STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345126	A. BUILDING _____ B. WING _____	04/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVE CARE AND REHABILITATION CENTER	228 SMITH CHAPEL RD BOX 569 MOUNT OLIVE, NC 28365

(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 upon observations and staff interviews the facility failed to provide a homelike environment by storing mechanical lifts, a broom and dust pan in 2 of 4 dining rooms and maintain an environment free of lingering odors for 2 of 2 rooms and 4 of 4 halls. Findings include: 1. A lunch meal observation on 3/28/11 at 12:05pm revealed two mechanical lifts and a broom located in the station one restorative dining room. Each mechanical lift was located on the left and right side of the television. The broom was leaning against the wall next to the television. Residents were eating while these items were in the dining room. An interview with Nursing Assistant (NA) #1 at 3:02pm on 3/30/11 indicated they don't leave brooms or mechanical lifts in dining rooms. If items were used they were to be taken out of dining room after use. An Interview NA #2 on 3/30/11 at 3:12 pm revealed that the mechanical lifts, brooms and	F 252	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Mount Olive Care & Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." **F252-E** 1. A. The Hoyer Lifts, broom, dustpan, and wet floor sign were removed from the recreational/restorative dining rooms on 4/1/11 by NHA & DNS. B. Lingering odors from the survey were resolved on 4/1/11 by Housekeeping Supervisor and Housekeeping Staff.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Will J Mercer	Administrator	4/22/11

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 252	Continued From page 1 dust pan were not to be left in dining room while residents were eating. Station one restorative dining room was viewed by the NA. The NA indicated they try to keep items in corner when they were not eating. An observation on 3/30/11 at 3:33pm revealed a mechanical lift next to the television in the recreational dining room. An observation of the station one restorative dining room on 3/31/11 at 8:20am revealed a resident being fed breakfast by a NA. A mechanical lift was in the corner of room and another mechanical lift front side was facing the dining table where the resident was being fed. A dust pan, wet floor sign and broom were leaning against the wall in sight of the resident. An observation on 3/31/11 at 12:05pm revealed residents eating lunch in station one restorative dining room. A mechanical lift, dust pan and broom were leaning against the wall in the dining room. The items were visible to the residents. An interview with the Director of Nursing (DON) on 3/31/11 at 2:54pm revealed she would not expect for a broom, dust pan and/or mechanical lifts to be present in the dining rooms while residents were eating. The dining room was not to be used as a storage room. 2. An observation on 3/30/11 at 9:15am in room 114, on nurse station one revealed a urine odor. The bathroom did not have an odor. The odor remained until 9:22am. An observation on 3/30/11 at 2:32pm from	F 252	2 .A. Environmental rounds were completed on 4/6/11 by NHA and Housekeeping Supervisor to identify equipment stored improperly and any found was removed. B. Environmental rounds were completed on 4/6/11 by NHA and Housekeeping Supervisor to identify any lingering odors. Any odors identified were eliminated by housekeeping. 3. A. Staff were re educated on storage of patient care and housekeeping equipment to assure these items are not present when residents are eating their meals in these areas by SDC on 4/6/11 Appropriate storage locations for residents' lifts have been designated for each nursing station. B. Staff re educated on quickly identifying and responding to remove/resolve the source of any noticeable odors by SDC on 4/6/11. 4. A. Department Managers and NHA will observe the resident recreation/restorative dining rooms 5 days a week times one month, then weekly times 2 months to assure lifts and housekeeping equipment are not stored in dining area.	

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F 252	Continued From page 2 3:10pm revealed nurse station one hall having an odor of feces. An Interview with NA #1 at 3:02pm on 3/30/11 revealed she does not use any chemicals to keep down odor. The NA makes sure she cleans a resident when they are soiled and dispose of dirty linens in dirty linen bins. If other areas of the resident room were soiled, the NA would contact housekeeping to clean the area. Another observation on 3/30/11 at 4:25pm revealed an odor of feces in the section of the back hallway from rooms 1 to 3 until 4:45pm. Residents were being transported to dining room for dinner. An observation on 3/31/11 at 8:10am revealed the Maintenance Manager taking water temperature in the bathroom of room 130. He made the comment, " This bathroom stinks. " The water temperature check lasted to 8:13am. An odor was detected in the bathroom. On 3/31/11 at 8:45am, Room 130 remained of a urine odor. NA #3 was brought into the room. The NA was asked how the room smelled. The NA indicated it smelled like urine. The NA indicated he just got in on his shift and the odor may be from last night. The NA checked one of the residents in the room to see if the resident had soiled himself. An observation 3/31/11 at 8:45am revealed an odor of urine along the hallway of nursing station two. The urine odor lingered until 9:35am. An Interview with the Director of Nursing (DON) on 3/31/11 at 2:54pm revealed she would not expect lingering odors in the building. The DON	F 252	B. Department managers will be alert for the presence of any offensive odors during Customer First rounds 5 days a week times one month then weekly by 2 months and will respond to have staff identify and remove the source of the odors. NHA will document findings at least weekly during formal rounds. . Findings will be reviewed 5 days a week for the next 30 days, then weekly times 2 months by NHA and results will be reviewed at the monthly Process Improvement (PI) meetings for 3 months.	4/22/11

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F 252	Continued From page 3 indicated that she noticed yesterday odors around station one hallway around 3pm.	F 252	**F272-D** 1. Required AIMS was completed for resident #176 on 3/31/11 by MDS Coordinator	
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the	F 272	2. An audit of medical records of residents receiving drugs that require the completion of AIMS evaluation was completed on 4/20/11 by MDS Coordinator. AIMS evaluations were completed as appropriate 3. . Licensed nurses were re educated on AIMS evaluation completion on 4/7/11 and 4/11/11 by SDC. AIMS forms are placed in admission packet. Director of Nursing Services will audit newly admitted residents within the first 3 days of admission to assure AIMS evaluation was completed as appropriate. 4. Health Information Manager will complete medical record audit, within the first week of newly admitted residents to assure AIMS evaluation was completed. A monthly audit will be completed for AIMS evaluations for long term stay residents. Results from audits will be reviewed weekly for the next 4 weeks then monthly times 2 months. Summary of audit results will be reviewed at the PI meeting for the next three months.	4/22/11

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F 272	Continued From page 4 facility failed to complete an assessment to identified abnormal involuntary movements for 1 (Resident #176) of 9 residents receiving antipsychotic medication. Findings include: Review of the facility policy titled " Managing Psychoactive Medication " dated January 2008/ Rev. 12/10, under the section titled Medical Need the fourth bullet point read in part: " The AIMS (Abnormal Involuntary Movement Scale) is use to evaluate the presence and severity side effect associated with anti-psychotic drugs. It is completed when anti-psychotic drug therapy is initiated (or upon admission to the center if the resident is receiving these drugs) and quarterly thereafter. Resident #176 was admitted to the facility on 02/25/11. Cumulative diagnoses included diabetes mellitus, retention of urine, history of schizophrenia, anxiety and depression Review of physician order, dated 02/25/11, read Seroquel 50 mg (milligram) per mouth at bedtime. Review of a physician order, dated 03/07/11, read Seroquel 25 mg per mouth twice a day. Review of Resident #176's medical record found no documentation related to an AIMS being completed. An interview, on 03/31/11 at 9:45 AM, was conducted with the MDS (Minimum Data Set) nurse. The MDS nurse indicated that she was responsible to complete the AIMS for the quarterly and annual MDS assessments. She relayed the admitting nurse would be responsible	F 272		

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F 272	Continued From page 5 for the admission AIMS. The MDS nurse stated the AIMS form was in the admission forms used by the nurses at the time of admission of a resident. On 03/31/11 at 10:30 AM, the MDS nurse relayed she was unable to find an AIMS in the resident's chart. Review of the admission paperwork given to nurses to complete at time of admission revealed no AIMS form in the paperwork. An interview, on 04/01/11 at 9:30 AM, was conducted with Nurse #3. The nurse indicated that she had not completed an AIMS ass during an admission of aresident.. She stated she did not recall the AIMS form being part of the admission paperwork. An interview, on 04/01/11 at 9:40 AM, was conducted with Nurse #8. The nurse relayed that she had not completed an AIMS during an admission of a resident. An interview, on 04/01/11 at 10:35 AM, was conducted with the Director of Nursing.Services (DNS). The DNS confirmed the AIMS assessment had not been completed at the time of admission, but the form had been added to the admission packet to be completed on admission when needed not recall the assessment being part of the admission paperwork.	F 272		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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F 281	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to follow the facilities' policy for administration of multiple eye medications for 1 (Resident #36) of 1 residents observed receiving eye drops Findings include: 1. Review of an undated facility policy titled, Instillation of Eye Medications, revealed Nursing Action #14 read in part: "If additional eye drops are ordered, wait 5 minutes between each medication." On 03/30/11 at 12:45 PM, the facility Nurse Consultant presented the requested policy, he stated the facility used the nursing policies from Lippincott Nursing Procedures. Resident #36 was admitted to the facility On 01/15/07. Cumulative diagnoses included diabetes mellitus, hypertension, and dementia. On 03/30/11 at 8:25 AM, during a med pass observation, Nurse #6 was observed to administer Liquid Tears to Resident #36. She was observed to place one drop of Liquid Tears to the left eye and then placed one drop to the right eye. The nurse recapped the Liquid Tears bottle and opened a Patanol Opthalmic Solution bottle. Nurse #6 then administered Patanol eye drops to Resident #36. The nurse was observed to place one drop of Patanol to the left eye and one drop to the right eye. Liquid Tears are indicated to be used for treatment of dry eyes.	F 281	**F281-D** 1. Resident #36 is receiving Liquid Tears and Patanol Ophthalmic Solution eyes with a 5 minute interval.. 2. Residents receiving more than one different eye drops were identified by completion of audit of physician orders by Nursing Supervisor on 4/15/11. 3. Licensed nurses were re educated on eye drop administration on 3/30/11, 4/7/11 & 4/11/11 by SDC. Licensed nurses were observed administering eye drops by Pharmacy Consultant on 4/6/11 & 4/14/11 and on 4/15/11, 4/17/11, 4/18/11, 4/19/11 and 4/20/11 by SDC. 4. Three Licensed Nurses will be observed administering eye drops weekly times one month then monthly time 2 months Re-education will be conducted as required.. Newly hired licensed nurses will complete competency on medication administration by the Staff Development Coordinator with in the first week of hire. The results of the medication observation will be reviewed monthly times 3 months at PI meeting.	4/22/11

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F 281	Continued From page 7 Per Lexi-Comp's Geriatric Dosage Handbook, 12 Edition, Patanol is used to temporally prevent itching of the eye caused by a condition known as allergic conjunctivitis. An interview, on 03/30/11 at 8:45 AM, was conducted with Nurse #6. Nurse #6 indicated she was not aware of any policy regarding waiting in between administering eye drops. An interview, on 04/01/11 at 10:35 AM, was conducted with the Director of Nursing Services (DNS). The DNS stated her expectation was for the policy to be followed.	F 281	**F309D** 1. Care plan for resident #215 was reviewed by DNS and MDS Director on 3/31/11 and changed to reflect physician's orders. Assessment of the dialysis shunt was placed on the medication administration record by MDS Coordinator on 4/1/11. 2. Care plans of other residents receiving dialysis were reviewed on 3/31/11 by MDS Director and were updated as appropriate. Medication administration records of residents receiving dialysis were reviewed and updated as appropriate by MDS Coordinator on 4/1/11.	
F 309 SS=D	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 observations, interviews, and record review the facility failed to follow the care plan for after dialysis monitoring of blood pressure for one of one (#215)sampled residents. The findings include: Resident #215 was admitted on 2/28/11 with the diagnoses of a major stroke and left dense right plegia, Diabetes Mellitus, Hypertension,End	F 309	3. Licensed nurses were re educated on care of residents and following plan of care of receiving dialysis on 4/7/11, 4/13/11 and 4/19/11 by SDC. Resident receiving dialysis will be reviewed in at the weekly IDT meeting to assure plan of care is being followed. 4. Residents receiving dialysis will have care plans and medication administration records audited for appropriate documentation weekly times 4 weeks, then monthly by Director of Nursing Services or designee. Audit summary will be reviewed at Performance Improvement Committee meeting monthly times 3 months	4/22/11

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F 309	Continued From page 8 Stage Renal Disease(ESRD) with Hemodialysis (HD) and significant swelling in the right arm where an old HD catheter site was previously located. Review of the care plan dated 2/28/11 included a goal that the catheter site would not have any signs or symptoms of infection as evidenced by having no local pain,redness,warmth,or drainage during the next 90 days. Interventions included calling 911 for an emergent situation if dialysis site was rupture or bleeding was heavy, apply pressure bandage and elevate site until emergency medical service arrived, apply dsg for 24 hrs.,communicate with HD unit for abnormal labs or excessive weight gain, complete communication form, ensure appropriate communication records were sent to the facility, ensure appropriate records were sent with the resident to HD, monitor vital signs as ordered, no blood draws from the access side, notify the physician of weight.gain of 3 lbs or more since last weight, observe site after HD for excess bleeding, notify physician if bleeding is present, obtain monthly labs from HD unit and place on record for the physician to review, evaluate access and monitor blood pressure before the resident resumes any activity. Careplan dated 2/28/11 included a goal of catheter site will not have any signs or symptoms of infection as evidenced by no local pain,redness,warmth, or drainage during the next 90 days. Interventions include call 911 for emergent situation if dialysis site is ruptured/bleeding is heavy ,apply pressure bandage and elevate site until EMS arrives,apply dsg for 24 hrs.,communicate with HD unit for abnormal labs or excessive wt. gain,complete	F 309		

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F 309	Continued From page 9	F 309		

communication form, ensure appropriate comm. records are sent to the facility, ensure appropriate records are sent with the res. to HD, Monitor VS as ordered, no blood draws from the access side, notify MD of wt.gain of 3 lbs or more since last weight, observe site after HD for excess bleeding ,notify physician if present, obtain monthly labs from HD unit and place on record for the physician's review and monitor the resident's blood pressure until stable before the resident resumes activity.

The HD record dated 3/30/11 included a HD communication form including a blood pressure of 154/68 and instructions to monitor the blood pressure until stable before the resident resumes activity.

On 3/30/11 at 4:00 pm an observation of the resident lying in her bed asleep.

On 3/30/11 at 4:30 pm in an interview with the nursing assistant #7 she was asked what she should report to the nurse regarding a HD catheter she stated she would report swelling of the catheter site ,pain at the catheter site, and bleeding at the site.

In an interview on 3/30/11 at 4:40 pm with nurse # 9 she was asked what to assess when a resident returns from HD she stated she was unsure what to assess but she thought the site should be checked for bleeding.

On 3/30/11 at 4:55 pm a review of the resident's MAR revealed there was no HD assessment flowsheet on the MAR.

On 3/31/11 at 9:10 am in an interview with nurse

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F 309	Continued From page 10 # 1 when asked what assessment was done when a resident returned from HD and she stated, "We get the resident something to eat and check the HD site and that's about all we do." The nurse said the assessment of the site was documented on the Medication Administration Record (MAR). On 3/31/11 at 9:15 am in an interview with nurse # 10 she was asked what assessment was done on a HD resident after returning to the facility and where was the assessment documented. She said we check the site (HD catheter) and record the assessment on the MAR. The nurse stated vital signs were documented in the nurses notes. On 3/31/11 at 10:15 an a review of the resident's nurses notes revealed there no blood pressures documented after the resident returned from HD. A complete review of the resident's nurses notes revealed there were no blood pressures documented related to a post HD assessment throughout the medical record. On 3/31/11 a review of the res. MAR revealed there was no HD assessment flow sheet on the res MAR. On 3/31/11 review of the HD communication sheet dated 3/24/11 revealed documentation of the resident's blood pressure 194/86 recorded by the dialysis nurse post treatment and a note stating "please monitor" the residents blood pressure. Review of the resident's medical record and MAR indicated there was no documentation of blood pressure after HD on 3/24/11. On 4/1/11 at 9:30 am in an interview with the Director of Nursing Services she stated her	F 309		

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F 309	Continued From page 11 expectation was when a resident returned to the facility after hemodialysis an assessment including monitoring the site, vital signs to include blood pressure would be conducted and the complete assessment would be documented on the hemodialysis flow sheet and the nurses notes.	F 309	**F314D** 1. Resident #103 had padding placed between her legs and feet to prevent skin to skin contact along with feet floated on pillows on 3/31/11 by DNS and CNA.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to have interventions in place to provide pressure relief of the contracted bilateral lower extremities for 1 (Resident #103) of 1 resident with an existing pressure ulcer. Findings include: Resident #103 was admitted to the facility on 05/04/06. Cumulative diagnoses included contractures of joint of multiple sites, ulcer of ankle, failure to thrive, dysphagia, urinary incontinence and muscular wasting and disuse. Review of the Care Area Assessment (CAA) summary, dated 10/22/10, revealed Resident #103 triggered for activities of daily living (ADLs) function, urinary incontinence and pressure ulcer.	F 314	2. Other residents that may be at risk for developing or that have pressure ulcers were identified by completing audit of Norton Plus assessment on 4/21/11 by DNS and observation of residents on 4/21/11 by DNS/Designee. Appropriate preventative measures were implemented as appropriate by DNS/Designee on 4/21/11. 3. Licensed nurses were re educated on preventation of pressure ulcers and use of devices for positioning on 4/7/11, 4/11/11 and 4/13/11 by SDC Nursing assistants were reeducated on preventation of pressures and use of devices to prevent pressure ulcers on 4/6/11, 4/7/11, 4/8/11, 4/12/11, 4/13/11, 4/17/11, 4/18/11, 4/19/11, and 4/20/11 by SDC. 4. Director of Nurses and/or designee will complete rounds to monitor positioning and proper use of preventative devices 3 times weekly for one month, then weekly for 2 months. The results of the monitoring rounds for positiong and use of preventative devices will be reviewed monthly at the PI meeting for 3 months.	4/22/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345126	A. BUILDING _____ B. WING _____	04/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVE CARE AND REHABILITATION CENTER	228 SMITH CHAPEL RD BOX 569 MOUNT OLIVE, NC 28365

(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 314	Continued From page 12 Review of the CAA worksheet for ADLs, dated 10/22/10, read in part that the resident required total care with all of her ADLs; was unable to communicate any of her needs; and, the staff continued to provide total care to resident. The CAA worksheet for Urinary Incontinence, dated 10/22/10, read in part that the resident has degenerative brain disease and was in a vegetative state; required total care with all of her toileting needs; was incontinent of bladder; and, staff continued to provide incontinence care as needed. The CAA for Pressure Ulcers, dated 10/22/10, read in part that the resident was in vegetative state; skin currently was intact but has a hx (history) of skin breakdown; was on an air mattress; weekly body check continued; was on continuous tube feeding; Centrum silver continued daily; and, Calazine-Zinc Oxide was applied daily to sacrum for protection. The quarterly Minimum Data Set (MDS) assessment, dated 02/08/11, revealed the resident was cognitively impaired; was totally dependent on staff for activities of daily living (ADLs); was assessed to be incontinent of bowel and bladder, to have a gastrostomy tube and a pressure ulcer. Review of Resident #103 Care Plan, initiated 12/01/09 and revised 02/15/11, identified a focus area as potential for skin breakdown related to immobility, incontinence, cognitive impairment, chronic progressive disease, and a history of skin impairments. The goal was that the resident would have no skin breakdown. Interventions listed were: apply protective/preventative barrier to skin every shift; keep skin clean and dry; observed skin every shift for s/sx (signs/symptoms) of potential skin breakdown	F 314		

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	345126	A. BUILDING _____ B. WING _____	04/01/2011

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F 314	Continued From page 13 (e.g.) redness/discoloration or open areas; pressure reducing/relieving devices as ordered-resident was on an air mattress; provide peri-care when incontinence occurs; weekly skin assessment-notify nurse/treatment nurse of any reddened area. Review of Resident #103 Care Plan, initiated 01/20/11 and revised 02/16/11, identified a focus area as the resident has impaired skin integrity related to pressure ulcer on her right ankle bone secondary to chronic progressive disease and the pressure ulcer on the right ankle was a Stage III. The goal was that the pressure ulcer would heal and show no s/sx in the next 90 days. Interventions listed were: air mattress, document on flow sheet if skin intact or if skin as reddened or open areas and report any new openings to Licensed Nurse; monitor healing process-notify Medical Doctor and responsible party if no improvement, change treatment as indicated; treatment as ordered to affected area; continue tube feeding; Registered Dietitian to evaluate; Centrum Silver to help with wound healing. A pressure ulcer assessment completed on 12/03/10 for Resident #103 revealed a score of 6, which indicated the resident to be at high risk for pressure ulcers. A pressure ulcer assessment completed on 02/08/11 revealed a score of 6, which indicated the resident to be at high risk for pressure ulcers. Review of Registered Dietitian (RD) documentation, dated 02/06/11, indicated Resident #103 received adequate protein and vitamin from her tube feeding. The documentation revealed the resident required 1900 calories, 76 gms (grams) of protein and	F 314		

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	345126	A. BUILDING _____ B. WING _____	04/01/2011

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MOUNT OLIVE CARE AND REHABILITATION CENTER	228 SMITH CHAPEL RD BOX 569 MOUNT OLIVE, NC 28365

(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 314	Continued From page 14 1900 cc ' s (cubic centimeters) of fluids. The RD indicated that the resident ' s tube feeding formula and water flushes provided 1800 calories, 77 gms of protein and 2400 free water. Review of an undated Nursing Assistant Care Card, a form used by Nursing Assistants, which provided information and identified care for a resident to be provided by the nurse aides (NAs). Resident #103 ' s Care Card under the section titled, Skin Care, revealed the bed was pressure relieving and to turn and reposition as needed. On 03/30/11 at 1:35 PM, an observation of a gastrostomy tube dressing change was made. Nurse #1 pulled down the covers over the resident to lift the resident ' s gown to access the tube site and exposed the upper portions of the resident ' s legs. The resident was observed in fetal position lying on her right side with the legs drawn up. The observation revealed the left leg lying against the right leg. No padding was noted between the skin to skin areas of the legs. On 03/30/11 at 3:30 PM, an observation of a dressing change to the right ankle was made. The resident was observed to be lying on her left side in fetal position. When Nurse #5 pulled back the covers to expose the right ankle, the arch of the right foot was observed to be lying against the arch of the left foot. Also observed was the right leg lying against the left leg. No padding was noted between either of the skin to skin areas on the feet or legs. On 03/31/11 at 8:50 AM, an interview was conducted with the MDS nurse. The nurse relayed that the pressure relieving device listed in the care plan was the air mattress and that the	F 314		

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	345126	A. BUILDING _____ B. WING _____	04/01/2011

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MOUNT OLIVE CARE AND REHABILITATION CENTER	228 SMITH CHAPEL RD BOX 569 MOUNT OLIVE, NC 28365

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F 314	Continued From page 15 facility did not use bunny boots. She indicated the NAs should be floating the resident heels if needed. On 03/31/11 at 11:40 AM, an observation and interview was conducted at the bedside of Resident #103 with NA #7. She indicated she provided total care for the resident, turned and repositioned the resident every hour and a half to two hours. NA #7 relayed that she placed a blanket between the resident ' s legs when the resident was positioned on her side. When NA pulled back the covers to point out the blanket in place, the resident ' s right foot arch was lying against the left foot arch. The NA confirmed that the facility did not use bunny boots and the observation of the feet was the usual position when the resident was on her side. She indicated if there was a change in treatment she would receive the information from the nurse or the information would be placed on the care card in the NA book located at the nurse ' s station. On 04/01/11 at 8:00 AM, an observation and interview was conducted at the bedside of Resident #103 with Nurse #4. The nurse removed the covers over the resident ' s legs and feet. The resident was observed lying on her right side, the left leg was lying against the right leg and the left foot arch was lying against the right foot arch. Nurse #4 indicated that the resident should have a pillow or blanket between knees and legs; and, also that the feet should not be against each other. Nurse #4 stated she would have a NA come and put a pillow between the resident ' s legs and place a pillow under the feet to help separate them. On 04/01/11 at 8:10 AM, an observation and	F 314		

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	345126	A. BUILDING _____ B. WING _____ SDC	04/01/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 16 interview was conducted at the bedside of Resident #103 with the Director of Nursing Services (DNS). When she removed the covers over the legs and feet, the resident ' s knees and legs were lying against each other and the left foot was lying against the right foot. The DNS stated it would be her expectation that the legs should have a blanket or pillow in place to separate the knees and calves from touching each other. She indicated the feet should be separated and not atop each other. The DNS relayed the facility did not use bunny boots as it defeated the purpose of the air mattress. 04/01/11 at 8:20 AM, an interview was conducted with the MDS nurse. The nurse stated when an intervention on the care plan indicated pressure reducing/relieving devices as ordered, it would mean that an air mattress was in place. When asked if any other type of pressure relieving device would be used, she indicated the air mattress was the pressure relieving device.	F 314	**F332E** 1. Resident #36 receives Miralax in 8 ounces of water as prescribed by physician and Liquid Tears and Patanol eye drops with a 5 minute interval. Resident #9 had order for Klor Con changed to KCL Liquid by physician on 3/30/11. Resident # 35 's G tube is checked for placement by licensed nurses prior to administration of medication 2. Other residents that may be effected were identified by audit of residents receiving medication that have to be crushed, residents receiving medication through a enternal tube and residents receiving more that 2 types of eye drops. Audit was completed on 4/21/11 by DNS/Designee. 3. Nurse #6 was re educated on 3/30/11 by SDC on administration of Miralax and administration of eye drops. Nurse #7 was re educated on 3/30/11 by SDC regarding crushing medication. Nurse #9 was reeducated on administration of medication per G-tube on 4/11/11 by SDC . Medication pass observation on nurse #6 was completed on 4/6/11 by SDC Medication pass observation on nurse #7 4/17/11 by SDC and Medication pass observation on nurse #9 was completed on 4/19/11 by SDC. Nurses were re educated on medication administration on 3/30/11 and 4/7/11 by SDC. "Original" J. Hatchett, RN	
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to maintain a medication error rate of less than 5% as evidenced by 6 errors out of 56 opportunities for errors (Residents #9, #35, #36) resulting a medication error rate of 10.714%. Findings include:	F 332		

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	345126	A. BUILDING _____ B. WING _____	04/01/2011

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F 332	Continued From page 17 1. Resident #36 was admitted to the facility On 01/15/07. Cumulative diagnoses included diabetes mellitus, hypertension, and dementia. a. Review of the physician's monthly order sheet for 03/01/11 to 03/31/11 revealed an order that read Miralax GMs in 8 ounces of water. During a medication pass observation on 03/30/11 at 8:21 AM, Nurse #6 was observed to pour water directly into a small plastic juice size cup. She proceeded to pour a cap of Miralax into the water and stirred the medication. When asked the amount of water in the cup she indicated that is was 240 ccs (cubic centimenters). An interview, on 03/30/11 at 8:45 AM, was conducted with Nurse #6. Nurse #6 stated The cup being used was the cup on the medication cart and she thought it held 240 ccs (cubic centimeters) of liquid. She confirmed she did not measure the water separately. An interview, on 04/01/11 at 10:35 AM, was conducted with the Director of Nursing Services (DNS). The DNS stated it was her expectation that the physician's orders would be followed. b. Review of the physician's monthly order sheet for 03/01/11 to 03/31/11 revealed an order that read Liquid Tears one drop in each eye three times a day. During a medication pass observation on 03/30/11 at 8:25 AM, Nurse #6 was observed to place one drop of Liquid Tears in the left eye and then one drop of Liquid Tears in the right eye. After replacing the cap on the Liquid Tears, the	F 332	Staff was educated on G-Tube Medication Administration to check G-Tube placement prior to administering medications on: 4/7, 4/11, 4/13, 4/17, 4/18, 4/19, and 4/20. Medication pass observation was completed with licensed nurses on 4/6/11 and 4/14/11 by Pharmacy Consultant and on 4/15/11, 4/17/11, 4/18/11, 4/19/11 and 4/20/11 by SDC. 4..Three licensed nurses per week times one month will be observed during medication pass, then monthly times 2 months by Staff Development Coordinator. Results of medication pass observation will be reviewed weekly by Director of Nursing Services and summary of findings presented to Performance Improvement Committee monthly for 3 months. Changes made 5/5/11 Janeelea Hatchett RN	4/22/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345126	A. BUILDING _____ B. WING _____	04/01/2011

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F 332	Continued From page 18 nurse was observed to administer a second eye drop medication to each eye. An interview, on 03/30/11 at 8:45 AM, was conducted with Nurse #6. Nurse #6 indicated that she was not aware of any policy regarding waiting in between administering the eye drops. An interview, on 04/01/11 at 10:35 AM, was conducted with the Director of Nursing Services (DNS). The DNS stated her expectation was for the policy to be followed. c. Review of the physician's monthly order sheet for 03/01/11 to 03/31/11 revealed an order that read Patanol 0.1% Solution Opthalmic, instill 1 drop each eye three times a day. During a medication pass observation on 03/30/11 at 8:28 AM, Nurse #6 was observed to administer one drop of medication to the left eye and then one drop of medication to the right eye. After replacing the cap on the administered eye drop, the nurse administered one drop of Patanol to the left eye and then one drop of Patanol to the right eye. Nurse #6 then exited the room. An interview, on 03/30/11 at 8:45 AM, was conducted with Nurse #6. Nurse #6 indicated that she was not aware of any policy regarding waiting in between administering the eye drops. An interview, on 04/01/11 at 10:35 AM, was conducted with the Director of Nursing Services (DNS). The DNS stated her expectation was for the policy to be followed. 2. Resident #9 was admitted to the facility on 05/14/08. Cumulative diagnoses included	F 332		

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F 332	Continued From page 19 congestive heart failure, hypertension, and chronic obstructive pulmonary disease. Review of the physician ' s monthly order sheet for 03/01/11 to 03/31/11 revealed an order that read Klor Con 20 meq (milliequivalent) " Do Not Crush " . During a medication pass observation on 03/30/11 at 4:15 PM, Nurse #7 was observed to place a caplet of Klor Con 20 meq in a plastic medication cup with other pills. Nurse #7 took the cup of medications and poured them into a plastic sleeve. She proceeded to use the pill crusher to crush the medication. Nurse #7 poured the crushed medication into a plastic medication cup and mixed the medications with applesauce. Nurse #7 gathered the medications and began to proceed to the resident ' s room. Nurse #7 was then requested to review the Medication Administration Record (MARS) regarding Klor Con. After reviewing the MARS, she stated she had not seen the directions on the MARS to not crush the Klor Con. An interview, on 04/01/11 at 10:35 AM, was conducted with the Director of Nursing Services (DNS). The DNS stated it was her expectation that the physician ' s orders would be followed. 4. Review of the facility's policy for "Gastrostomy Tube Drug Administration" read in part :"A gastrostomy tube allows direct instillation of medication in the GI system of patients who can't ingest the drug orally. Before instillation , the patency and positioning of the tube must be carefully checked because the procedure is	F 332		

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	345126	A. BUILDING _____ B. WING _____	04/01/2011

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F 332	Continued From page 20 contraindicated if the tube is obstructed or improperly positioned." Review of the medical record revealed Resident # 35 was admitted to the facility on 3/16/10 with diagnoses including congestive heart failure,swallowing problem,gastrostomy tube placement, depression, and hip fracture. Review of the most recent Quarterly Minimum Data Set (MDS) Assessment dated 9/29/10 indicated Resident # 35 had a defecit with long and short term memory and was moderately impaired in making daily decisions regarding his care needs. Resident # 35 required extensive assistance with all his Activities of Daily Living (ADL). An observation of a medication pass on 3/31/11 at 9:10 am, Nurse # 9 prepared the medications for administration. After draping Resident # 35 for privacy, Nurse # 9 opened the gastrostomy tube and inserted the syringe barrel into the tube. Immediately following insertion of the barrel, nurse # 9 flushed the tube with water and then administered Resident # 35's medications into the gastrostomy tube. During an interview on 3/31/11 at 9:30 am, Nurse # 9 revealed she was supposed to check for tube placement before giving any medications or water in the gastrostomy tube.	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345126	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 012 SS=E	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: Based on observation on Wednesday 5/3/11 from 8:45 AM onward the following was noted. 1) There area holes and/or penetration in the ceiling that were not sealed in order to maintain there required rating of the area for the following areas, a) Kitchen b) Sprinkler Riser Room c) Mechanical/Electrical Room 42 CFR 483.70(a)	K 012	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Mount Olive Care & Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency." **K-012** 1. The holes and/or penetrations in the ceiling in the a) Kitchen, b) Sprinkler Riser Room, c) Mechanical/Electrical Room observed by the surveyor on 5/4/11 were repaired by the maintenance supervisor on 5/4/11 and 5/5/11. 2. Maintenance staff completed a thorough inspection of the ceilings throughout the facility on 5/13/11and any penetrations were repaired.	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation on Wednesday 5/3/11	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
William J Moseley	Administrator	5/20/11

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
	345126	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/04/2011

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(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 025	Continued From page 1 from 8:45 AM onward the following was noted. 1) The smoke wall located in the located in resident room 13 has a hole in the wall above the ceiling that was not sealed in order to maintain the required rating of the wall. 42 CFR 483.70(a)	K 025	**K-012-Continued** 3. Maintenance staff will perform an inspection of ceilings weekly for 4 weeks and then monthly to assure there are no penetrations. Any penetrations identified during inspections will be repaired. 4. Maintenance supervisor or assigned staff will report results of the ceiling inspections to the Process Improvement (PI) committee monthly for the next three months..	6/3/11
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation on Wednesday 5/3/11 from 8:45 AM onward the following was noted. 1) The staff were not familiar with the master override switches at the nurse stations for the mag locks on the exterior doors. 42 CFR 483.70(a)	K 038	**K-025** 1. The hole observed in resident room 13 was repaired on 5/4/11 by the Maintenance Supervisor. 2. Maintenance staff inspected smoke walls above the ceiling to assure there are no holes to maintain the rating of the walls from on 5/4/11 with inspections continuing thru 5/20/11. Any openings were sealed with an approved sealant by maintenance staff. 3. Maintenance staff will perform an inspection of smoke walls that may be penetrated during the course of equipment installation or maintenance.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345126	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVE CARE AND REHABILITATION CENTER	228 SMITH CHAPEL RD BOX 569 MOUNT OLIVE, NC 28365

(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 056	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation on Wednesday 5/3/11 from 8:45 AM onward the following was noted. 1) The exterior roof/overhang outside the kitchen door was not sprinklered. (Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in depth per NFPA 13 section 5-13.8.1.) 2) The sprinkler riser room located outside the kitchen area was not provided with heat in order to prevent the pipr from freezing. 42 CFR 483.70(a)	K 056	<u>K-025-Continued</u> 4. Maintenance supervisor or assigned staff will inspect smoke walls monthly for three months and then quarterly and report findings to the Process Improvement (PI) committee. <u>K-038</u> 1. Staff received training on the proper operation of the override switches for the mag lock doors on 5/4/11 and 5/5/11 by the Maintenance Supervisor. 2. Proper operation of the override switches for the mag lock doors will be incorporated into the new staff orientation program and will be covered during periodic Life Safety Training presented to current staff. 3. Staff will be questioned about proper operation of the mag lock door override switches during monthly fire drills by the Maintenance Supervisor. 4. Results of monthly fire drills and staff knowledge of the override system for mag lock doors will be reviewed monthly for 3 months during PI meetings.	6/3/11 6/3/11
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation on Wednesday 5/3/11 from 8:45 AM onward the following was noted.	K 076		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345126	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/04/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT OLIVE CARE AND REHABILITATION CENTER	228 SMITH CHAPEL RD BOX 569 MOUNT OLIVE, NC 28365

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K 076	Continued From page 3 1) An oxygen cylinders were not properly chained or supported in a proper cylinder stand or cart. [NFPA 99 4-3.5.2.1b(27)] (Nurse Station #1) 42 CFR 483.70(a)	K 076	K-56 1. A. BFPE, our licensed fire sprinkler contractor was contacted on 5/5/11 by the Maintenance Supervisor and will install the required sprinkler head in the roof/overhang outside the kitchen door. (Completed 5/20/11) B. An approved heating unit will be installed by the Maintenance Supervisor in the sprinkler riser room located outside the kitchen to prevent the pipes from freezing 2. A. No other exterior roof/overhangs were identified by the surveyor on 5/4/11 as requiring a fire sprinkler head. B. There are no other exterior rooms containing sprinkler system pipes. 3. In the event of any building modifications, steps will be taken to assure areas are sprinkled as required through the state plans review process. 4. A. The required sprinkler head will be installed and inspected as required by BFPE. B. Operation of the heating unit will be checked by maintenance personnel during cold weather to assure proper operation to prevent freezing of the pipes.	6/3/11

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1. The unsecured oxygen tanks were immediately removed and secured as required on 5/4/11 by nursing personnel. Staff received additional training about properly storing and securing oxygen tanks in the designated area on 5/4/11 and 5/9/11 by the SDC.

2. Maintenance staff and nursing supervisors will check each nursing unit first thing each morning - after lunch and before the end of the day to identify any unsecured oxygen tanks and remove them to the designated storage area. Upon finding an unsecured oxygen tank, staff will receive additional training on the proper handling and storage of oxygen tanks by the Maintenance Supervisor.

3. Staff will receive training during orientation about the proper storage of full and empty oxygen bottles by the Maintenance Supervisor. Staff will continue to receive periodic training during Life Safety Training sessions by the Maintenance Supervisor.

4. Maintenance Supervisor will report of the effectiveness of the monitoring and training program at the monthly PI meeting for 3 months.

Completion Date: 6/3/11