and placed on the "Drug Order Sheet" you must hand write the patient's name, Rx number and name of medication of the form. 5. Fax the "Drug Order Sheet" form to the pharmacy." Resident #15 had a diagnosis of Scoliosis. Record review of the MAR (Medication Administration Record) revealed an order for "Calcium + Vit (vitamin) D 500/400 mg. (milligram) tablet. Take 1 tab (tablet) via G/tube (gastrostomy tube) twice daily with meals." Observations on 3/9/11 at 9:05 AM, during the medication pass, revealed that there was no Calcium with Vitamin D 500/400 mg. available for the resident. On the back of the MAR Nurse #2 wrote, "3/9/11 0900 Calcium Vit. D 500-400 (mg) not given unavailable." She then initialed the MAR and circled her initials, indicating that the medication was not given. Interview with Nurse #2 on 3/9/11 at 9:05 AM revealed, "I will call the pharmacy to see if it was ordered so she doesn't miss the 5:00 PM dose." Interview on 3/9/11 at 9:50 AM with the DON (Director of Nursing) revealed that the nurse was responsible for the re-order. She needed to pull the sticker off of the last card of the medication to re-order. If the medication was not here within 24 hours, the nurse should call the pharmacy. Interview on 3/9/11 at 3:45 PM with the pharmacist revealed that they received the order 3/8/11 at 11:00 PM. She continued that it was	F 425		

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F 425	Continued From page 22 sent out on 3/9/11 and should receive it no later that 9:30 PM. Interview on 3/9/11 at 4:15 PM with the DON revealed that she did not have the calcium. She said she called the pharmacy and that it would be at the facility that night. The resident would not receive her 5:00 PM calcium. 2. 1. Record review of the policy and procedure titled "Ordering of Drugs", undated revealed the following procedure: 3. Existing Patient: Refill prescription: A. Rapid order procedure (Same day delivery required) 1. Fax to the pharmacy with the following information: a. Specify that this is a refill order that must have same day delivery on your order sheet. b. Patient name c. Rx (prescription) number d. Name of medication B. Method of ordering routing refills: 1. Take "Drug Order Sheet" form with you during your pass. 2. As you pass your meds and you discover a med of any kind (topical, liquid, etc.) which has only a 5-day supply left, peel the top portion of the label off the medication container (card, bottle, etc.) and stick it on the "Drug Order Sheet." 3. When the pass is completed, take the "Drug Order Sheet" into the med room to check the following: a. Is there an additional supply (e.g. bottle, card, etc.) of any of the medications you re-ordered? If so, put a big "X" through the label on the	F 425		

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F 425	Continued From page 23 re-order form for those items(s). 4. If for some reason, the peel-off label can't be removed and placed on the "Drug Order Sheet" you must hand write the patient's name, Rx number and name of medication of the form. 5. Fax the "Drug Order Sheet" form to the pharmacy." Resident #16 had diagnoses of Acute Bronchitis and COPD (Chronic Obstructive Pulmonary Disease). Record review of the MAR (Medication Administration Record) revealed an order for "Albuterol 60's 0.5-2.5/3 ampul-neb. (nebulizer) Use one 3 ml. (milliliter) vial every 4 hours for SOB/ (shortness of breath) /COPD." The resident did not receive the Albuterol nebulizer treatment on 3/8/11 at 4:00 PM. This was a routine order that the resident received every hour hours. Observations on 3/8/11 at 4:07 PM, during the medication pass, revealed that there was no Albuterol nebulizer treatment available for the resident. Interview with Nurse #5 revealed pm 3/8/11 at 4:07 PM revealed that the other nurse said she called the pharmacy and it should be at the facility that night. She continued that she just signed her initials with the circle when it wasn't available for the resident. On the back of the MAR the nurse wrote, "3/8/11 @ 1600 Duoneb TX. (treatment) not given med not available." Interview on 3/8/11 at 5:20 PM with the DON (Director of Nursing) revealed, "I told them ASAP (as soon as possible). It should be on its way." Interview on 3/9/11 at 3:45 PM with the	F 425		

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F 425	Continued From page 24 pharmacist revealed that they received the order 3/7/11 at 6:27 AM. She continued that it was sent out on 3/8/11 and was received by the facility on 3/8/11 at 9:30 PM.	F 425		

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	345316	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/30/2011

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SENIOR CITIZENS HOME	2275 RUIN CREEK RD HENDERSON, NC 27536

(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
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Surveyor: 26594 Based on observation on Wednesday 3/30/31 between 9:30 AM and 1:00 PM the following was noted: 1) The area around the sprinkler head in the beauty shop and front right hall shower were not sealed in order to maintain the required rating of the ceiling. This situation was found at other sprinkler heads in corridors and rooms. 42 CFR 483.70(a)	K 012	The sprinkler heads in the beauty shop and front right hall shower room have been sealed. Maintenance will make rounds and check all sprinklers to ensure they have been sealed. Maintenance will check on a monthly basis to ensure the sprinklers remain intact. Any negative findings will be sent to the next quarterly QA meeting. RECEIVED APR 15 2011	5-5-11
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	The doors for resident room #4 and # 11 have been repaired and the doors now latch. Maintenance will check all resident doors to ensure that they latch. Maintenance will checks resident doors on a monthly basis to ensure the doors latch. Any negative findings will be sent to the next quarterly QA meeting.	5-5-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 4-14-11

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
	345316	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 018	Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 26594 Based on observation on Wednesday 3/30/31 between 9:30 AM and 1:00 PM the following was noted: 1) The corridor doors to resident room 4 and 11 did not close, latch and seal when checked. 42 CFR 483.70(a)	K 018		