STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345344	A. BUILDING _____ B. WING _____ JUN 03 2011	05/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF HENDERSON	280 SOUTH BECKFORD DR 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 161 SS=B	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview, and record review, the facility failed to maintain a surety bond which designated the obligee (recipient of the bond) as the residents whose monies were managed by the facility. The facility had resident trust fund accounts for forty three (43) of seventy seven (77) residents in the facility. Findings include: Review of the surety bond on 5/12/11 at 8:00 am revealed a document issued by an insurance company dated 7/7/10 and effective to 8/20/11 was written in favor of the State of North Carolina and not the residents of the facility. In an interview on 5/12/11 at 8:05 am the Business Office Manager stated she had not noticed the surety bond designated the State of North Carolina as obligee and that the surety bond was provided by corporate. The Business Office Manager stated she would contact corporate for a corrected surety bond designating the Residents of Guardian Care of Henderson as obligees.	F 161	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1. The surety bond verbage was corrected to identify the residents of Guardian Care of Henderson as the obligees. A copy of the corrected surety bond was provided to the survey team prior to the survey exit. 2. The Administrator and Business Office Manager were in-serviced on the residents of the facility being named as obligees on the surety bond. 3. The Business Office Manager will notify the Administrator annually when the new surety bond is received. The Administrator and Business Office Manager will validate the residents of the facility are named as obligees on the surety bond. 4. The facility's Performance Improvement Committee will review the surety bond annually in August to validate the residents of the facility are named as obligees.	F 161 6/6/2011
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jacqueline V Mitchell — TITLE: Executive Director — (X6) DATE: 6/1/11

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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	345344	A. BUILDING _____ B. WING _____	05/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF HENDERSON	280 SOUTH BECKFORD DR 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 312	Continued From page 1 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 observations, staff and resident interviews and record review, the facility failed to provide nail care to 2 of 13 residents (#4, #5) requiring total dependence on the staff for hygiene. The findings include: Resident #4 Resident #4 was admitted 04/28/10 with diagnoses, in part, diabetes and blind in the left eye. The Minimum Data Set (MDS) dated 01/19/11 indicated the resident required total dependence on the staff for hygiene. The Care Plan updated 05/03/11 indicated the resident had a self-care deficit. The goals included to be neatly groomed every day with a clean and neat appearance. The Nursing Assistant (NA) Flow Sheet in the Activities of Daily Living Book identified Resident #4 required shampoo, shower/bath two times per week, partial sponge bath on other days, fingernails and toenails cleaned and checked. The Nursing Notes referred to Resident #4 as " alert and verbal. " On 05/10/11 at 2:37 PM, the fingernails of	F 312	1. Fingernail and toenail care provided for residents #4 and #5 by licensed nurse and nursing assistants. 2. Current residents were observed to validate fingernails and toenails were clean and trimmed. Licensed staff and nursing assistants were in-serviced on providing fingernail and toenail care for residents. Diabetic residents will have fingernails and toenails trimmed by licensed nurses. Nursing assistants will clean fingernails and toenails daily during AM care and PRN. Nursing assistants will trim nails of non-diabetic residents. 3. DNS or SDC will monitor nail care of residents daily from 5/16-5/19/2011, 2 x week 5/23-5/27/2011, then weekly ongoing. 4. Results of nail monitoring will be reviewed by the facility's Performance Improvement Committee monthly x 3 months for further recommendation.	F 312 6/6/2011

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F 312	Continued From page 2 Resident #4 were observed to have dark matter under 10 of 10 fingernails. The fingernails were one quarter inches long. On 05/11/11 at 7:55 AM, Resident #4 stated " nobody takes care of my nails. " On 05/11/11 at 9:20 AM, during an observed bed bath for Resident #4, the resident stated to NA #1 " I want to have my nails cut. " Resident #4 was observed scratching self. NA #1 stated the resident ' s posterior upper thigh was red from scratching. The fingernails of Resident #4 were observed to have dark matter under 10 of 10 fingernails. The fingernails were one quarter inches long. The toenails were one eighth to one quarter inches long. The large toenail on each foot was one quarter inches thick. On 05/12/11 at 8:14 AM, the Staff Development Coordinator (SDC) observed the fingernails of Resident #4. The SDC stated Resident #4 needed fingernails cleaned and cut. The SDC stated nail care was supposed to be done on shower days or during bed baths. The SDC stated residents ' nails should be clean every day. The SDC stated she suspected nail care was a widespread problem. On 05/12/11 at 8:24 AM, the Patient Care Coordinator (PCC) observed the fingernails and toenails of Resident #4. The PCC stated Resident #4 needed fingernails cleaned and cut. The PCC stated Resident #4 needed toenails cut. The PCC stated fingernail and toenail care for diabetics is done in-house by licensed staff. On 05/12/11 at 8:40 AM, the Director of Nursing	F 312		

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F 312	Continued From page 3 Services (DNS) stated the expectation is residents should have clean nails every day. The DNS stated if resident nails need to be cut then " just cut them. " The DNS stated nail care should be monitored daily. The DNS stated the expectation is NAs and licensed staff are responsible for nail care. Resident #5 Resident #5 was admitted 12/18/10 with diagnoses, in part, a history of cerebral vascular accidents and sacral and left hip pressure sores. The MDS dated 03/03/11 identified the resident had impaired decision-making for activities of daily living. The MDS identified the resident required total dependence on the staff for hygiene. On 05/10/11 at 12:10 PM, the fingernails of Resident #5 were observed to have dark matter under 8 of 10 fingernails. The fingernails were one sixth inches long. On 05/11/11 at 10:45 AM, post pressure sore wound care with the DNS and the PCC present, the fingernails of Resident #5 were observed to have dark matter under 8 of 10 fingernails. The fingernails were one sixth inches long. On 05/12/11 at 8:14 AM, the SDC observed the fingernails of Resident #5. The SDC stated Resident #5 needed fingernails cleaned. The SDC stated nail care was supposed to be done on shower days or during bed baths. The SDC stated residents ' nails should be clean every day. The SDC stated she suspected nail care	F 312		

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F 312	Continued From page 4 was a widespread problem. On 05/12/11 at 8:24 AM, the PCC observed the fingernails of Resident #5. The PCC stated Resident #5 needed fingernails cleaned and cut. The PCC stated fingernail care for non-diabetics is done by the NAs. On 05/12/11 at 8:40 AM, the Director of Nursing Services (DNS) stated the expectation is residents should have clean nails every day. The DNS stated if resident nails need to be cut then " just cut them. " The DNS stated nail care should be monitored daily. The DNS stated the expectation is NAs and licensed staff are responsible for nail care.	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to have a safe environment due to 2 out of 48 (Rm #151 & #122) rooms having broken, jagged metal casing edge in a room , a overhead light with a broken covering hanging outside of the room and exposed phone wires in 1 of 2 nursing stations, (#2).	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1. Rooms #151 and #122 had broken metal casing replaced and overhead light covering replaced. Century Link technician placed covering over exposed wires at Nurse's station #2 and verified no health/safety risk possible from exposure. 2. Maintenance Director performed facility rounds to validate other metal casings and light covers were in good repair. Facility staff in-serviced on notification of maintenance Director when repairs are needed. Maintenance Director in-serviced on timely repair of identified issues.	F 323 6/6/2011

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F 323	Continued From page 5 Findings include: 1. On 05/10/2011 at 9:30 am it was observed in a resident room (#151), at the head of the resident ' s bed was a broken, jagged metal casing for wires. The broken, jagged metal casing was within reach of the resident with sharp edges. On 05/10/2011 at 2:00 pm, and on 5/11/2011 at 8:15 am, 11:15 am, 4:00 pm and on 05/12/2011 at 8:00 am observations showed the broken, jagged metal casing remained in room #151. On 05/11/2011 at 11:15 am observation and interview with the Administrator indicated the expectation was to have the metal casing fixed to prevent injury. On 05/11/2011 at 12:25 pm interview with the Director of Maintenance (DOM) indicated there were issues within the building that were present before his employment that he has been working on. He indicated that safety of the residents was most important. 2. On 05/10/2011 at 9:30 am an observation was made of an overhead light with a broken covering with a jagged edge hanging loosely outside of room 122. The physical therapy room was across the hall from room 122. Multiple residents observed in the hallway. On 05/10/2011 at 2:00 pm and observation was made of the physical therapy staff assisting several residents with ambulation in the hall	F 323	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 3. Maintenance Director and Administrator will conduct weekly facility rounds ongoing to identify equipment needing repair. Administrator will review Maintenance Director's repair log weekly ongoing to validate repairs are completed timely. 4. Maintenance Director's repair log and results of weekly rounds will be reviewed by the facility's Performance Improvement Committee monthly x 3 months for further recommendation.	

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F 323	Continued From page 6 throughout the day, and observed a resident sitting in a wheel chair near the overhead light. The broken overhead light covering remained. On 05/11/2011 at 11:15 am observation and interview with the Administrator indicated the expectation was to have the broken light covering fixed to prevent injury. On 05/11/2011 at 12:25 pm interview with the Director of Maintenance (DOM) indicated there were issues within the building that were present before his employment that he had been working on. He indicated that safety of the residents was most important. Broken overhead light covering pointed out to DOM. 3. On 05/10/2011 at 9:30 am an observation was made of several exposed uncovered phone wires behind 1 of 2 nursing stations (#2). The area was accessible to the residents. On 05/10/2011 at 11:15 am, 2:00 pm, and on 05/11/2011 at 8:10 am, 3:30 pm, on 05/12/2011 at 8:00 am and 12:30 pm the same observations were noted: the wires continue to be exposed behind the nursing station #2. Multiple residents were around the nursing station. On 05/11/2011 at 11:15 am on observation and interview with the Administrator indicated she had no safety concerns about the exposed wires. The Administrator was observed to visualize the exposed wires. She indicated she would contact the contracted phone company to request covers for the wires. She indicated the covers were requested previously.	F 323		

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F 323	Continued From page 7 On 05/11/2011 at 12:25 pm interview with the Director of Maintenance (DOM) indicated there were issues within the building that were present before his employment that he has been working on. He indicated that safety of the residents was most important. On 05/11/2011 at 3:30 pm observed the Administrator talking with a representative from the phone company who indicated he thought the wires were to be covered last year and he told the Administrator he would place another work order into his supervisor to cover the exposed wires. On 05/12/2011 at 11:20 am an interview with the DOM indicated the phone wires were functioning and that the voltage was minimal and did not cause a shock to any person when touched. DOM indicted the exposed wires should have been covered from the phone company. On 05/12/2011 at 11:40 am an interview with the Regional Director of Maintenance for the facility (RDM) when asked about his expectations of wires being safe and covered, indicated that the voltage to the exposed wires was small and did not place anyone at risk for shock. On 05/12/2011 at 11:40 am the Administrator was observed talking with a representative from the phone company and placed a service ticket to have the exposed phone wires covered. The representative indicated there was no potential health risk to anyone who would touch exposed wires.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 8 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, record review, and staff interviews the facility failed to label and date dry food items, and failed to ensure the following: kitchen utensils were clean, a hair net was worn by a vendor, and a glue board was not changed on a fly catcher during food preparation / serving. 1. During an observation of the kitchen on 5/11/11 at 7:50 AM a pest control vendor, without a hair net, was observed removing a white paper-like sheet from what appeared to be a white plastic container located near the top of the ceiling and to the left of the 3 compartment sink and the reach-in refrigerator. Resident trays were observed located on a cart to the left of the plastic container and near the front of the reach-in refrigerator. A Dietary Aide was observed completing the resident trays. The Dietary Aide was observed handing the trays to other staff so the breakfast foods could be put on the plates / bowls serving. An interview was held on 5/11/11 at 7:55 AM with the pest control vendor. He indicated he had	F 371	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1. Pest control vendor was contacted and request made for facility visits to be scheduled around meal times. Hairnets were placed at the entrance to the kitchen. Dry food items were labeled and dated. Pots and pans identified as having heavy carbon build up were discarded and replacements ordered. 2. Dietary staff were in-serviced on timing of pest control visits around meal times, identification of heavily carbonized pots and pans, and labeling of dry food storage containers, and use of hairnets by outside vendors. 3. Dietary manager will monitor pest control visits monthly to ensure visits do not occur during meal times and hairnets are worn by the pest control employees. Dietary staff will monitor pots and pans daily and notify dietary manager when heavily carbonized equipment is identified. Dietary manager will audit dry food storage containers daily x 1 week, 3 x week x 1 week, then weekly ongoing to validate containers are dated and labeled as appropriate. 4. Results of these audits will be reviewed by the facility's Performance Improvement Committee monthly x 3 months for further recommendation.	F 371 6/6/2011

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F 371	Continued From page 9 stuck a new glue board on the fly catcher. He indicated he changed the glue board on the fly catcher once a month. An interview was held on 5/11/11 at 7:57 AM with the Dietary Manager. She indicated the pest control vendor usually came during down time in the kitchen. The Dietary Manager indicated the pest control vendor had a routine and unless she had a problem she did not speak with him. An interview was held on 5/11/11 at 12:55 PM with the Dietary Manager. The Dietary Manager indicated in the future she would have the pest control vendor ring the door bell and give him a hair net. She indicated if something was going on in the kitchen the pest control vendor would have to wait to do the bug stuff. 2. Record review of the facility 's Food Storage Guide dated 12/11/04 revealed, under the General Guidelines section, to label each package, box, can, etc. with appropriate date and to store foods removed from their original packaging in a closed container or tightly wrapped package and labeled with the date it was opened. Under the General Guidelines for Maximum Food Storage Periods revealed brown sugar, listed as 4 months, and to keep in an airtight container. During an observation of the food storage area on 5/11/11 at 8:05 AM with the Dietary Manager two covered plastic containers were observed unlabeled and undated. An interview was held on 5/11/11 at 8:05 AM with the Dietary Manager who indicated the two	F 371		

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F 371	Continued From page 10 containers were not labeled or dated. She indicated one plastic container held graham cracker crumbs and one container held brown sugar. She indicated usually all food items were labeled and dated. 3. During an observation of the kitchen on 5/11/11 at 8:15 AM a sheet pan containing rolls was observed with black encrusted matter on the bottom of the pan, one empty sheet pan was observed with black encrusted matter on the inside corners and the bottom of the pan, one large frying pan was observed with black matter on the bottom of the pan and from the top to approximately 1½ inches inside the pan, and one small pot was observed with black encrusted matter on the bottom, sides, and from the top to approximately 1½ inches inside the pan. During an interview on 5/11/11 at 8:15 AM the Dietary Manager indicated the blackened areas on the frying pan was from cooking and because a deep fryer was not used, and the blackened areas on the other pans was from cooking. During an interview and observation with the Administrator on 5/11/11 at 8:40 AM she indicated the blackened areas on the pans were from cooking and the inside areas would not flake off. An interview was held on 5/11/11 at 12:35 PM with the Registered Dietitian. She indicated the Administrator had ordered new pans for the kitchen. An interview was held on 5/11/11 at 12:55 PM with the Dietary Manager. She indicated the pots	F 371		

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F 371	Continued From page 11 and pans had been removed from service and there was one new sheet pan available for use. An interview was held on 5/12/11 at 10:25 AM with the Registered Dietitian. She indicated the plastic container of graham cracker crumbs and brown sugar should have been labeled. The Registered Dietitian indicated the fly trap should not have been changed during food preparation or serving. An interview was held on 5/12/11 at 11:15 AM with the Administrator. She indicated the pest control vendor usually came in during the evenings. She indicated the pest control vendor should not have come into the kitchen during that time. The Administrator indicated they would encourage vendors to wear hair nets and put them by the kitchen door.	F 371		

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PRINTED: 06/20/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345344	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF HENDERSON	280 SOUTH BECKFORD DR 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 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. This STANDARD is not met as evidenced by: A. Based on observation on 06/14/2011 the door to the theropy room failed to latch. 42 CFR 483.70 (a)	K 018	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* K-018 It is the practice of the facility to ensure doors close and latch properly. The Maintenance Director has corrected the latch on the door to the therapy room to prevent failure. The Maintenance Director will inspect all doors daily x 2 weeks; then weekly per PM program to ensure doors close and latch properly. Findings will be discussed during monthly Performance Improvement Meetings.	06/27/2011

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

Joseph Mitchell | Executive Director | 6/27/11

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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