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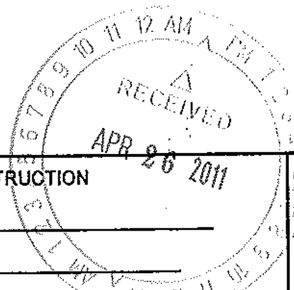

PRINTED: 04/14/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345194	A. BUILDING ______ B. WING ______	03/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENFLORA	5701 FAYETTEVILLE ROAD LUMBERTON, NC 28360

(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 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 clean the area surrounding a pressure ulcer prior to applying a new wound dressing for 1 of 3 sampled residents with a pressure ulcers (Resident #3). Findings included: Resident #3 was admitted to the facility on 4/12/10 with the cumulative diagnoses of cerebral palsy, aphasia, debility, and decubitus ulcer. Record review of the most recent Quarterly Minimum Data Set (MDS) assessment dated 2/17/11 revealed Resident #3 was severely impaired for daily decision making skills. The MDS also revealed Resident #3 was totally dependent for bed mobility, transfer, toileting, personal hygiene, bathing, and was always incontinent of bowel. Record review of Care Plan dated 2/11 revealed Resident # 3 had a Stage 4 sacral pressure ulcer and was at risk for the development of more	F 314	**DISCLAIMER** *GlenFlora* acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of Residents. The plan of correction is submitted as a written allegation of compliance. *GlenFlora's* response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, *GlenFlora* reserves the right to refute any deficiency on this statement of deficiencies through informal dispute resolution, formal appeal, and/or other administrative or legal procedures. F-314 Plan of Correction • One-on-one discussion with Nurse #1 involving expectations regarding incontinent care as it relates to wound care by D.O.N. and Infection Control RN on March 30, 2011.	4/22/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Executive Director
(X6) DATE: 4/22/2011

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 314	Continued From page 1 areas due to mobility issues, contractures, and incontinence. The approach section indicated wound care would be provided for Resident #3 as ordered by the physician. Record review of Physician ' s Orders dated 3/24/11 revealed Resident #3 was to have a hydrofiber antimicrobial dressing applied every other day. Record review of a Treatment / Flow Sheet dated 3/11 revealed Resident #3 was to have the sacral wound irrigated with normal saline, packed lightly with a hydrofiber antimicrobial dressing, covered with a folded 2 x 2 inch gauze, and secured with an extra thin hydrocolloid dressing every other day. During an observation on 3/30/11 at 10:05 AM, Nurse #1 unfastened Resident #3 ' s brief and turned him on his side. Resident #3 was observed to have stool present and expelled some flatus (gas in the digestive tract) when the brief was removed. Nurse #1 indicated Resident #3 usually had gas and oozing of stool when the pressure ulcer dressing was changed. Nurse #1 placed some 4 x 4 inch gauze over the stool and Resident #3 ' s rectal area. She removed the packing and dressing from Resident #3 ' s pressure ulcer and placed them in a bag and changed gloves. Nurse #1 irrigated Resident #3 ' s pressure ulcer with normal saline. Nurse #1 used 4 x 4 inch gauze and wiped some stool from the sacral area and then folded the gauze and cleaned the sacral area in a circular motion. Nurse #1 placed the gauze in a plastic bag. Nurse #1 packed Resident #3 ' s sacral pressure ulcer with a hydrofiber dressing and placed 2 x 2 inch gauze over the dressing. Nurse #1 covered	F 314	Nurse #1 was scheduled to complete treatments again on April 7th, 2011, and Infection Control RN observed Nurse #1 completing the dressing change for resident #3 on that date. Appropriate technique in regards to incontinent care was observed. MD was notified on March 30, 2011 regarding elder's continual leakage of stool during dressing changes. Subsequent changes were made to medications per MD. • The Infection Control Coordinator held an in-service on April 18th and 19th regarding incontinent care (Attachment A & B) At the end of the in-services, all treatment personnel present were given a separate in-service regarding wound care as it relates to incontinent care and the appropriate techniques to use with wound care (Attachment A & B). All treatment personnel that were unable to attend will receive a handout of the information covered and appropriate dressing change technique by April 27, 2011.	

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	345194	A. BUILDING ______ B. WING ______	03/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 2 Resident #3 ' s hydrofiber dressing and 2 x2 inch gauze with a dated hydrocolloid dressing. Nurse #1 then proceeded to clean the stool from Resident #3 ' s rectal area. An interview was held on 3/30/11 at 10:30 AM with the Treatment and Infection Control Nurse. She indicated if stool was present on a resident it should be cleaned prior to changing a dressing. An interview was held on 3/30/11 at 10:45 AM with Nurse #1 who indicated Resident #3 had a lot of gas and oozing of stool when the pressure ulcer dressing was changed. Nurse #1 indicated she put gauze over the rectal area to keep it from coming back on her. She indicated Resident #3 had oozing stool all the time. Nurse #1 indicated she always changed the pressure ulcer dressing and then cleaned the stool off of Resident #3 ' s rectal area. An interview was held on 3/30/11 with the Director of Nursing (DON). The DON indicated her expectation was any stool would be cleaned prior to placing a new dressing on a resident with a pressure ulcer. The DON indicated if a resident was cleaned and kept oozing stool she would expect the dressing to be changed. The DON indicated she would not expect a (staff member) to cover a resident ' s rectal area that had stool present with gauze and then change a pressure ulcer dressing.	F 314	• All personnel performing treatments will be observed for appropriate technique during dressing changes every six months. These evaluations will be completed by the Infection Control Coordinator, Director of Nursing or administrative RN (Attachment C). Evaluation results with be reported to the Quality Assurance Committee in order for the purpose of monitoring progress. A minimum of 10% of these will be completed monthly; these evaluations began April 7th, 2011. Annual in-services will continue in regards to incontinent care.	

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	345194	A. BUILDING 1A - MAIN BLDG B. WING ______	05/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLENFLORA	5701 FAYETTEVILLE ROAD LUMBERTON, NC 28360

(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 038 SS=E	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 the observations and staff interview during the tour on 5/13/2011 the facility had a screened in porch on the egress corridor on the 300 hallway that has a magnetic locking device installed on the corridor side door. There is no door release device installed in the room to release the magnet in an emergency other than fire.. NOTE: the locking device did release with activation of the fire alarm system. CFR#: 42 CFR 483.70 (a)	K 038	**DISCLAIMER** RESPONSE PREFACE: *GlenFlora* acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of Residents. The plan of correction is submitted as a written allegation of compliance. *GlenFlora's* response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, *GlenFlora* reserves the right to refute any deficiency on this statement of deficiencies through informal dispute resolution, formal appeal, and/or other administrative or legal procedures.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 4/20/2011 the following items were observed as noncompliant with the sprinkler system in the main sprinkler riser room, specific	K 062		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David Thomas [signature]
TITLE: Executive Director
(X6) DATE: 5/27/2011

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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K 062	Continued From page 1 findings include: The facility has accelerator/ air supply lines to the dry side of the sprinkler risers that have valves if closed will affect the operation of the sprinkler system. These particular valves are not equipped with electronically supervised tamper alarms. CFR#: 42 CFR 483.70 (a)	K 062	K-038 Plan of Correction • In order to resolve deficiency a brake beam sensor will be installed at the rear 300 hall door (leading to screened in porch) to allow for patients to access in order to enter facility from the porch. • The brake beam sensor will function by deactivating door despite the presence of a wandering device. • The brake beam sensor will be tested weekly in conjunction with the door alarm tests. • Any failures will be reported by the plant operations director to the executive director for immediate corrective action.	6/26/2011
			K-062 Plan of Correction • The accelerator, which is connected to the sprinkler risers, will be tied into the monitoring system through a tamper alarm/switch to be installed by the vendor. • The tamper alarm will be tested on site on the day of installation to ensure functionality. • The vendor will continue to conduct routine inspections of the facility's critical monitoring system to ensure compliance.	6/26/2011