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FORM APPROVED
OMB NO. 0938-0391

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

DEC 0 2 2011

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345366 | A. BUILDING ______ <br> B. WING ______ | 11/03/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| RICH SQUARE HEALTH CARE CENTER | 320 NORTH MAIN STREET <br> RICH SQUARE, NC 27869 |

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| F 253 SS=D | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES <br><br> The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. <br><br> This REQUIREMENT is not met as evidenced by: <br> 2. Based on observations and interviews the facility failed to label denture cups on 1 of 3 halls (hall 100). <br> During the initial tour of hall 100 on 10/31/2011 at 9:30 AM six denture cups in 4 double occupancy rooms were observed to have no names on them. Another observation on 11/1/11 at 5:10 PM and on 11/2/11 at 8:50 AM revealed no changes in the denture cup labels. <br><br> Room #102 had two denture cups sitting on the bathroom sink. One denture cup was labeled with a resident name and was empty. The other denture cup was unlabeled and had a set of dentures in it. <br><br> Room # 105 had two unlabeled denture cups on the bathroom sink. One denture cup was empty and one cup contained a set of dentures. <br><br> Room # 106 was observed to have two sets of empty unlabeled denture cups on the bathroom sink. <br><br> Room # 114 was observed to have one empty unlabeled denture cup on the bathroom sink. <br><br> An interview was conducted with Nursing Assistant (NA) #1 on 11/2/11 at 10:24 AM. | F 253 | Preparation and/or execution of the plan of corrections does not constitute admission or agreement by the provider of the truth of the items alleged or conclusions set forth in the statement of deficiencies. <br><br> The plan of correction is prepared and or executed solely because it is required by the provision of the Federal and State laws. <br><br> F 253 <br> 483.15 (h)(2) <br> Housekeeping and Maintenance Services Central Supply has removed the denture cups in rooms #102, #105, #106, #114 and replaced with new denture cups marked with resident's name. Each resident's denture cup has been removed and replaced with a new properly identified denture cup in the facility. <br><br> Each new admission receives a complimentary admission packet including a denture cup which is labeled and placed in the resident's room by Central Supply. These items are replaced as needed and identified with the resident's name. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joyce Perry RN BSN DON
TITLE: Director of Nsg
(X6) DATE: 11/29/11

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.



Jim Levesque - NHA

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| F 253 | Continued From page 1<br>She stated she did not usually put in resident dentures. The NA revealed most of the residents had their dentures in when she came on first shift. NA#1 reported night shift put in dentures for residents dependent on staff for care. Residents who could walk went to the bathroom and did their own oral care. She indicated if she had to assist a resident with their dentures in a double occupancy room she would look at the name on the denture cups to identify which resident the dentures belonged to. NA#1 stated she was not aware who was responsible for labeling denture cups.<br><br>During an interview with NA #3 on 11/2/2011 at 5:25 PM she was shown 2 unlabeled denture cups in room #102. NA #3 did not know who was responsible for labeling denture cups. She stated she would go to the patient care guide inside each resident ' s closet door to determine if the resident had dentures vs. partials to help identify which denture cup belonged to which resident. Closet patient care guides were reviewed in all 4 double occupancy rooms with unlabeled denture cups. Seven of the eight patient care guides had no denture status indicated.<br><br>An interview with the facility Infection Control Nurse on 11/3/11 at 8:40 AM revealed Central Supply issues dental cups to new admissions and replaces as needed. She indicated Central Supply was responsible for labeling the denture cups when they were issued to residents.<br><br>An interview with NA #4 revealed she is responsible for Central Supply and Transport Services. She stated she works the floor as an NA when coverage is needed. She indicated | F 253 | Central supply and nursing staff have been educated on the proper identification of denture cups. The observation period for the presence of denture cups with proper labeling will continue for two (2) months or 98% compliance, whichever comes first.<br><br>The Central Supply employee will retain a listing of residents, currently in-house and denote in monthly columns that residents received new denture cups with labels of names. Denture cups and labeling as needed will not be tracked or recorded.<br><br>The DNS will review and reeducate the Central Supply employee on room stocking and proper labeling.<br><br>The DON and Administrator have delegated administrative staff to do daily rounds in assigned rooms and provide a room audit to the Administrator.<br><br>Date correction in place:<br>December 1, 2011 | |

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| F 253 | Continued From page 2<br>each resident receives an admission kit upon arrival. She explained if the resident did not bring a personal denture cup to the facility she issued one to the resident with their name clearly labeled. She stated any cups I issue are labeled when I leave them in the room. NA #4 revealed some residents are admitted when she is not in the facility. She did not know who labeled the denture cups then. She also stated names wear off eventually and need to be relabeled. Central Supply does not check for worn off names or unlabeled denture cups.<br><br>During an interview with the Director of Nursing (DON) on 11/3/11 at 10:10 AM she revealed it was her expectation denture cups should be labeled clearly and easily identifiable to staff and residents. The DON indicated nursing and administrative staff do daily rounds in assigned rooms and should know who has dentures and be aware of any unlabeled denture cups. | F 253 | | |
| F 279 SS=G | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and | F 279 | F279<br>483.20(d), 483.20(k)(1)<br>DEVELOP COMPREHENSIVE CARE PLANS<br>Rich Square Health Care Center will continue to review and revise comprehensive care plans<br>1. ***For those residents found to have been affected:***<br>The Care Plans for residents #84 and #51 have been updated to include appropriate diagnosis and skin care elements. | |

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| F 279 | Continued From page 3<br>psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based upon staff interviews and record reviews the facility failed to develop and revise comprehensive plans of care for 2 of 15 sampled Residents (Resident #84 and Resident #51).<br><br>Findings Include:<br><br>Resident #84 was admitted to the facility on 8/18/2011 with diagnoses of dementia, psychosis, arthritis, depression, anxiety, and rehabilitation for a fractured left arm. The fracture was sustained in a fall on 7/13/11 while living in an assistive living community. She was admitted to the facility for physical and occupational therapy.<br>A review of the medical record revealed Resident #84 was assessed by Staff Nurse#1 upon her admission. The Admission Nursing Assessment was completed on 8/18/11 and revealed the resident had reddened areas on both elbows and sacrum. The resident scored 13 on the Braden Scale - for Predicting Pressure Sore Risk on 8/18/11. Per scoring scale, any number higher than 12 represented a high risk for the development of pressure sores. A dietary assessment completed on 8/29/2011 indicated the resident had good skin tugor, no wounds, and no swelling.<br>Review of the Minimum Data Set (MDS) dated | F 279 | Resident #84: A head to toe skin assessment was completed and any new or resolved areas were noted and the care plan was updated to reflect these changes.<br>Resident #51: The Care Plan was reviewed and updated to reflect dialysis care measures and precautions.<br>2. ***For those residents having the potential to be affected by the same alleged deficient practice:***<br>A Care Plan Audit was performed to ensure that new admissions have an interim care plan in place following admission assessment.<br>Wound Care Audit was performed for residents who are at risk for pressure ulcers on admission.<br>MDS Coordinator will ensure that a Dialysis Care Plan is in place for residents who are admitted with or are diagnosed with a diagnosis of end stage renal disease and are receiving dialysis.<br>The Care Plan Team and Nursing Staff were inserviced on 11/28 regarding identification of residents at risk for pressure ulcers with documentation on the appropriate forms, i.e. Braden Scale, Skin | |

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| F 279 | Continued From page 4<br>8/31/11 documented Resident #84 had a Brief Interview Mental Status (BIMS) score of 5 out of 12. The resident was severely impaired in cognitive skills and was a total care patient who required extensive assistance in all areas of daily care and was incontinent of bladder and bowel. The MDS indicated the resident had (3) stage 1 pressure sores. A stage 1 pressure sore is defined in the MDS as intact skin with nonblanchable redness of a localized area usually over a bony prominence.<br>A review of the Care Area Assessment (CAA) Summary dated 8/31/11 indicated care areas triggered to be addressed in care plans. Pressure ulcers triggered but were not checked to be addressed in care plans for the resident. A care plan for Resident #84 was initiated on 9/6/2011 which identified one of the residen's problems as at risk for skin breakdown related to decreased mobility. The care plan was updated on 9/7/11 from at risk to the presence of (2) pressure ulcers on the resident's heels. The care plan was never updated to include the sacral ulcer or to note the pressure wounds had healed. During the review of the resident's medical record no interim care plan was found for the time period of admission on 8/18/2011 until 9/6/2011.<br>A review of the nursing notes in Resident #84 ' s medical chart on 9/7/2011 revealed the resident complained of bilateral heel pain after therapy. The presence of a stage II pressure ulcer measuring 0.5cm x 0.6cm (centimeters) was documented on the left heel. A Stage II pressure ulcer is defined as partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater. A stage I unopened pressure wound was documented on the right | F 279 | Assessment forms, Nurses Notes goals and interventions.<br>On 11/7, Treatment Nurse, Charge Nurses, Admitting Nurses and Nursing Staff were inserviced on the technique of performing head to toe assessment on admission and documentation of findings, communication to the RN Supervisor, Treatment Nurse, MDS Coordinator using the Skin Referral Sheets and provide MD and family with notification of changes.<br>3. ***To ensure the same alleged deficient practices will not occur:***<br>The Treatment Nurse will ensure that all new admissions have Skin Assessments and preventive interventions are put in place.<br>The Charge Nurses have been re-educated by Nursing Administration on performing Skin Audits on all admissions with appropriate documentation and communication to Treatment Nurse, MDS Nurse and Nursing Administration with follow up notification to MD and Family on 11/7/2011.<br>The Charge Nurses, RN Supervisor and MDS Coordinator has been re-educated on the Dialysis | |

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| F 279 | Continued From page 5<br>heal. A note was faxed to the primary doctor and an order was obtained for Polymen 7 days and prn to left heel Stage II pressure ulcer. Clean with sea clean with each dressing change.<br>A Wound / Skin Healing Record dated 9/7/11 indicated a pressure ulcer to the left heel but did not document an original stage when discovered. On 9/14/11 the Wound /Skin Healing Record revealed the pressure ulcer measured 2cm x 2.5cm, had a small amount of drainage, and was identified as a Stage II. An albumin level of 3.4 (3.4-5.0) was obtained on 9/14/11. On 9/21/11 the Treatment Nurse documented the wound measured 0.5cm x 0.5 cm with no drainage. The Wound / Skin Healing Record dated 9/28/11 indicated the left heel area was closed and had healed.<br>A separate Wound /Skin Healing Record was initiated on 9/10/11 for a sacral pressure wound. An original stage at time of discovery was not documented. On 9/14/11 the wound measured 5cm x 0.5cm and was documented as a Stage II. Review of the 9/21/11 Wound/Skin Healing Record sacral pressure ulcer had decreased to 0.4cm x 0.3cm. The Monthly Summary completed by Nurse #1 dated 10/5/11 indicated no open areas to skin and no pressure ulcers. Observation of incontinence care on 11/2/2011 at 8:55 AM revealed no open areas and all pressure ulcers had healed.<br>During an interview with the MDS Nurse on 11/2/11 at 3:20 PM she revealed it was the facility policy to initiate an interim care plan for all new admissions within 24 hours. She indicated the interim care plan was based on the Nursing Admission Assessment and admitting diagnoses. She stated if a resident was admitted during first shift or the beginning of second shift she initiated | F 279 | Communications Sheet, follow up assessments and documentation relating to the dialysis Care Plan and communication of findings to the MDS Coordinator, the Director of Nursing Services, the MD and the family as indicated.<br>The treatment Nurse will audit the Body Audit Book and Skin Referrals on a daily basis to ensure appropriate follow- up on identified issues as evidenced by Interim Care Plan, Care Plans, CAAs, Treatment Record, MD orders, chart documentation and family notification documentation.<br>***4. Achieved and sustained:***<br>The Director of Nursing Services / Treatment Nurse or designee will audit the Interim Care Plans, Comprehensive Care Plans and Wound Care Records utilizing a QI tool weekly x4 weeks, then monthly for 3 months on any resident assessed at risk for potential skin breakdown and any issues identified will be corrected with 98% compliance.<br>The Director of Nursing Services / Treatment Nurse or designee will audit the Dialysis Care Plans using a | |

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| F 279 | Continued From page 6<br>an interim care plan the day of admission. The MDS Nurse reported residents admitted after she went home had an interim care plan initiated the next morning. The MDS Nurse was not able to find an interim care plan for Resident #84 in the medical record. The MDS Nurse revealed she had just recently taken over the MDS position and was still learning how to complete all the care plans. She stated she did not know how Resident # 84 had been at the facility for 19 days with no care plan. She indicated she had missed doing an interim for the resident. The MDS Nurse revealed the Treatment Nurse sends out a weekly report to update staff on wounds and treatments. The update was given to nursing, MDS, and dietary. The MDS Nurse stated she had not received an update Resident #84 had developed a sacral wound or that the pressure ulcers had healed.<br>An interview was conducted with Nurse # 2 on 11/3/11 at 9:40 AM. She revealed a new admission was given a head to toe assessment by nursing staff, medical orders were clarified, and MDS created an interim care plan the day of admission or the next day. She reported the interim care plan was based on MD orders, diagnoses, and assessments. She stated the interim care plan told staff how to care for the new resident until a comprehensive care plan was completed.<br>During an interview with the Nurse #3 on 11/3/11 at 9:55 AM she revealed she had recently become the facility Treatment Nurse. She stated she was learning how to do the treatments and how to document the treatments given. She indicated she tried to update staff on which residents had new pressure ulcers and when pressure ulcers had healed. The Treatment | F 279 | QI tool weekly x4 weeks, then monthly for 3 months on any resident diagnosed with ESRD and receiving dialysis.<br>The Director of Nursing Services / Treatment Nurse or designee will audit the Body audits book and residents with pressure ulcers on a weekly basis and the Director of Nursing Services will ensure that the plan and the Treatment Nurse and MDS documentation is appropriate with 98% compliance.<br>The findings and concerns will be tracked and trended in the QA&A monthly meeting.<br>***5. Date correction in place:***<br>December 1, 2011 | |

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| F 279 | Continued From page 7<br>Nurse could not remember reporting to MDS the sacral ulcer or the healing of the wounds.<br>During an interview with the Director of Nursing (DON) on 11/3/11 at 10:10 AM she revealed it was her expectation each resident would have an interim care plan in place within 24 hours of admission to inform staff of the care the resident requires. She stated the interim care plan was based on the ICD9 (diagnosis codes) and assessments by nursing and therapy. She indicated she was not aware a resident had gone 19 days without a care plan and had developed pressure ulcers until the MDS Nurse made her aware. She stated the MDS Nurse and Treatment Nurse were new but the interim care plan should have been initiated and the comprehensive care plan should have been updated as the status of the pressure ulcers changed.<br><br>2. Resident #51 was admitted to the facility on 8/29/11 with diagnoses of end stage renal disease, hypothyroidism, cardiomyopathy and peripheral vascular disease. The Minimum Data Set (MDS) dated 9/11/11 indicated Resident #51 was cognitively intact with a disease diagnosis of chronic kidney disease.<br><br>A record review of the physician orders revealed an order for dialysis treatment on the days of Tuesday, Thursday and Saturday.<br><br>A record review of Resident #51 medical record revealed there was no comprehensive care plan for dialysis treatment.<br><br>An interview with the MDS Nurse Assistant on | F 279 | | |

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| F 279 | Continued From page 8<br>11/2/11 at 10:55am revealed she did not recall doing a dialysis care plan for Resident #51. She indicated she would follow-up with this concern.<br><br>An Interview with MDS Nurse Assistant on 11/2/11 at 11:19am revealed she did not know how she missed doing a care plan for her dialysis but she has now created a care plan.<br><br>A record review of the facility policy and procedures for dialysis residents dated 3/13/11 was conducted. It indicated a care plan would be present to include other dialysis care measures and precautions as prescribed by the physician.<br><br>An interview with the Director of Nursing (DON) on 11/3/11 at 9:37am revealed they had a care plan meeting for Resident #51 but did agree there needed to be formal care plan documentation for the staff. | F 279 | | |
| F 282 SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews the facility failed to put a clip alarm on 1 of 2 sampled residents with clip alarms as written in the resident ' s care plan (Resident #21). The findings include:<br><br>Resident #21 was admitted to the facility on | F 282 | ***F282***<br>483.20(k)(3)(ii)<br>SERVICES BY QUALIFIED PERSONS / PER CARE PLAN<br>The service provided or arranged by the facility must be provided accordance with each resident's written plan of care.<br>***1. For those residents found to have been affected:***<br>CNA care plans have been updated and Staff Development Coordinator has inserviced direct care staff on the revised communication tool. This | |

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| F 282 | Continued From page 9<br>12/29/09 and had diagnoses including Dementia and Gait Instability.<br><br>The Care Area Assessment (CAA) dated 12/28/10 stated that the resident required extensive assistance of one for transfers and that staff would assist with all transfers.<br><br>A review of the Fall Risk Assessment done on 09/23/11 showed that the resident was a high risk for falls.<br><br>The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 09/27/11 showed that the resident had short and long term memory loss and was cognitively impaired.<br><br>A review of the resident ' s clinical record showed that on 10/11/11, Resident #21 attempted to transfer from the chair to the bed without calling for assistance and fell.<br><br>The resident ' s Care Plan for falls showed an entry dated 10/11/11 that read: " Clip alarm when up in chair. "<br><br>The Director of Nursing (DON) stated in an interview on 11/01/11 at 2:30 PM that the resident ' s fall on 10/11/11 was reviewed and a clip alarm was added to the resident ' s recliner.<br><br>On 11/02/11 at 10:00 AM, Resident #21 was observed sitting in his recliner in his room. A clip alarm was hanging on the back of the recliner but the clip was not attached to the resident.<br><br>On 11/03/11 at 8:45 AM Nursing Assistant (NA) #3 stated that she was assigned to Resident #21. | F 282 | tool will be updated by RN Supervisor and Charge Nurses as changes occur or as Therapy recommends.<br><br>CNA Staff have also been inserviced on the proper placement and use of bed alarms and chair alarms and how to monitor their function when setting them up after a transfer or change of shift.<br><br>**Dates. Those on vacation or holiday will receive training on/before they resume rotation at work.**<br><br>2. ***For those residents having the potential to be affected by the same alleged deficient practice:***<br><br>The revised CNA care plan tool will be implemented for all residents as of November 30th, 2011. The input for these care plans will come from the MD diagnosis, MDS, admission assessments, therapy (PT/ST/OT) assessments and treatments, resident / family interview and goals for discharge related to the resident's care. These Care Plans will be updated as changes in resident's care occur. | |

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| | 345356 | A. BUILDING ____ B. WING ____ | 11/03/2011 |

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| RICH SQUARE HEALTH CARE CENTER | 320 NORTH MAIN STREET RICH SQUARE, NC 27869 |

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| F 282 | Continued From page 10<br>The NA stated that the resident was unsteady on his feet and that the staff did not let the resident get up unassisted because they were afraid that he would fall. The NA stated that no alarms were used for this resident. The NA stated that there was a guide on the inside of the resident ' s closet door that provided the staff with information about the care of the resident. A review of the Pictorial Care Card for Resident #21 contained no information regarding a clip alarm.<br><br>On 11/03/11 at 9:15 AM Nurse #5 stated in an interview that the resident had experienced no recent falls and that no alarms were used for the resident. The Nurse stated that the resident did not attempt to get up unassisted.<br><br>On 11/03/11 at 9:42 AM the resident was observed to be sitting in the recliner in his room. The clip alarm was not attache to the resident. During the observation, NA #2 entered the room and when asked if the clip alarm was supposed to be used for the resident the NA picked up the alarm clip and attached the clip to the resident ' s clothing and stated that she was not sure.<br><br>In an interview with the Director of Nursing (DON) and the Administrator on 11/03/11 at 10:26 AM the DON stated that the clip alarm should have been added to the pictorial care card posted inside the closet door in the resident ' s room and that the clip alarm should have been attached to the resident. The DON stated that the MDS nurse was responsible for updating the pictorial care cards and that the previous MDS nurse should have added the clip alarm to the resident ' s care card. | F 282 | ***3. To ensure the same alleged deficient practices will not occur:***<br><br>Care Plans will be modified as new orders are received from the physicians, as the resident's status changes, as assessments from members of the IDT dictate the need to change the plan.<br><br>Lists of residents with safety devices will be maintained and the lists will be used to identify those residents with chair alarms.<br>**4. Achieved and sustained**<br>CNA Care Plans will be audited on daily rounds by the Charge Nurses. RN Supervisors will monitor for documentation and compliance. The Staff Development Coordinator will monitor for compliance and re-educate as needed.<br>***Date correction in place:***<br>December 1, 2011 | |

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| F 282 | Continued From page 11<br>The current MDS Nurse stated in an interview on 11/03/11 at 10:38 AM that there was a list of residents with alarms in the front of the Medication Administration Record (MAR) and the nurse should have known that this resident was suppose to have a clip alarm. The Nurse stated that when an alarm was initiated for a resident, the alarm was ordered from central supply and central supply updated the list on the MAR. The MDS nurse was observed to check the MAR and stated that there was not a list of residents with alarms on the MAR. | F 282 | | |
| F 309 SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based upon observations, staff and resident interviews and record reviews the facility failed to provide the necessary care and services to attain or maintain the highest physical well belling for 1 of 1 sampled dialysis Resident's (Resident #51).<br><br>Findings Include:<br><br>Resident #51 was admitted to the facility on 8/29/11 with diagnoses of end stage renal disease with dialysis treatment, hypothyroidism, cardiomyopathy and peripheral vascular disease. | F 309 | ***F309***<br>483.25<br>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br>1. ***For those residents found to have been affected:***<br>The Plan of Care for resident #51 has been updated to include resident diagnosis of ESRD and need for dialysis. The Dialysis Communication Form will accompany resident #51 to dialysis center.<br>Nurses were inserviced on observation and assessments of residents receiving dialysis and their pre and post guidelines and documentation of shunt site, bleeding, weights and vital signs, medications and labs. | |

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| F 309 | Continued From page 12<br>The Minimum Data Set (MDS) dated 9/11/11 indicated Resident #51 was cognitively intact with a disease diagnosis of chronic kidney disease.<br><br>A record review of the dialysis care plan dated 11/2/11 revealed the following: 1. communicate with the dialysis center for updates on Resident #51 condition, 2. observe the shunt site on return from dialysis for bleeding and 3. monitor vital signs and document resident weights per protocol. Also Resident #51 was care planned for a therapeutic diet of a fluid restriction and a history of significant weight loss. It indicated to monitor food and beverage intake daily.<br><br>A record review of the physician orders revealed Resident #51 had orders to receive dialysis treatment on Tuesday, Thursday and Saturday and a fluid restriction of 32 ounces (960cc).<br><br>A record review of the facility nurse notes documented for the return from dialysis was conducted. The notes did not contain documentation of weight status or vital signs.<br><br>A record review of the facility fluid restriction calculation form was conducted from August 2011 to November 2011. There were missing and incomplete documentation throughout this time period.<br><br>An observation on 11/2/11 at 11:45am revealed a large pitcher of water on Resident #51 bedside table.<br><br>An interview with Resident #51 on 11/2/11 at 3:43pm revealed staff fills her water pitcher daily and she drinks it. | F 309 | The Dietary manager provides the calculated fluid breakdown as ordered by the MD and ensures that it is on the Care Plan and the CNA Care Plan.<br><br>CNAs and Licensed Nurses have been inserviced on fluid restrictions, intake and output documentation, consistent methods for obtaining and documenting weights.<br><br>***2. For those residents having the potential to be affected by the same alleged deficient practice:***<br><br>An Audit was performed on documentation of resident's monthly weights and variances to identify residents at risk for potential weight loss / gain.<br><br>Care plan audit will be performed by the Care Plan Team and updated based on results of the audit.<br><br>The Dietary manager provides the calculated fluid breakdown as ordered by the MD and ensures that it is on the Care Plan and the CNA Care Plan.<br><br>The RN Supervisor / MDS coordinator / Dietician will review all residents with orders for fluid restrictions and with a diagnosis of ESRD and review and update their | |

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| F 309 | Continued From page 13<br><br>A record review of the facility vital signs flow sheet was conducted. There was missing documentation for blood pressure readings on the following days: 9/15/11, 9/16/11, 9/19/11, 9/30/11, 10/5/11 to 10/11/11, and 10/18/11 to 11/2/11.<br><br>An interview with Nurse #2 on 11/2/11 at 2:44pm revealed Resident #51 is on dialysis and remains on fluid restriction. They would monitor the intake on the facility fluid restriction calculation form daily. The facility uses a dialysis communication booklet to assess residents once they return from dialysis treatment. The assessment would also include checking the arm site of dialysis treatment.<br><br>A record review of the facility dialysis communication booklet from August 2011 to November 2011 was conducted. The days documented were 9/1/11, 9/6/11, 9/10/11, 9/27/11, 10/18/11 and 10/25/11. There was missing documentation for her dialysis treatment days.<br><br>An interview with Nurse #4 on 11/2/11 at 4:36pm revealed she would check vitals, edema and shunt arm site when coming back from dialysis. The dialysis center documents information such as vitals and weight when residents return from dialysis treatment. If this information is not present in the dialysis communication booklet, it would be documented in the facility daily summary sheets. They would monitor and document fluid intake and output daily when a resident is on a fluid restriction. They document this on the facility fluid calculation form. At the | F 309 | care plans to reflect the MD orders, the diagnosis and assessments required for their care.<br>3. ***To ensure the same alleged deficient practices will not occur:***<br>The RN Supervisor/ MDS Coordinator or designee will review dialysis residents with MD orders for fluid restrictions, for compliance and consistency and documentation I/O documentation.<br>RN Supervisors and Charge Nurses will monitor Dialysis communication form and the appropriate documentation with weights, site observations and vital signs, changes in medications or labs and hospitalization.<br>RN Supervisors and Charge Nurses will monitor CNA compliance with fluid restrictions and I & O.<br>The care plans have been updated to include all interventions related to monitoring of fluids, weights and changes pre-post dialysis. The Staff Development Coordinator / designee will Inservice CNAs and Charge nurses on fluid restrictions and recording of I/O and managing and | |

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| F 309 | Continued From page 14<br>end of the shift, the facility fluid calculation form is given to the next shift nurse to document.<br><br>A record review of the facility daily summary nurse notes was conducted from August 2011 to November 2011. There were missing documentation of blood pressure, shunt site assessments and weights throughout these months.<br><br>A record review of the facility policy and procedures for dialysis residents dated 3/13/10 was conducted. It indicated the physician would prescribe fluid restrictions. The care of a resident would be coordinated between the nursing facility and the dialysis center in accordance with the dialysis contract and physician orders. Also it indicated nursing staff would palpate the shunt site.<br><br>An interview with the Director of Nursing on 11/3/11 at 9:37am revealed the Quality Assurance Team is working on a communication form sheet for dialysis. This form would include the vitals and pre and post weight. She foresees starting this new form the beginning of November 2011.The communication from the dialysis center has been inconsistent. She would expect staff to record and monitor of intake and output for fluid restrictions daily. Also she would expect weights and vitals to be take after returning from dialysis. | F 309 | documentation of fluids to meet ordered restrictions.<br><br>***4. To ensure that the correction is achieved and sustained***<br>The MDS Coordinator, RN Supervisor or designate will audit weight book, I&O documentation, Dialysis Communication form, MARs weekly x 4 weeks then Monthly x3 for documentation appropriate with 98% compliance. The MDS Coordinator will do random audits weekly.<br><br>***5. Date correction in place:***<br>December 1, 2011 | |
| F 314 SS=G | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>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 | F 314 | ***F314***<br>48325(c)<br>TREATMENT/SVCS TO PREVENT/ HEAL PRESSURE SORES | |

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| F 314 | Continued From page 15<br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record reviews and staff interviews the facility failed to provide interventions to prevent pressure ulcer development in 1 of 3 residents (Resident # 84).<br>Findings Include:<br>Resident #84 was admitted to the facility on 8/18/2011 with diagnoses of dementia, psychosis, arthritis, depression, anxiety, and rehabilitation for a fractured left arm. The fracture was sustained in a fall on 7/13/11 while living in an assistive living community. She was admitted to the facility for physical and occupational therapy.<br>A review of the medical record revealed Resident #84 was assessed by Staff Nurse #1 upon her admission. The Admission Nursing Assessment was completed on 8/18/11 and revealed the resident had reddened areas on both elbows and sacrum. The resident scored 13 on the Braden Scale - for Predicting Pressure Sore Risk on 8/18/11. A number higher than 12 represented a high risk for the development of pressure sores Review of the Minimum Data Set (MDS) dated 8/31/11 documented Resident #84 had a Brief Interview Mental Status (BIMS) score of 5 out of 12. The resident was severely impaired in cognitive skills and was a total care patient who required extensive assistance in all areas of daily care and was incontinent of bladder and bowel. The MDS indicated the resident had (3) stage 1 | F 314 | 1. ***For those residents found to have been affected:***<br>The Care Plan on resident #4 was reviewed and revised and updated to meet current conditions.<br>A head to toe skin assessment was completed on resident #84 and the Interim Care Plan and Comprehensive Care Plan have been updated to include current diagnosis and skin care assessment. Any new or resolved areas were noted and the care plan was updated to reflect these changes.<br>MDS Coordinator has updated MDS records and CAAs Summary to reflect the Care Plan for accuracy.<br>Treatment Nurse reviewed and revised wound care records to reflect wound and skin healing and documentation of new wound areas.<br>2. ***For those residents having the potential to be affected by the same alleged deficient practice:***<br>A Care Plan Audit was performed to ensure that new admissions have an interim care plan in place following admission assessment. | |

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| F 314 | Continued From page 16<br>pressure sores. A stage 1 pressure sore is defined in the MDS as intact skin with nonblanchable redness of a localized area usually over a bony prominence.<br>A review of the Care Area Assessment (CAA) Summary dated 8/31/11 indicated care areas which triggered to be addressed in care plans. Pressure ulcers triggered but were not checked to be addressed in care plans for the resident. A care plan for Resident #84 was initiated on 9/6/2011 which identified one of the resident ' s problems as at risk for skin breakdown related to decreased mobility. The care plan was updated on 9/7/11 from at risk to the presence of (2) pressure ulcers on the resident ' s heels. The care plan was never updated to include the sacral ulcer or to note the pressure wounds had healed. During the review of the resident ' s medical record no interim care plan was found for the time period of admission on 8/18/2011 until 9/6/2011.<br>A review of Resident #84 ' s nursing notes revealed no change in skin assessment status, no treatments to the 3 documented Stage I pressure sores, and no interventions to prevent further skin breakdown until 9/6/2011. A comprehensive care plan initiated on 9/6/2011 addressed risk of skin breakdown due to decreased mobility. The care plan was updated on 9/7/2011 due to development of 1 Stage II pressure ulcer to the left heel and 1 Stage II pressure ulcer to the right heel. The care plan never addressed the Stage II sacral ulcer which developed on 9/14/2011.<br>A review of the nursing notes in Resident #84 ' s medical chart on 9/7/2011 revealed the resident complained of bilateral heel pain after therapy. The presence of a stage II pressure ulcer measuring 0.5cm x 0.6cm (centimeters) was | F 314 | Wound Care Audit was performed for residents who are at risk for pressure ulcers on admission.<br>MDS Coordinator will ensure that an Interim Care Plan is in place and a Comprehensive Care Plan is in place for residents who are admitted with a diagnosis of pressure ulcers or potential for pressure ulcers and that these are addressed in the Care Plan.<br>The Care Plan Team and Nursing Staff were re-inserviced on 11/28 regarding identification of residents at risk for pressure ulcers with documentation on the appropriate forms, i.e. Braden Scale, Skin Assessment forms, Nurses Notes goals and interventions.<br>On 11/7, Treatment Nurse, Charge Nurses, Admitting Nurses and Nursing Staff were re-inserviced on the technique of performing head to toe assessment on admission and documentation of findings, communication to the RN Supervisor, Treatment Nurse, MDS Coordinator using the Skin Referral Sheets and provide MD and family with notification of issues, when found. | |

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| F 314 | Continued From page 17<br>documented on the left heel. A Stage II pressure ulcer is defined as partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater. A stage I unopened pressure wound was documented on the right heal. A note was faxed to the primary doctor and an order was obtained for Polymen 7 days and as needed to left heel Stage II pressure ulcer. Clean with Sea Clean with each dressing change.<br>A Wound / Skin Healing Record dated 9/7/11 indicated a pressure ulcer to the left heel but did not document an original stage when discovered. On 9/14/11 the Wound /Skin Healing Record revealed the pressure ulcer measured 2cm x 2.5cm, had a small amount of drainage, and was identified as a Stage II. An albumin level of 3.4 (3.4-5.0) was obtained on 9/14/11. On 9/21/11 the Treatment Nurse documented the wound measured 0.5cm x 0.5 cm with no drainage. The Wound / Skin Healing Record dated 9/28/11 indicated the left heel area was closed and had healed.<br>A separate Wound /Skin Healing Record was initiated on 9/10/11 for a sacral pressure wound. An original stage at time of discovery was not documented. On 9/14/11 the wound measured 5cm x 0.5cm and was documented as a Stage II. Review of the 9/21/11 Wound/Skin Healing Record sacral pressure ulcer had decreased to 0.4cm x 0.3cm. The Monthly Summary completed by Nurse #1 dated 10/5/11 indicated no open areas to skin and no pressure ulcers.<br>Observation during incontinent care on 11/2/2011 at 11:55 AM revealed no open areas and wounds healed.<br>During an interview with the MDS Nurse on 11/2/11 at 3:20 PM she revealed it was the facility | F 314 | 3. ***To ensure the same alleged deficient practices will not occur:***<br>The Treatment Nurse will ensure that all new admissions have Skin Assessments and preventive interventions are put in place.<br>The Charge Nurses have been re-educated by Nursing Administration on performing Skin Audits on all admissions with appropriate documentation and communication to Treatment Nurse, MDS Nurse and Nursing Administration with follow up notification to MD and Family on 11/7/2011.<br>The treatment Nurse will audit the Body Audit Book, Skin Referrals and CNA Care Records on a daily basis to ensure appropriate follow- up on identified issues as evidenced by Interim Care Plan, Care Plans, CAAs, Treatment Record, MD orders, chart documentation and family notification documentation.<br>***4. Achieved and sustained:***<br>The Director of Nursing Services / Treatment Nurse or designee will audit the Interim Care Plans, Comprehensive Care Plans and Wound Care Records utilizing a QI tool weekly x4 weeks, then monthly | |

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| F 314 | Continued From page 18<br>policy to provide nursing with an interim care plan within 24 hours for each new admission. She indicated the interim care plan was based on the Nursing Admission Assessment and admitting diagnoses. She reported a comprehensive care plan was developed for each resident after the first full MDS assessment was completed. She stated the purpose of care plans was to provide nursing staff with guidance in the care of the facility residents. The MDS Nurse was unable to find an interim care plan for Resident #4. The MDS Nurse revealed she had just recently taken over the MDS position and was still learning how to complete all the care plans. She stated she did not know how Resident # 84 had been at the facility for 19 days with no care plan. She stated she had missed doing the interim for the resident. The nurse revealed she was not aware Resident #84 was not receiving treatments for the pressure ulcers documented on the MDS 8/31/2011 until 9/7/2011.<br>An interview was conducted with Nurse # 2 on 11/3/11 at 9:40 AM. She revealed a new admission was given a head to toe assessment by nursing staff, medical orders were clarified, and MDS created an interim care plan in the first 24 hours. She reported the interim care plan was based on MD orders, diagnoses, and assessments. She stated the interim care plan told staff how to care for the new resident until a comprehensive care plan was completed.<br>During an interview with the Nurse #3 on 11/3/11 at 9:55 AM she revealed she had recently become the facility Treatment Nurse. She indicated she initiated treatment on Resident #84 as soon as the pressure ulcers were reported to her. She stated she obtained a Dr. ' s order per facility protocol and initiated a Wound / Treat | F 314 | for 3 months on any resident assessed at risk for potential skin breakdown and any issues identified will be corrected with 98% compliance.<br>The Director of Nursing Services and / or designee will audit the Body audit book on residents with pressure ulcers on a weekly basis to ensure that the Care Plan, the treatment documentation and MDS documentation is appropriate with 98% compliance. The Treatment Nurse will review daily.<br>The findings and concerns will be tracked and trended in the QA&A monthly meeting.<br>***5. Date correction in place:***<br>December 1, 2011 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345356 | A. BUILDING ______ B. WING ______ | 11/03/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| RICH SQUARE HEALTH CARE CENTER | 320 NORTH MAIN STREET RICH SQUARE, NC 27869 |

| (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 19<br>Healing Record. She indicated once treatment was begun the wounds healed in less than a month.<br>During an interview with the Director of Nursing (DON) on 11/3/11 at 10:10 AM she revealed it was her expectation each resident would have an accurate assessment, an interim plan of care, and interventions in place to prevent pressure sores when a new admission was identified as high risk. She stated the interim care plan was based on the ICD9 (diagnosis codes) and assessments by nursing and therapy. She indicated she was not aware a resident identified on admission as high risk with a reddened sacral area had gone 19 days without a care plan and had received no treatment for documented pressure ulcers until the MDS Nurse made her aware. She stated the MDS Nurse and Treatment Nurse were new but nursing staff should have identified the pressure sores and notified the Treatment Nurse so she could provide care to areas of breakdown. | F 314 | | |
| F 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by: | F 371 | F 371<br>483.35(i) Food Procure, Store/Prepare/Serve-Sanitary<br>Dietary maintains a morning temperature and evening temperature log of both the freezer and refrigerator daily to assure the proper temperatures are maintained. | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 345356 | A. BUILDING ______ B. WING ______ | 11/03/2011 |

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| F 314 | Continued From page 19<br>Healing Record. She indicated once treatment was begun the wounds healed in less than a month.<br>During an interview with the Director of Nursing (DON) on 11/3/11 at 10:10 AM she revealed it was her expectation each resident would have an accurate assessment, an interim plan of care, and interventions in place to prevent pressure sores when a new admission was identified as high risk. She stated the interim care plan was based on the ICD9 (diagnosis codes) and assessments by nursing and therapy. She indicated she was not aware a resident identified on admission as high risk with a reddened sacral area had gone 19 days without a care plan and had received no treatment for documented pressure ulcers until the MDS Nurse made her aware. She stated the MDS Nurse and Treatment Nurse were new but nursing staff should have identified the pressure sores and notified the Treatment Nurse so she could provide care to areas of breakdown. | F 314 | | |
| F 371<br>SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by: | F 371 | F 371<br>483.35(i) Food Procure, Store/Prepare/Serve-Sanitary<br>Dietary maintains a morning temperature and evening temperature log of both the freezer and refrigerator daily to assure the proper temperatures are maintained. | |

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| | 345356 | A. BUILDING ______ B. WING ______ | 11/03/2011 |

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| F 371 | Continued From page 20<br>Based upon observations and staff interview the facility failed to maintain the temperatures of pureed chicken at or above 135 degrees fahrenheit and pudding at or below 41 degrees fahrenheit<br><br>Findings Include:<br><br>1. An observation was conducted on 11/2/11 at 11:48am with the Dietary Manager (DM). The lunch food temperatures were taken. The pureed chicken temperature reading was 121 degrees fahrenheit. There were three pureed meals plated on the tray cart.<br><br>At 12:14pm on 11/3/11 the tray cart remained with three prepared pureed meals containing pureed chicken. The tray cart was preparing to be delivered to the resident floors for lunch.<br><br>2. An observation was conducted on 11/2/11 at 11:48am with the Dietary Manager. The lunch food temperatures were taken. The vanilla pudding temperature was 58 degrees fahrenheit. The tray line continued with vanilla pudding being plated. A tray of vanilla puddings remained at the tray line.<br><br>A second temperature was taken of the vanilla pudding at 12:01pm on 11/2/11. The temperature reading was 60 degrees fahrenheit.<br><br>An Interview on 11/3/11 at 9:17am with the DM revealed she conducts in-services and audits with her staff regarding food temperatures. She would expect the pudding temperature to be at 40 degrees fahrenheit. Her pureed food | F 371 | Dietary has placed all cold food after preparation in the walk-in refrigerator on metal trays. These trays of cold food are removed from the walk-in refrigerator one tray at a time and the tray is placed on a bed of ice. Each covered bowl of cold food is removed and placed on the resident's tray for serving.<br><br>New deep small pots for the steam table have been purchased and these pots make contact with the steam table water. This maintains small portions of pureed food at the proper temperature prior to serving.<br><br>The Dietary manager monitors the hot and cold food temperatures using a digital thermometer before meals are served and near the end of the serving process.<br><br>The Dietary Manager monitors the temperatures at the beginning of the line and the end of the line insuring the proper food temperature is being served.<br><br>Dietary staff has been instructed on the new procedure and proper food temperatures for hot and cold food served.<br><br>Date correction in place:<br>December 1, 2011 | |

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|---|---|---|---|
| | 345356 | A. BUILDING ______ B. WING ______ | 11/03/2011 |

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|---|---|---|---|---|
| F 371 | Continued From page 21<br>temperature standard is 165 degrees fahrenheit. | F 371 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | F 441 | F441<br>1. ***For those residents found to have been affected:***<br>Immediate cleaning of contaminated items in the room:<br>Barrier cream discarded, disposables in bedside drawer were discarded, non-disposables were disinfected and the drawer was cleaned and disinfected by housekeeping.<br>Call bell cleaned with disinfectant<br>Nurse and Housekeeping cleaned and disinfected the feeding pump.<br>Director of Nursing Services inserviced the nurse #2: 1:1<br>All Nursing Staff Inserviced by Staff Development Coordinator on Infection Control<br>2. ***For those residents having the potential to be affected by the same alleged deficient practice:***<br>In- house review has been performed of all acquired infections for the last 3-6 months with tracking and trending of nosocomial infections by shift, hall, location on the hall, type of infection and caregiver exposure. | |

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| F 441 | Continued From page 22<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record review and staff interviews the facility failed to ensure that staff remove their gloves and wash their hands after incontinent care and prior to handling clean items in the room for 1 of 1 residents observed during incontinent care (Resident #59). The findings include:<br><br>The undated facility policy titled Hand Washing Requirements under Policy read: "Employees will wash hands at appropriate times to reduce the risk of transmission and acquisition of infections." C3 read: "Change gloves during patient care if moving from a contaminated body site to a clean body site."<br><br>Resident #59 was admitted to the facility on 06/17/11. On 11/01/11 at 11:24 AM, Nurse #3 was observed to roll the resident onto the right side and remove the incontinent brief. The resident had been incontinent of stool. While wearing gloves, the nurse used pre-moistened wipes to clean the stool from the resident. The nurse picked up a tube of barrier cream while wearing the same gloves and applied the cream to the resident ' s buttocks. With the same gloves, the nurse picked up the resident ' s call bell and placed on the top of the covers within reach of the resident. The nurse replaced the tube of barrier cream in the drawer of the bedside table and then removed the gloves and put in a trash bag and tied up the top of the trash bag. The nurse turned the resident ' s feeding pump on and then used a | F 441 | Inservice held with nursing staff on infection control measures including hand washing, standard precautions and handling and waste of contaminated materials.<br><br>3. ***To ensure the same alleged deficient practices will not occur:***<br><br>Nursing staff members inserviced on infections control, disposal of contaminated items, contaminated waste, proper hand washing, disposal of PPEs after single use and between tasks on the same resident if contamination of gloves, hands, PPEs, etc. has occurred.<br><br>4. ***Achieved and sustained:***<br><br>Audits will be performed of infection control information by the Infection Control Nurse looking for patterns of contamination monthly and quarterly.<br><br>Findings will be reviewed by the Director of Nursing Services and / or her Designee for signs of patterns or indications of ineffective staff infection control measures and will be presented to the QA&A Committee monthly.<br><br>***5. Date correction in place:***<br>December 1, 2011 | |

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| F 441 | Continued From page 23<br>hand sanitizer to clean her hands.<br><br>On 11/02/11 at 11:52 AM Nurse #3 stated in an interview that she should have changed her gloves and washed her hands after providing incontinent care prior to applying the barrier cream and handling the call bell and other clean items.<br><br>In an interview with the Director of Nursing (DON) and the Administrator on 11/02/11 at 5:07 PM, the DON stated that the nurse should have removed her gloves and washed her hands after providing incontinent care prior to handling clean items in the room. | F 441 | | |

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

PRINTED: 11/24/2011
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 |
|---|---|---|---|
| | 345558 | A. BUILDING 03 - NEW BUILDING /NEW LOI<br>B. WING ______ | 11/17/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| RICH SQUARE HEALTH CARE CENTER | 320 NORTH MAIN STREET<br>RICH SQUARE, NC 27869 |

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| K 029 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1<br><br>This STANDARD is not met as evidenced by:<br>A. Based on observation on 11/17/2011 the door to the dry storage room in the kitchen did not have a listed closer on it. It failed to close and latch.<br>42 cfr 483.70 (a) | K 029 | K 029<br>Preparation and/or execution of the plan of corrections does not constitute admission or agreement by the provider of the truth of the items 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 provision of the Federal and State laws.<br><br>A functioning listed closure was installed on the kitchen dry storage room on 12/6/2011. | |
| K 050 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2<br><br>This STANDARD is not met as evidenced by:<br>A. Based on observation on 11/17/2011 the staff interviewed did not know the fire drill procedure.<br>42 CFR 483.70 (a) | K 050 | The maintenance and safety supervisor visually and physically checks doors at random throughout the facility for proper functioning concentrating on hazardous areas on a daily basis.<br><br>The staff was in serviced by the maintenance and safety supervisor on the codes pertaining to door regulations.<br><br>The maintenance supervisor will document these checks and locations on weekly basis for a period of 3 months. | 12/28/2011 |
| K 072 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Means of egress are continuously maintained free | K 072 | | |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Joyce [signature] for DON | Director of Nursing | 12/[illegible]/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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|---|---|---|---|
| | 345356 | A. BUILDING 03 - NEW BUILDING NEW LOO1<br>B. WING | 11/17/2011 |

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| RICH SQUARE HEALTH CARE CENTER | 320 NORTH MAIN STREET<br>RICH SQUARE, NC 27869 |

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| K 029<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1<br><br>This STANDARD is not met as evidenced by:<br>A. Based on observation on 11/17/2011 the door to the dry storage room in the kitchen did not have a listed closer on it . It failed to close and latch.<br>42 cfr 483.70 (a) | K 029 | K 029<br>Preparation and/or execution of the plan of corrections does not constitute admission or agreement by the provider of the truth of the items 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 provision of the Federal and State laws.<br><br>A functioning listed closure was installed on the kitchen dry storage room on 12/6/2011. | |
| K 050<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2<br><br>This STANDARD is not met as evidenced by:<br>A. Based on observation on 11/17/2011 the staff interviewed did not know the fire drill procedure.<br>42 CFR 483.70 (a) | K 050 | The maintenance and safety supervisor visually and physically checks doors at random throughout the facility for proper functioning concentrating on hazardous areas on a daily basis.<br><br>The staff was in serviced by the maintenance and safety supervisor on the codes pertaining to door regulations.<br><br>The maintenance supervisor will document these checks and locations on weekly basis for a period of 3 months. | 12/28/2011 |
| K 072<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Means of egress are continuously maintained free | K 072 | | |

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

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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|---|---|---|---|
| | 345356 | A. BUILDING 03 - NEW BUILDING /NEW LO( <br> B. WING | 11/17/2011 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| K 072 | Continued From page 1<br>of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10<br><br>This STANDARD is not met as evidenced by:<br>A . Based on observation on 11/17/2011 there were chairs and tables stored in the corridor at Physical Therapy.<br>42 CFR 843.70 (a) | K 072 | K 050<br>Fire drills are held on each shift at least on a quarterly basis and documented.<br><br>In services have been held reviewing fire drill procedures, R.A.C.E., pull alarm locations, proper technique for locating fire area, unlocking doors.<br><br>New employees will be trained on fire drill procedures on a one-on-one basis by the safety supervisor and will pass an oral exam pertaining to fire drills.<br><br>The safety supervisor will conduct 1 documented fire drill per shift, per month for a period of 3 months and continue training until 98% compliance is achieved. | 12/28/2011 |
| | | | K 072<br>Furniture was removed from the "therapy"/300 hall exit on 11/17/2011.<br><br>The safety supervisor in-serviced all employees regarding maintaining all exit routes free from obstructions.<br><br>The safety supervisor will randomly visually check all exit corridors for obstructions on a daily basis and report any violations to the Administrator. | 12/28/2011 |