PRINTED: 11/22/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345260	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 11/10/2011

NOV 30 2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation Event ID #MX7711.	F 000	*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.*	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to have medical justification for the use of an indwelling urinary catheter for 1 of 4 sampled residents (Resident #20) who had catheters. Findings include: Resident #20 was admitted to the facility on 09/22/11. Cumulative diagnoses included dementia, congestive heart failure, atrial fibrillation, diabetes mellitus and anasarca (generalized edema). According to a hospital history and physical of 08/12/11, Resident #20 had an indwelling urinary catheter inserted due to incontinence and an infected coccyx ulcer. The transfer physician orders of 09/21/11	F 315	1. Resident number 20 was admitted with an indwelling catheter 9/22/11 related to sacral wounds, a sore on his penis and generalized 4+ edema. As the resident progressed, the facility failed to reassess resident 20's need to keep the catheter in place. Based on a thorough assessment on 11/09/2011, the catheter was removed 2. All residents with indwelling catheters are identified as at risk for having a catheter remain in place beyond the time it should. All residents with catheters were reviewed for appropriate CMS approved justification. The nursing team meets weekly to review specific quality measures and will now include catheterization justification and management in that Standards of Care meeting thus each resident with an indwelling catheter will be reviewed on a weekly basis. Any catheter that no longer meets CMS criteria will be discontinued as appropriate. All nurses will be in-serviced on this change in process.	F 315 11/28/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lynn A. Lancaster Executive Director
TITLE
(X6) DATE: 28NOV11

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ______ B. WING ______	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 315 Continued From page 1

indicated Resident #20 had an indwelling urinary catheter.

The hospital transfer/discharge summary of 09/22/11 indicated Resident #20 had an infected coccyx wound that had improved and was stable.

According to a telephone physician's order of 09/22/11 Resident #20 had an indwelling urinary catheter due to an infected coccyx decubitus.

A weekly pressure ulcer report indicated that a stage 2 pink pressure ulcer to the coccyx/sacral area that had been first observed on 09/23/11. On 09/28/11 the area measured 0.5 centimeters (cm) by 0.5 cm.

A skin inspection anatomy diagram of 09/25/11 indicated Resident #20 had 4+ edema all over his body.

An Evaluation of Medical Justification for indwelling catheter use of 09/22/11 indicated the coccyx decubitus was healed.

The Admission Minimum Data Set (MDS) of 09/29/11, indicated Resident #20 had an indwelling urinary catheter. Included in the Care Area Assessment (CAA) triggers was indwelling urinary catheter. The CAA detail associated with this assessment noted he had been admitted to the facility for rehabilitation and was at risk for urinary tract infection from his catheter. It was noted that he had 2 unstageable pressure ulcers.

Resident #20's care plan, last reviewed 10/04/11, noted a problem with altered urinary elimination due to an indwelling urinary catheter.

F 315

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. The Assistant Director of Nursing will maintain a current list of all residents with indwelling catheters updated as admissions, discharges, new catheters and discontinuation of existing catheters take place. The list will be brought to the weekly Standards of Care meeting review. The list will be updated to reflect the date of last review and the justification presented.
4. The number and reasons for indwelling catheters will be entered into the minutes of the facility's performance review committee meeting.
5. The Director of Nursing has responsibility for maintaining compliance with this corrective action.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ______ B. WING ______	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 315	Continued From page 2	F 315		

A physician's progress note of 10/08/11 indicated Resident #20 had excoriation over his sacrum and generalized pelvic/scrotal/thigh edema.

A physician's telephone order of 10/12/11 indicated Resident #20 had an indwelling urinary catheter for an open sore around the penis site.

Another Evaluation of Medical Justification indwelling catheter use of 10/27/11 indicated the justification for the catheter was an open sore around Resident #20's penis per a physician's order of 10/17/11.

A physician's telephone order of 10/28/11 for Resident #20 indicated the indwelling urinary catheter was inserted for generalized edema, anasarca and scrotal edema.

According to a physician's progress note of 10/28/11, the anasarca had resolved.

According to a weekly non-pressure skin condition report of 11/01/11, the open area to the penis had healed.

During an interview with the treatment nurse, on 11/07/11 at 10:45 AM, she stated Resident #20 had an
indwelling urinary catheter due to a sore on his penis, edema and weakness.

Wound care was observed being provided to Resident #20 on11/09/11 at 2:15 PM. There was an indwelling urinary catheter present with a leg strap securing it to his upper right thigh. He had 2 less than 0.5 cm superficial open areas noted

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ______ B. WING ______	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 315	Continued From page 3 to his sacrum/coccyx. There was no generalized edema noted however he did have edema to the left arm and hand. There were no open areas noted to his penis. During an interview with the Director of Nurses (DON), on 11/09/11 at 4:40 PM, she stated Resident #20 had been admitted with severe edema (anasarca). She stated he had some urinary retention due to the swelling. The DON commented that he had lost a significant amount of the edema with the use of diuretics and was pretty much back to normal. A nurse's note of 11/09/11 at 9:00 PM indicated the indwelling urinary catheter had been discontinued. Upon record review on 11/10/11 at 8:30 AM, it was noted that there was a physician's telephone order indicated the indwelling urinary catheter was to be discontinued. Resident #20 was to be monitored for output and to re-insert the catheter if no urine output. Nurse #2 reported on 11/10/11 at 8:40 AM that Resident #20 had no problems with urinary elimination since the catheter was removed. During another interview with the DON, on 11/10/11 at 10:30 AM, she stated she had reassessed Resident #20. She reported his sore to the penis had healed and he had a stage 2 pressure ulcer to his sacrum. The DON stated his anasarca (generalized edema) had subsided so the catheter had been removed. The Assistant Director of Nurses stated on	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ______ B. WING ______	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 315	Continued From page 4 11/10/11 at 11:00 AM that the new process for catheter justification was to check physician orders upon admission for an appropriate diagnosis. She stated the appropriate uses for catheters were outlined on the catheter justification form. The ADON added that when Resident #20 was admitted he had a lot of edema to his scrotal area as well as his body but had been diuresed and the edema had resolved. She also stated that the catheter should have been discussed during morning rounds but was not. The ADON stated when the anasarca resolved, Resident #20 should have been re-evaluated for the use of the indwelling urinary catheter. The treatment nurse reported on 11/10/11 at 11:10 AM that the open area Resident #20 had to his penis was in the form of little red bumps that had healed.	F 315	*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*	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record	F 325	1. Resident #3 has gained 8 pounds on his large portions and was removed from large portions on 23 Nov 11 at his request. Resident #14 has terminal cancer, irritable bowel syndrome, failure to thrive, dementia and depression. At admission her weight was 130.8 pounds. It is now 131.4 on Megace and large portions. Resident number 65's weight is stable. 2. All residents have the potential to be effected by improper portion sizes. Resident weights are reviewed at least monthly and residents with weight changes are identified. Residents experiencing weight changes are evaluated for cause and appropriate interventions added to stabilize weight. Large portions are one potential intervention and are implemented for residents with weight loss who are eating greater than 75% of their meal and are agreeable to the intervention. The dietician and dietary manager maintain a current	F 325 11/28/2011

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ______ B. WING ______	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 325	Continued From page 5 review the facility failed to provide large meal portions to 3 of 3 sampled residents (Resident #3, #14, and #65) with physician orders for large portions to help prevent weight loss or to promote nutritional health. Findings include: 1. Resident #65 was admitted to the facility on 07/05/05. The resident's documented diagnoses included hypertension and cerebrovascular accident. Record review revealed a 12/28/09 physician order initiated large portions for Resident #65 (this order was carried forward and was present on the resident's November 2011 monthly physician orders). Resident #65's Weight History documented she weighed 71 pounds on 04/06/11, 67 pounds on 06/06/11, 70.5 pounds on 08/11/11, and 70 pounds on 10/05/11. Resident #65's current care plan, revised after the resident's 08/31/11 Minimum Data Set (MDS) was completed, identified nutrition as a problem area for the resident due to decreased intake at meals. Interventions to this problem included large portions at each meal, which was added on 10/27/11. At 12:13 PM on 11/08/11 a nursing assistant (NA) set up Resident #65's meal tray, and left the resident's room. The resident's tray slip documented she was on a puree diet with large portions. Resident #65's roommate was also eating the lunch meal in the room, and her tray slip documented she was on a puree diet with standard portions. Both residents received their	F 325	*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* list of residents who are receiving large portions as an intervention. Those residents have the portion adjustment added to their tray cards and a red napkin placed on the tray as a visual reminder to staff. On the tray line, the "Caller" instructs the server to put large portions on the tray. The server now uses a large sized scoop to serve large portions, serves two portions of side dishes and 1.5 to double portions of meat. At the end of the tray line, the "checker" assures the correct portions are on the tray. All dietary staff has been in-serviced on the Red Napkin Program. 3. Weights continue to be reviewed at the weekly Standards of Care meeting. The dietician will review residents with weight changes and determine if the interventions are appropriate and effective. The list of residents receiving large portions will be maintained by the dietician and provided to the dietary manager. The dietary manager will monitor 100% of	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ______ B. WING ______	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 325	Continued From page 6 food in the same size sectional plate, and received the same amount of puree meatloaf, potatoes, and greens. At 5:23 PM on 11/08/11 the Dietary Manager (DM) stated three dietary employees worked on the trayline preparing resident plates. She reported one person functioned as a "caller" and was supposed to call out the diet, dislikes, supplements, and portion size documented on the tray slips. She commented the cook actually placed the food on the resident plates. According to the DM, a "checker" at the end of the line inspected the plates to make sure what was placed on the plates matched documentation on the tray slips. At 5:34 PM on 11/08/11 the DM stated stated there were problems with residents not receiving the large portions ordered by the physician during a previous survey. In response to this problem the DM reported the facility held in-servicing with the dietary and NA staff to explain what constituted large portions. The DM also commented she did an audit to ensure that all residents with physician orders for large portions had the information documented on tray slips. The DM reported the staff was educated that large portions not only applied to the protein food at the meal but also to the starch and vegetable served. According to the DM, in order to be consistent with serving sizes, there should be two size serving utensils used at the tray line for puree foods, one used for standard portions and one used for large portions. The DM also commented that not only did the dietary staff working on the trayline have a responsibility to provide large portions documented on tray slips,	F 325	*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* residents on large portions for one meal a day X 5 days a week X 4 weeks. If the portions are consistently appropriate the dietary manager will begin monitoring 10% of large portions trays at random each week. 4. Results of the program will be reviewed at monthly Process Improvement meeting and evaluated for effectiveness. 5. The Nursing Home Administrator is responsible for assuring ongoing compliance with this corrective action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ______ B. WING ______	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 325	Continued From page 7 but the NA staff was responsible for comparing the tray slips against the food on resident plates when they set them up. She explained that if residents did not receive the large portions documented on their tray slips, the NAs were supposed to notify the kitchen so the problem could be corrected. At 5:40 PM on 11/08/11 a NA began feeding Resident #65 puree chicken, ziti pasta, and corn salad. The resident's tray slip documented she was on a puree diet with large portions. At 5:44 PM on 11/08/11 a plate for a resident receiving a puree diet with standard portions was uncovered, and the DM stated the amount of puree food on Resident #65's large portions supper plate was the same as the the amount of puree food on this standard portion plate. At 5:48 PM on 11/08/11 the "caller" on the supper trayline stated the portion size listed on resident tray slips was part of the information she called out to the cook. The cook reported the "caller" had called called out some large portion meals to her that evening. There was only one size serving utensil in the puree foods at the trayline. The cook explained she would just add some more puree food on the large portion plates, and it would be obvious visually that there was more puree food on the large portion plates than on the standard portion plates. At 5:57 PM on 11/08/11 the "checker" at the trayline stated she did check plates against the tray slips before placing them in the carts, and one of the things she was supposed to verify was that the portion size was correct on all plates.	F 325		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ______ B. WING ______	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 325	Continued From page 8 At 11:22 AM on 11/09/11 NA #1 stated she was taught what large portions were and where the portion sizes residents were to receive was documented on the tray slips. She reported the portion size was one of the things the NAs were supposed the check for accuracy when setting up resident trays. NA #1 commented it was pretty easy to tell if residents were receiving large portions because the food was about double the amount which appeared on resident plates receiving standard portions. At 3:55 PM on 11/09/11 NA #2 stated she was not in-serviced about large portions until 11/08/11. During the 11/08/11 in-service this NA reported staff were reminded to check the portion size documented on tray slips against what actually appeared on resident plates. She commented it was easy to tell if residents received their large portions by just comparing the amount of food on their plates against the amount on resident plates who received standard portions. At 4:18 PM on 11/09/11 NA #3 stated she had attended two in-services which dealt with large portions. During the first she reported the staff was taught what constituted large portions and where to find portion size information on tray slips. During the second the NA commented staff were reminded to check tray slips to make sure residents received the correct portion size on their plates. According to NA #3, residents receiving large portions should have double the amount of food on their plates compared to the amount on standard portion plates. She explained she was told to notify the nurse and the dietary department if residents were not receiving	F 325		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ______ B. WING ______	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 325	Continued From page 9 the portion size documented on their tray slips. 2. Resident #14 was admitted to the facility on 09/28/11. The resident's documented diagnoses included anemia, hypertension, and renal insufficiency. On 10/04/11 Resident #14's care plan identified the resident as being at risk for nutritional decline due to variable intakes of food/beverages. Resident #14's Weight History documented she weighed 128.2 pounds on 10/06/11, 124.2 pounds on 10/10/11, and 128.4 pounds on 10/19/11. Record review revealed a 10/27/11 physician order initiated large portions for Resident #14 (this order was carried forward and was present on the resident's November 2011 monthly physician orders). On 10/27/11 the intervention of large portions at meals was added to Resident #14's care plan to address possible nutritional decline. The resident's Weight History documented she weighed 132.2 pounds on 11/01/11. At 12:55 PM on 11/08/11 the nursing assistant (NA) set Resident #14's lunch tray up, and left the resident's room. The resident's tray slip documented she was supposed to receive large portions. The same amount of meatloaf, potatoes, and greens were on Resident #14's plate as on other resident plates on the cart who received standard portions.	F 325		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ______ B. WING ______	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 325	Continued From page 10 At 5:23 PM on 11/08/11 the Dietary Manager (DM) stated three dietary employees worked on the trayline preparing resident plates. She reported one person functioned as a "caller" and was supposed to call out the diet, dislikes, supplements, and portion size documented on the tray slips. She commented the cook actually placed the food on the resident plates. According to the DM, a "checker" at the end of the line inspected the plates to make sure what was placed on the plates matched documentation on the tray slips. At 5:28 PM on 11/08/11 the NA set up Resident #14's supper tray, and left the resident's room. The resident's tray slip documented she was supposed to receive large portions. The resident had two very small chicken legs, a small side dish of corn, and a scoop of ziti on her plate. This same amount of food was present on other resident plates on the cart who received standard portions. The Dietary Manager (DM) reported Resident #14 did not receive large portions like she was supposed to. At 5:34 PM on 11/08/11 the DM stated stated there were problems with residents not receiving the large portions ordered by the physician during a previous survey. In response to this problem the DM reported the facility held in-servicing with the dietary and NA staff to explain what constituted large portions. The DM also commented she did an audit to ensure that all residents with physician orders for large portions had the information documented on tray slips. The DM reported the staff was educated that large portions not only applied to the protein food at the meal but also to the starch and vegetable	F 325		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ______ B. WING ______	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 325	Continued From page 11 served. According to the DM, a large portion of the chicken served at the supper meal would be three or four legs, a large portion of the ziti would be two scoops, and a large portion of the corn would be two side dishes. The DM also commented that not only did the dietary staff working on the trayline have a responsibility to provide large portions documented on tray slips, but the NA staff was responsible for comparing the tray slips against the food on resident plates when they set them up. She explained that if residents did not receive the large portions documented on their tray slips, the NAs were supposed to notify the kitchen so the problem could be corrected. At 5:48 PM on 11/08/11 the "caller" on the supper trayline stated the portion size listed on resident tray slips was part of the information she called out to the cook. The cook reported the "caller" had called called out some large portion meals to her that evening. She commented she would place more corn in the side dishes of residents receiving large portions, but was unable to explain how she would do so when the dishes were already filled to the brim of standard portions. The cook then remarked she guessed she would fill another side dish with the corn for large portions. The cook reported a large portion of chicken would be three chicken legs. She explained she would add another spoonful of pasta on the plates of residents receiving large portions. At 5:57 PM on 11/08/11 the "checker" at the trayline stated she did check plates against the tray slips before placing them in the carts, and one of the things she was supposed to verify was	F 325		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345260	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 325	Continued From page 12 that the portion size was correct on all plates. At 11:22 AM on 11/09/11 NA #1 stated she was taught what large portions were and where the portion size residents were to receive was documented on the tray slips. She reported the portion size was one of the things the NAs were supposed the check for accuracy when setting up resident trays. NA #1 commented it was pretty easy to tell if residents were receiving large portions because the food was about double the amount which appeared on resident plates receiving standard portions. At 3:55 PM on 11/09/11 NA #2 stated she was not in-serviced about large portions until 11/08/11. During the 11/08/11 in-service this NA reported staff were reminded to check the portion size documented on tray slips against what actually appeared on resident plates. She commented it was easy to tell if residents received their large portions by just comparing the amount of food on their plates against the amount on resident plates who received standard portions. At 4:18 PM on 11/09/11 NA #3 stated she had attended two in-services which dealt with large portions. During the first she reported the staff was taught what constituted large portions and where to find portion size information on tray slips. During the second the NA commented staff were reminded to check tray slips to make sure residents received the correct portion size on their plates. According to NA #3, residents receiving large portions should have double the amount of food on their plates compared to the amount on standard portion plates. She explained she was told to notify the nurse and the	F 325		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ____ B. WING ____	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 325	Continued From page 13 dietary department if residents were not receiving the portion size documented on their tray slips. 3. Resident #3 was admitted to the facility on 10/08/01. The resident's documented diagnoses included anemia, hypertension, and osteoporosis. Record review revealed a 11/24/08 physician order initiated large portions for Resident #3 (this order was carried forward and was present on the resident's November 2011 monthly physician orders). Resident #3's Weight History documented he weighed 225 pounds on 04/06/11, 218.4 pounds on 07/03/11, and 221 pounds on 09/08/11. Resident #3's current care plan, last updated after the completion of the resident's 09/24/11 Minimum Data Set (MDS), identified the resident as being at risk for nutritional decline secondary to variable intakes of food/beverages and history of very gradual weight loss. Interventions to this problem included providing meals per physician's diet order. Resident #3's Weight History documented he weighed 221 pounds on 10/04/11. At 6:00 PM on 11/06/11 Resident #3 was eating at a table in the dining room with three other residents. Resident #3's tray slip documented he was supposed to receive large portions, and the tray slips of the other three residents at the table documented they were on standard portions. All four residents at the table received one grilled cheese sandwich and the same size bowl of soup on their plates.	F 325		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ______ B. WING ______	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 325	Continued From page 14 At 12:18 PM on 11/08/11 Resident #3 was eating at a table in the dining room with three other residents. Resident #3's tray slip documented he was supposed to receive large portions, and the tray slips of the other three residents at the table documented they were on standard portions. All four residents at the table received one piece of meatloaf (all the same size pieces), a small side dish of greens, and one scoop of potatoes. At 5:08 PM on 11/08/11 Resident #3 was eating at a table in the dining room with three other residents. Resident #3's tray slip documented he was supposed to receive large portions, and the tray slips of the other three residents at the table documented they were on standard portions. All four residents at the table received two very small chicken legs, a small side dish of corn, and one scoop of ziti. The Dietary Manager (DM) stated Resident #3 did not receive large portions of food at this meal like he was supposed to. At 5:23 PM on 11/08/11 the DM stated three dietary employees worked on the trayline preparing resident plates. She reported one person functioned as a "caller" and was supposed to call out the diet, dislikes, supplements, and portion size documented on the tray slips. She commented the cook actually placed the food on the resident plates. According to the DM, a "checker" at the end of the line inspected the plates to make sure what was placed on the plates matched documentation on the tray slips. At 5:28 PM on 11/08/11 the NA set up Resident #14's supper tray, and left the resident's room.	F 325		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ______ B. WING ______	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 325	Continued From page 15 The resident's tray slip documented she was supposed to receive large portions. The resident had two very small chicken legs, a small side dish of corn, and a scoop of ziti on her plate. This same amount of food was present on other resident plates on the cart who received standard portions. The Dietary Manager (DM) reported Resident #14 did not receive large portions like she was supposed to. At 5:34 PM on 11/08/11 the DM stated stated there were problems with residents not receiving the large portions ordered by the physician during a previous survey. In response to this problem the DM reported the facility held in-servicing with the dietary and NA staff to explain what constituted large portions. The DM also commented she did an audit to ensure that all residents with physician orders for large portions had the information documented on tray slips. The DM reported the staff was educated that large portions not only applied to the protein food at the meal but also to the starch and vegetable served. According to the DM, a large portion of the chicken served at the supper meal would be three or four legs, a large portion of the ziti would be two scoops, and a large portion of the corn would be two side dishes. The DM also commented that not only did the dietary staff working on the trayline have a responsibility to provide large portions documented on tray slips, but the NA staff was responsible for comparing the tray slips against the food on resident plates when they set them up. She explained that if residents did not receive the large portions documented on their tray slips, the NAs were supposed to notify the kitchen so the problem could be corrected.	F 325		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ______ B. WING ______	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 325	Continued From page 16 At 5:48 PM on 11/08/11 the "caller" on the supper trayline stated the portion size listed on resident tray slips was part of the information she called out to the cook. The cook reported the "caller" had called called out some large portion meals to her that evening. She commented she would place more corn in the side dishes of residents receiving large portions, but was unable to explain how she would do so when the dishes were already filled to the brim of standard portions. The cook then remarked she guessed she would fill another side dish with the corn for large portions. The cook reported a large portion of chicken would be three chicken legs. She explained she would add another spoonful of pasta on the plates of residents receiving large portions. At 5:57 PM on 11/08/11 the "checker" at the trayline stated she did check plates against the tray slips before placing them in the carts, and one of the things she was supposed to verify was that the portion size was correct on all plates. At 11:22 AM on 11/09/11 NA #1 stated she was taught what large portions were and where the portion size residents were to receive was documented on the tray slips. She reported the portion size was one of the things the NAs were supposed the check for accuracy when setting up resident trays. NA #1 commented it was pretty easy to tell if residents were receiving large portions because the food was about double the amount which appeared on resident plates receiving standard portions. At 3:55 PM on 11/09/11 NA #2 stated she was not	F 325		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ______ B. WING ______	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 325	Continued From page 17 in-serviced about large portions until 11/08/11. During the 11/08/11 in-service this NA reported staff were reminded to check the portion size documented on tray slips against what actually appeared on resident plates. She commented it was easy to tell if residents received their large portions by just comparing the amount of food on their plates against the amount on resident plates who received standard portions. At 4:18 PM on 11/09/11 NA #3 stated she had attended two in-services which dealt with large portions. During the first she reported the staff was taught what constituted large portions and where to find portion size information on tray slips. During the second the NA commented staff were reminded to check tray slips to make sure residents received the correct portion size on their plates. According to NA #3, residents receiving large portions should have double the amount of food on their plates compared to the amount on standard portion plates. She explained she was told to notify the nurse and the dietary department if residents were not receiving the portion size documented on their tray slips.	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ______ B. WING ______	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 329	Continued From page 18 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to monitor therapeutic levels of medication for 1 of 10 sampled residents reviewed for unnecessary medications (Resident #71) as evidenced by failure to obtain a TSH (thyroid stimulating hormone) level ordered by the physician. Findings include: Resident #71 was admitted to the facility on 07/06/06 and readmitted on 05/18/11. The resident's documented diagnoses included hypothyroidism and dementia. Resident #71 was readmitted to the facility on Levothyroxine 150 micrograms (mcg) daily, to help treat his hypothyroidism. Lab results documented, from blood collected on 06/30/11, Resident #71's TSH level (obtained to determine the effectiveness of the Levothyroxine	F 329	*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. Resident #71s Levothyroxin dose was adjusted according to the physician's orders. 2. All residents have the potential to be effected by missed laboratory orders. The facility has reviewed the system that coordinates managing lab orders and has evaluated the reason for the TSH being missed. The lab notebook has been reorganized to include a draw list for each day of the year. Nurses have been in-serviced to record new lab orders on the draw sheet for the appropriate day as well a completing the physician's order form. All pink copies of the physician's order are maintained in a single location at the nurse's station for review during morning clinical rounds. Lab results will be received at the nurse's station and immediately reported to the physician with normal values faxed and abnormal values called to the physician. All nurses have been in-serviced on the revisions to the program.	F 329 11/28/2011

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ______ B. WING ______	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 329	Continued From page 19 in treating hypothyroidism) was 0.840 milli-international units per liter (mIU/L) with normal being 0.350 - 4.500 mIU/L. A 11/03/11 physician order clarified Resident #71 was to supposed to be receiving 150 mcg of Levothyroxine daily, and requested an immediate TSH level to be determined. On 11/09/11 review of the facility's lab notebook revealed there was no documentation that Resident #71 was to have blood drawn on 11/03/11 to determine his TSH level. At 8:52 AM on 11/09/11 the Assistant Director of Nursing (ADON) stated there was a folder at the nurse's station in which nurses were supposed to place the green copies of those orders which were taken for lab draws. From these green copies the ADON reported she logged the labs which were to be obtained into a lab notebook. In addition, the ADON commented the pink copies of orders for lab draws were discussed during daily clinical round meetings as a back up system to make sure lab orders were not missed. According to the ADON, she thought she was off on the day the TSH order was taken for Resident #71, and somehow copies of the order were not distributed as they should have been. At 4:27 PM on 11/09/11 the ADON reported an at once blood draw was completed for Resident #71, and his TSH came back slightly out of the normal range. At 8:33 AM on 11/10/11 the ADON provided a copy of the 11/09/11 lab results which documented Resident #71's TSH was 0.006	F 329	*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. As medication administration records are printed for each month, the Assistant Director of Nursing will review each MAR against the facility's lab protocol which states what labs are to be routinely ordered for monitoring, and assure that each has been added to the appropriate draw sheet. In addition, STAT lab orders are now recorded on the 24 hour report to ensure tracking of results. All physician's orders, as well as the 24 hour report, are reviewed in morning clinical rounds. 4. Results of this action will be reviewed at least monthly by the District Director of Clinical Operation and reported to the facility's Process Improvement meeting to evaluate the effectiveness and compliant of this correction action. 5. The Director of Nursing has ultimate responsibility for assuring ongoing compliance with this corrective action.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ____ B. WING ____	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 329	Continued From page 20 mIU/L with normal being 0.270 - 4.200 mIU/L. The ADON explained the physician requested a TSH level when Resident #71's hall nurse called seeking clarification because the computer and the printed Medication Administration Record (MAR) documented the resident was to receive Levothyroxine 150 mcg every Monday, but nurses had been initialing off the MAR daily that the resident was receiving this medication. Record review revealed the nurses were administering the Levothyroxine as ordered by the physician on a daily basis, and it was the resident's pulse which was to be taken once a week, on Mondays. At 8:49 AM on 11/10/11 Nurse # 1, Resident #71's hall nurse, stated she was trained to place green copies of physician telephone orders which concerned lab draws in a special folder at the nurse's station for the ADON, who coordinated the facility's laboratory monitoring procedure. At 8:58 AM on 11/10/11 the ADON stated in telephone conversation with Resident #71's primary physician it was determined that the resident's dosage of Levothyroxine needed to be adjusted based on the 11/09/11 lab results. A new physician order was written to begin Resident #71 on 0.1 milligrams (mg) of Synthroid daily.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ______ B. WING ______	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 371	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to keep sanitizing solutions at the strength recommended by the manufacturers and failed to stack tray pans dry in a storage area. Findings include: 1. At 2:32 PM on 11/08/11 a dietary employee wiped down a food preparation table where she had prepared mandarin oranges for the supper meal. The employee used a cloth from a red bucket to wipe down the table. At 2:59 PM on 11/08/11 the cook prepared mechanical soft chicken using the Robot Coupe. At 3:13 PM on 11/08/11 the cook wiped down the Robot Coupe with a cloth from a red bucket in the food preparation area. At 3:23 PM a strip was used to measure the strength of the bleach-based sanitizing solution in the red bucket which was kept in the food preparation area of the kitchen. The strip only measured 10 parts per million (PPM) hypochlorite. The Dietary Manager (DM) stated, per manufacturer's guidelines, the strip was supposed to register at least 50 PPM in order to effectively sanitize food preparation surfaces. At 11:42 AM on 11/09/11 the cook stated the dietary staff was using rags form the red bucket	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. No specific resident was mentioned in this citation. 2. All residents have the potential to be effected by this practice. 3. Dietary staff have been in-serviced on the requirements and procedures for making, and the frequency for checking, quaternary levels in the "red buckets" that are used for cleaning and sanitizing surfaces in the kitchen. Staff has been in-serviced on the use of test strips and instructed to remix the solution if sanitizer levels are not appropriate. All kitchen staff was also in-serviced on proper drying techniques for dishware as well as the importance of not putting wet dishware away or stacking/nesting while wet. 4. The Dietary Manager will randomly check levels in the red bucket and record findings twice per day, 5 days per week X 4 weeks. Results of this monitoring will be reviewed at the facility's monthly Process Improvement meeting. The Dietary Manager will check dishware at random	F 371 11/28/2011

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ______ B. WING ______	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 371	Continued From page 22 in the food preparation area of the kitchen to wipe down food preparation tables while preparing the lunch meal. A strip used to check the quaternary solution in this red bucket only registered 0 - 150 PPM. The DM reported, per manufacturer's guidelines, the strip was supposed to register at least 150 - 200 PPM in order to effectively sanitize food preparation surfaces. A dietary employee reported she prepared two buckets of quaternary sanitizer that morning at 5:30 AM, but she was not sure whether the bucket in question was one of those. No other dietary employees reported preparing any buckets of sanitizing solution afterwards. At 10:45 AM on 11/10/11 the DM stated she sometimes came in early to conduct audits of the kitchen, and she prepared a bucket of bleach-based sanitizer. However, she reported when the dietary staff reported to work later in the morning, they usually disposed of the bleach water, and prepared red buckets containing quaternary sanitizing solution from the two-compartment sink sanitizer dispensing system. The DM explained the dietary staff must not have made up a new bucket of sanitizing solution for the food preparation area when they came into work on 11/08/11. The DM commented the 11/09/11 bucket of quaternary solution may have been made up so early in the morning that it had begun to weaken with rags coming in and out of the solution during the preparation of the breakfast and lunch meals. According to the DM, she expected buckets of sanitizing solutions to be made up fresh at least twice a day, once in the morning and once when the PM staff began their shift. However, after the problems with sanitizing solutions not being	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.* times at least once per day X 5 days X 4 weeks. The results of these checks will also be recorded and presented at the facility's Process Improvement meeting for review. 5. The Nursing Home Administrator is responsible for assuring ongoing compliance with this corrective action.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ____ B. WING ____	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 371	Continued From page 23 strong enough, she explained she was thinking about having AM and PM staffs remake the solutions twice each and restrict the number of rags used in the buckets. At 11:05 AM on 11/10/11 a dietary employee stated during monthly in-services she was trained to make up quaternary sanitizing solution from the two-compartment sink dispensing system every two hours. She reported staff was supposed to check the strength of the solution, kept in red buckets, each time it was prepared using a strip which, per manufacturer's guidelines, was supposed to register 150 - 200 PPM. 2. During initial tour of the kitchen on 11/06/11, beginning at 4:05 PM, 2 of 7 tray pans in storage were stacked on top of one another with moisture trapped between them. The cook stated some of these tray pans in storage were washed after the breakfast meal, and some were washed after the lunch meal. The cook reported she thought a new employee mistakenly stacked them wet. At 10:45 AM on 11/10/11 the Dietary Manager (DM) stated it was okay for dietary employees to stack tray pans on top of one another in storage, but only if they were clean and dry before stacking. She reported the longer moisture stayed trapped between stacked tray pans the greater the chance that bacteria could form and multiply. At 11:05 AM on 11/10/11 a dietary employee stated she was trained during monthly in-services that tray pans and other kitchenware had to be clean and completely dry before stacking it in a	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING ______ B. WING ______	C 11/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 371	Continued From page 24 storage area. The employee reported it was the cooks who were responsible for stacking kitchenware, run through the two-compartment sink sanitizing system, in the storage areas. She commented the cooks were supposed to inspect the kitchenware before stacking it in storage, and if any moisture was still present, the kitchenware was to be allowed to continue air drying.	F 371		

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

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345260	MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	DATE SURVEY COMPLETE: 11/10/2011
NAME OF PROVIDER OR SUPPLIER GUARDIAN CARE OF ROCKY MOUNT	STREET ADDRESS, CITY, STATE, ZIP CODE 160 WINSTEAD AVE ROCKY MOUNT, NC		

NOV 3 0 2011

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 274	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE

A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to complete a significant change Minimum Data Set (MDS) assessment for 2 of 20 sampled residents (Resident #31 and #71) who experienced changes in condition. Findings include:

1. Resident #31 was admitted to the facility on 06/24/11 and readmitted on 10/17/11 with diagnoses of congestive heart failure,anorexia, anemia, and failure to thrive.

A quarterly MDS completed on 09/08/11 documented Resident #31 was at risk for pressure ulcers but did not have any wounds present. The same MDS did not indicate Resident #31 was receiving any special services.

Review of Resident #31's clinical record indicated she began receiving hospice services on 10/18/11.

Resident #31 had a physician's order written on 10/18/11 to cleanse the stage 2 wound on the sacrum and apply a [name of dressing] every 72 hours and as needed.

A review of wound care notes documented 10/19/11 documented Resident #31 was readmittted with a new stage 2 wound on her sacral area. The wound measured 3 cm(centimeters) by 1.5cm.

In an interview with MDS Coordinator on 11/09/11 at 3:05 PM, she said a significant change MDS should have been completed on Resident #31 as she had been readmitted to the facility from the hospital with a new wound and started receiving hospice services. The MDS Coordinator said it had been missed on Resident #31.

2. Resident #71 was admitted to the facility on 07/06/06 and readmitted on 05/18/11. The resident's documented diagnoses included dementia.

Resident #71's 05/25/11 Admission Minimum Data Set (MDS) documented he required extensive assistance by staff member with bed mobility, transfer, walking in the room/corridor, locomotion on and off the unit, and toilet use 3/2. The assessment also documented the resident had not experienced any significant weight loss.

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

The above isolated deficiencies pose no actual harm to the residents

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345260	MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	DATE SURVEY COMPLETE: 11/10/2011
NAME OF PROVIDER OR SUPPLIER GUARDIAN CARE OF ROCKY MOUNT	STREET ADDRESS, CITY, STATE, ZIP CODE 160 WINSTEAD AVE ROCKY MOUNT, NC		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 274	Continued From Page 1

Resident #71's 08/18/11 Quarterly MDS documented he was independent with bed mobility, transfer, walking in the room/corridor, locomotion on and off the unit, and toilet use. The assessment also documented the resident had experienced significant weight loss.

At 9:07 AM on 11/10/11 the MDS Coordinator stated Resident #71 had greatly improved in his ability to complete his own activities of daily living (ADLs) since being readmitted in May 2011. She explained working with therapy had allowed the resident to improve his mobility and strength. According to the MDS Coordinator, Resident #71's August 2011 MDS assessment should have been a Significant Change because the resident experienced significant changes in at least two areas of review.

At 9:17 AM on 11/10/11 Resident #71's hall nurse, Nurse #1, stated the resident had really improved in his ability to perform his own ADLs since being readmitted in May 2011. She reported the resident made great progress after medication regimen adjustments which discontinued the use of most of the resident's psychotropic medications and after extensive work with the therapy department. However, the nurse commented she thought the resident experienced some weight loss and temporary decline in appetite.

At 9:37 AM on 11/10/11 nursing assistant (NA) #4 stated when Resident #71 was admitted to the facility in May 2011 he required extensive assistance with his ADLs because of confusion and weakness. She reported currently about the only thing the resident asked the NA staff for assistance with was occasionally making his bed. She commented she thought therapy helped bring about the resident's transformation.

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

PRINTED: 12/04/2011
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
	345260	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/29/2011

NAME OF PROVIDER OR SUPPLIER: GUARDIAN CARE OF ROCKY MOUNT

STREET ADDRESS, CITY, STATE, ZIP CODE: 160 WINSTEAD AVE, ROCKY MOUNT, NC 27804

(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 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Tuesday 11/29/2011 at approximately 8:30 AM onward the following was noted: 1) The kitchen dry storage room door did not close, latch and seal in its frame when checked. 2) The soiled utility room corridor door on 300 hall did not close latch and seal. 42 CFR 483.70(a)	K 029	RECEIVED JAN 03 2012	
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by:	K 045		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: Executive Director
(X6) DATE: 16 Dec 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.

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

PRINTED: 12/04/2011
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
	345260	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5 4 protects hazardous areas When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted 19.3.2 1 This STANDARD is not met as evidenced by Based on observation on Tuesday 11/29/2011 at approximately 8:30 AM onward the following was noted 1) The kitchen dry storage room door did not close, latch and seal in its frame when checked. 2) The soiled utility room corridor door on 300 hall did not close latch and seal 42 CFR 483.70(a)	K 029	*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 kitchen dry storage room door and the 200 Hall soiled utility room door were repaired so as to close, latch and seal correctly on 4 December 2011. 2. All doors were inspected during the period December 7-9, 2011 to ensure each closes, latches and seals correctly. 3. The Maintenance Director will inspect 10 fire doors per week x 4 weeks, then 1 x month for 2 months to ensure compliance. 4. Results of these audits will be reported to the facility Performance Improvement (PI) committee monthly x 2 months for further review and evaluation.	K029 12/23/201
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8) 19.2.8 This STANDARD is not met as evidenced by	K 045	1. Outside lighting was added to the public way from the south hall exit to the parking lot on 4 December 2011. 2. All outside pathways were evaluated for the same deficient practice and found to be in compliance.	K045 12/23/2011

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING 01 - MAIN BUILDING 01 B. WING ____	11/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 045	Continued From page 1 Based on observation on Tuesday 11/29/2011 at approximately 8:30 AM onward the following was noted: 1) The path to the public way from the south hall exit to the parking lot was not completely illuminated with emergenncy lighting. 42 CFR 483.70(a)	K 045	*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. The Maintenance Director will inspect all outside lighting 1 x week for 4 weeks to ensure compliance. 4. Results of these audits will be reported to the facility PI committee for further review and evaluation.	
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on Tuesday 11/29/2011 at approximately 8:30 AM onward the following was noted: 1) One of two shower stalls in the soiled utility room on 300 hall was not cover by a sprinkler head. There are other shower stall in the corridor hall showers that were not covered with sprinkler protection due to wall or distance from other sprinkler heads in the area 2) In the basement area the sprinkler heads are rated for Intermediate Temperature Classification	K 056	1. Sprinkler heads were installed in the 300 Hall soiled utility room to ensure compliance with this requirement on December 12-15, 2011. Sprinkler heads in the basement were switched to Ordinary Temperature Classification with a temperature rating of 155 Degrees F on December 15, 2011. 2. All other sprinkler heads and were inspected for compliance on December 15, 2011. 3. The Maintenance Director will inspect all sprinkler heads during weekly rounds 1 x per month for two months to ensure compliance. 4. Results of these audits will be reported to the facility PI committee for further review and evaluation.	K056 12/23/2011

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 2 in place of Ordinary Temperature Classification, temperature rating of (155°F). 42 CFR 483 70(a) 42 CFR 483 70(a)	K 056	*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 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications 19 5.2.1, 9 2, NFPA 90A, 19 5 2 2 This STANDARD is not met as evidenced by. Based on observation on Tuesday 11/29/2011 at approximately 8.30 AM onward the following was noted 1) Access door were not provided for the smoke duct detectors for maintenance and/or inspection for two of the dietary HVAC units located in the attic. 42 CFR 483 70(a)	K 067	1. Access doors for smoke detectors for maintenance/inspection for two of the dietary HVACs on were installed on December 8, 2011. 2. All other HVAC units were inspected for compliance on December 8, 2011. 3. The Maintenance Director will audit 4 HVAC units per week x 4 weeks during his weekly rounds. 4. Results of these audits will be reported to the facility PI committee for further review and evaluation.	K067 12/23/2011
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2 3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by. Based on observation on Tuesday 11/29/2011 at approximately 8:30 AM onward the following was	K 069	1. The kitchen exhaust hood system was repaired on 30 November 2011. 2. The facility has no other systems impacted by this same deficient practice.	K069 12/23/2011

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	11/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 069	Continued From page 3 noted 1) Based upon inspection of the kitchen exhaust system it was observed that there was not sufficient make-up air provided for in the kitchen. The kitchen exhaust hood the fans operating was experiencing a high negative air imbalance. NFPA 96 (Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 1998 Edition) Section 5-3* Replacement Air " Replacement air quantity shall be adequate to prevent negative pressures in the commercial cooking area(s) from exceeding 0 02 in. water column (4.98 kPa). " 42 CFR 483.70(a)	K 069	*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. The Maintenance Director will audit the dietary exhaust hood system once per week x 4 weeks during his weekly rounds. 4. Results of these audits will be reported to the facility PI committee for further review and evaluation.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities (a) Oxygen storage locations of greater than 3,000 cu ft are enclosed by a one-hour separation (b) Locations for supply systems of greater than 3,000 cu.ft are vented to the outside. NFPA 99 4 3 1 1 2, 19 3.2 4 This STANDARD is not met as evidenced by. Based on observation on Tuesday 11/29/2011 at approximately 8 30 AM onward the following was noted: 1) By observation full and empty oxygen cylinders	K 076	1. Full and empty oxygen cylinders were separated into two marked storage areas on December 1, 2011. All nursing staff were inserviced on keeping full and empty oxygen cylinders stored separately during the period December 12-23, 2011. 2. The facility has no other systems impacted by this same deficient practice. 3. The Maintenance Director will audit the oxygen cylinder storage system once per week x 4 weeks during his weekly rounds. 4. Results of these audits will be reported to the facility PI committee for further review and evaluation.	K076 12/23/2011

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	11/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 076	Continued From page 4 were stored together If stored within the same enclosure, empty cylinders shall be segregated and designated (with signage) from full cylinders. Empty cylinders shall be marked to avoid confusion and delay if a full cylinder is needed hurriedly (NFPA 99 4-3 5.2 2b(2)) (oxygen storage near the nurses station) 42 CFR 483.70(a)	K 076	*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 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99 3.4 4.1 This STANDARD is not met as evidenced by: Based on observation on Tuesday 11/29/2011 at approximately 8:30 AM onward the following was noted. 1)The following operational inspection and testing was non-compliant Specific findings include documentation for monthly load test was conducted without recording percent rated load or temperature rise. A load bank test had not been completed within the past year NFPA 110 6-4 2 (1999 edition) generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods.	K 144	1. A load bank test was conducted on 9 December 2011. Documentation for monthly load tests now include both percent rated load and temperature rise. 2. The facility has no other systems impacted by this same deficient practice. 3. The Maintenance Director will audit the load test documentation once per month x three months. 4. Results of these audits will be reported to the facility PI committee for three months for further review and evaluation.	K144 12/9/201

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	11/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 144	Continued From page 5 (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. NFPA 110 6-4.2.2 (1999 edition) Diesel-powered EPS installations that do not meet the requirements of 6-4 2 shall be exercised monthly with the available EPPS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours (load bank testing) 42 CFR 483 70(a)	K 144	*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 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation on Tuesday 11/29/2011 at approximately 8:30 AM onward the following was noted. 1) Throughout the 200 hall resident rooms and throughout the facility receptacles were found to be cracked and/or broken 2) The medication refrigerator in the med room located at the main nurse station was not connected to emergency power. 3) In the South hall solarium room an electrical receptacle on the east wall was not secured in	K 147	1. All cracked receptacles found during walkthrough on 29 November 2011 have been replaced during the period December 1-16, 2011. 2. All other electrical outlets were inspected and, where required, replaced during the period December 1-16, 2011. 3. The Maintenance Director will audit ten rooms per week x 4 weeks, then ten rooms per month x 2 months for compliance. 4. Results of these audits will be reported to the facility PI committee for three months for further review and evaluation.	K147 12/23/2011

PRINTED 12/04/2011
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
	345260	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/29/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 147	Continued From page 6 the wall 42 CFR 483.70(a)	K 147		