

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

PRINTED: 02/21/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/09/2012
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NAME OF PROVIDER OR SUPPLIER  NORTH CAROLINA STATE VETERANS NURSING HOME SALISBU	STREET ADDRESS, CITY, STATE, ZIP CODE 1601 BRENNER AVE, BLDNG #10, PO BOX 599 SALISBURY, NC 28145
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F 159 SS=B	<p>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the</p>	F 159	<p>F159</p> <p>Resident #56 was provided a copy of his quarterly statement on 2/20/2012. The social worker educated Resident #56 on location of the business office on 2/20/2012 if he wished to go there for information or that the Business Office Manger will make visits to his room if requested to provide him information on his account.</p> <p>Residents #82, #23, #13, #40, #59, #76 and 81 were provided their financial statements by the social worker on 2/20/2012.</p> <p>All Residents with accounts in the facility have the potential of being affected by the same deficient practice. Their accounts were delivered to them on 2/20/2012.</p> <p>Systematic changes to prevent the same deficient practice occurring will be the Administrator and Bookkeeper will educate all Residents on receiving their financial statements every quarter and getting in contact with the Business office manager to find out the amount of money in their account as requested. 3/6/2012</p> <p>Responsible parties will be educated if the resident has the ability to make decisions a statement will be delivered, by the Social Worker, to those residents and a statement will</p>	<p>2-20-12</p> <p>2-20-12</p> <p>2-20-12</p> <p>2-20-12</p> <p>3-6-12</p> <p>3-4-12</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Stacy OS*

ADMINISTRATOR

(X8) DATE

3-13-12

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 159	<p>Continued From page 1</p> <p>resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interviews, the facility failed to inform 1 of 8 residents (Resident #56), who was capable of self-expression and decision making, the availability of money in his trust funds account; as well as failed to issue quarterly financial statements, within 30 days of receipt, to 7 of 7 alert and oriented residents with trust funds accounts (Residents # 13, 23, 40, 59, 76, 81 and 82).</p> <p>The findings include:</p> <p>1. Resident #56 was admitted to the facility on 10/03/11. Upon admission, the business office file revealed that Resident #56 had signed an authorization form to transfer his social security check to the facility on 10/31/11; however his authorization was not sought on 10/31/11, when his RP's signature was obtained to sign a Resident Trust Fund Agreement. On an 11/8/11 Social Services Assessment, it stated that Resident #56 managed his income and finances, with help by the Responsible Party (RP).</p> <p>During an interview with Resident #56 on 2/6/12 at 4:01pm, he shared that he didn't have a resident trust fund account and did not know what</p>	F 159	<p>be mailed to responsible party 3/4/2012</p> <p>The Social Worker will be educated by the Administrator s on March 6, 2012 on maintaining/delivering Resident Trust money account summaries.</p> <p>The Social Worker will deliver quarterly statements to the residents un opened quarterly. Documented monitoring will occur for two quarters to track the residents who received the quarterly statements and if they had any questions.</p> <p>The Business Office manager will documented Resident request for funds weekly for two weeks, monthly for two months.</p> <p>The tracking and trending of the documented monitoring will be reported to the quarterly Performance Improvement Committee by the Social Worker and Business office Manager for suggestions and recommendations.</p>	3-6-12	

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F 159	<p>Continued From page 2</p> <p>happened to his \$30 Medicaid monthly personal allowance. He shared that his RP handled his finances, but that it was "Hard to live on nothing."</p> <p>On 2/8/12 at 4:00pm, Administrative Staff #5 was interviewed. She confirmed that Resident #56 had a resident trust fund account and that the facility recently started to receive his social security check, which was previously routed to his former nursing home. She shared that his RP deposited Resident #56 monthly pension, which totaled \$96.74. She then stated that the RP informed Administrative Staff #5 that she did not want Resident #56 to know how much money he had in his account, due to past issues with money management. To the Administrative Staff #5 knowledge, she didn't think that anyone had discussed Resident #56's trust fund account with him, but he was allowed to access his money, if he requested a withdrawal.</p> <p>Further, she shared that Administrative Staff #4 had been responsible for giving alert and oriented residents their quarterly statements and discussed their statements with them. Otherwise, a copy of the quarterly statement was sent to the RP's for residents who cannot understand the contents.</p> <p>The Administrative Staff #5 produced a court document, which illustrated that the RP for Resident #56, only recently became his General Power of Attorney on 1/10/12.</p> <p>2. Resident #13 was admitted to the facility on 9/21/10.</p> <p>On 2/8/12 at 10:52am, Administrative Staff #3</p>	F 159			

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F 159	<p>Continued From page 3</p> <p>was interviewed. She shared that she has not handed out any trust fund statements yet. She commented that when she took over for Administrative Staff #4 on 1/25/12, she was given a stack of bank statements, dated 10/1/11 to 12/31/11 from the former social worker. She was told that they needed to be delivered and reviewed with select residents. The statement for Resident #13 was observed on the desk of Administrative Staff #3.</p> <p>On 2/8/12 at 10:53am, the Administrative Staff #2 was interviewed. She stated that it was her understanding that Administrative Staff #4 used to pull the quarterly bank statements of residents who did not have short term memory problems, and then she would proceed to go through the statements with the residents, to make sure that they didn't have any questions.</p> <p>3. Resident # 23 was admitted to the facility on 8/27/09.</p> <p>On 2/8/12 at 10:52am, Administrative Staff #3 was interviewed. She shared that she has not handed out any trust fund statements yet. She commented that when she took over for Administrative Staff #4 on 1/25/12, she was given a stack of bank statements, dated 10/1/11 to 12/31/11 from the former social worker. She was told that they needed to be delivered and reviewed with select residents. The statement for Resident #23 was observed on the desk of Administrative Staff #3.</p> <p>On 2/8/12 at 10:53am, the Administrative Staff #2 was interviewed. She stated that it was her understanding that Administrative Staff #4 used</p>	F 159			

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F 159	<p>Continued From page 4</p> <p>to pull the quarterly bank statements of residents who did not have short term memory problems, and then she would proceed to go through the statements with the residents, to make sure that they didn ' t have any questions.</p> <p>4. Resident #40 was admitted to the facility on 5/21/09.</p> <p>On 2/8/12 at 10:52am, Administrative Staff #3 was interviewed. She shared that she has not handed out any trust fund statements yet. She commented that when she took over for Administrative Staff #4 on 1/25/12, she was given a stack of bank statements, dated 10/1/11 to 12/31/11 from the former social worker. She was told that they needed to be delivered and reviewed with select residents. The statement for Resident #40 was observed on the desk of Administrative Staff #3.</p> <p>On 2/8/12 at 10:53am, the Administrative Staff #2 was interviewed. She stated that it was her understanding that Administrative Staff #4 used to pull the quarterly bank statements of residents who did not have short term memory problems, and then she would proceed to go through the statements with the residents, to make sure that they didn ' t have any questions.</p> <p>5. Resident # 59 was admitted to the facility on 6/8/11.</p> <p>On 2/8/12 at 10:52am, Administrative Staff #3 was interviewed. She shared that she has not handed out any trust fund statements yet. She commented that when she took over for Administrative Staff #4 on 1/25/12, she was given</p>	F 159			

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F 159	<p>Continued From page 5</p> <p>a stack of bank statements, dated 10/1/11 to 12/31/11 from the former social worker. She was told that they needed to be delivered and reviewed with select residents. The statement for Resident #59 was observed on the desk of Administrative Staff #3.</p> <p>On 2/8/12 at 10:53am, the Administrative Staff #2 was interviewed. She stated that it was her understanding that Administrative Staff #4 used to pull the quarterly bank statements of residents who did not have short term memory problems, and then she would proceed to go through the statements with the residents, to make sure that they didn ' t have any questions.</p> <p>6: Resident # 76 was admitted to the facility on 7/16/10.</p> <p>On 2/8/12 at 10:52am, Administrative Staff #3 was interviewed. She shared that she has not handed out any trust fund statements yet. She commented that when she took over for Administrative Staff #4 on 1/25/12, she was given a stack of bank statements, dated 10/1/11 to 12/31/11 from the former social worker. She was told that they needed to be delivered and reviewed with select residents. The statement for Resident #76 was observed on the desk of Administrative Staff #3.</p> <p>On 2/8/12 at 10:53am, the Administrative Staff #2 was interviewed. She stated that it was her understanding that Administrative Staff #4 used to pull the quarterly bank statements of residents who did not have short term memory problems, and then she would proceed to go through the statements with the residents, to make sure that</p>	F 159			

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F 159	<p>Continued From page 6 they didn ' t have any questions.</p> <p>7. Resident # 81 was admitted to the facility on 1/16/11.</p> <p>On 2/8/12 at 10:52am, Administrative Staff #3 was interviewed. She shared that she has not handed out any trust fund statements yet. She commented that when she took over for Administrative Staff #4 on 1/25/12, she was given a stack of bank statements, dated 10/1/11 to 12/31/11 from the former social worker. She was told that they needed to be delivered and reviewed with select residents. The statement for Resident #81 was observed on the desk of Administrative Staff #3.</p> <p>On 2/8/12 at 10:53am, the Administrative Staff #2 was interviewed. She stated that it was her understanding that Administrative Staff #4 used to pull the quarterly bank statements of residents who did not have short term memory problems, and then she would proceed to go through the statements with the residents, to make sure that they didn ' t have any questions.</p> <p>8. Resident #82 was admitted to the facility on 12/21/09.</p> <p>On 2/8/12 at 10:52am, Administrative Staff #3 was interviewed. She shared that she has not handed out any trust fund statements yet. She commented that when she took over for Administrative Staff #4 on 1/25/12, she was given a stack of bank statements, dated 10/1/11 to 12/31/11 from the former social worker. She was told that they needed to be delivered and</p>	F 159			





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F 166	Continued From page 8 "The following procedure will be followed when a patient/resident, guardian, or representative voices a complaint concerning treatment or care, or believes that his or her rights have been violated."  "1. The staff member taking the grievance:" "If the patient/resident or family member needs assistance in writing the grievance, the staff person will assist them by filling in the questions on top of the form and describing the grievance." "Grievances should be resolved within three business days with the administrator's signature and reported back to the person filing the grievance."  "2. The Social Services Director will be responsible for tracking all grievances:" "The Social Services Director will enter the grievance forms onto the grievance log form. This will provide a central place for all grievances." "The Social Services Director will then refer the grievance to the appropriate department if it has not already been referred."  "3. Once the referral is made to the appropriate discipline, they are responsible for taking action."  "6. The Social Services Director will maintain all grievances together in a confidential central file."  Review of the Hospital Discharge Summary dated 12/19/11 revealed Resident #22 had a seizure disorder and was on Dilantin and Keppra for this. It also indicated Resident #22 had a seizure at the facility prior to admission to the hospital. His Dilantin level was found to be low (less than 3	F 166	This education included: when a grievance is made to the staff member, they are to take action by reporting the grievance to the correct department manager if they are not capable of beginning corrective action themselves. The action taken will be recorded on a grievance form and then returned to the Social Services Director for follow up as indicated.  The investigation will be completed by the appropriate department manager with follow up to the responsible party or resident within 3 business days.  The Social Worker will do weekly documented monitoring of responses to grievances for 4 weeks and then monthly for 3 months.  Tracking and trending of these results will be reported by the Social Worker to the quarterly Performance Improvement Committee for recommendations and suggestions	3-8-12

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F 166	<p>Continued From page 9</p> <p>with a therapeutic range of 10 - 20) on admission to the hospital. He was continued on his Dilantin and his level became therapeutic on day 2 of the hospital admission.</p> <p>On 2/6/12 at 11 AM, interview with the Responsible Party and another family member revealed they had questioned nursing staff at the facility about why the Resident's Dilantin level had been so low when he arrived at the hospital. They stated that they thought the resident may have missed a Dilantin dose or doses and that was why his Dilantin level had been so low and he had a seizure. They also stated that their concern had not been addressed.</p> <p>On 2/9/12 at 2:05 PM interview with Nurse #6 revealed that she recalled one of Resident#22's family members telling her that the resident's "Dilantin level had been non existent when he got to the hospital" after his seizure and that she was concerned that Resident #22 may not have received his Dilantin as ordered. Nurse #6 stated that she informed Administrative Staff #3 of this and believed Administrative Staff #3 had addressed it. Administrative Staff #3 no longer worked at the facility and was not interviewed.</p> <p>On 2/9/12 at 3:00 PM interview with Administrative Staff #4 revealed she had no record in her files of a grievance that the Dilantin may not have been given as ordered to Resident #22.</p> <p>On 2/9/12 at 4 PM interview with Administrative Staff #2 indicated she had not been aware of a family concern that Resident #22 may not have received Dilantin as ordered, leading to a low</p>	F 166			

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F 166	Continued From page 10 Dilantin level and a subsequent seizure, but acknowledged it should be investigated.  On 2/16/12 at 11 AM (post survey on-site interview) Administrative Staff #1 stated that potential or suspected medication errors are to be reported to her for investigation and action. She further added that there was also a medication error report that staff could fill out	F 166			
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE  A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.  The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.  This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews, the facility failed to post "Survey Results" in a prominent location, which would be easily accessible.  The findings include:  On 2/6/2012 at 11:30am, a tour of the facility was conducted. On the first floor and in the general lobby area, there were no observed signs posted for the "Survey Results".	F 167	F167 There are no identified residents in this practice statement.  The Administrator relocated the survey results to a more accessible location for residents and families to review. A large sign is posted in 72 point font at both nursing stations indicating the location of the survey book. 3/6/2012  The administrator will ensure that survey results will remain available.  During the monthly Resident Council meetings the Social Worker will educate residents on the location of the survey results. 3/6/12	3-6-12  3-6-12	

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F 167	<p>Continued From page 11</p> <p>On 2/6/12 at 12:09pm, a sign was observed at the 2nd floor nurse ' s station which read that "Survey Results located behind the nurses station". The nurses' station was entered and a large white binder on the bottom shelf of a small bookcase, behind the nurse's desk, was observed, marked "Survey Results." No residents were observed behind the station.</p> <p>On 2/8/12 at 12:25pm, the survey book was observed behind the 2nd floor nurse's station and the sign announcing the survey results remained in place at the station. No residents were observed behind the station.</p> <p>On 2/8/12 at 12:35pm, the facility's Resident Handbook was reviewed. Under the section of Examination of Survey Results, it read: "You have the right, upon request, to examine the results of the most recent survey of the facility conducted by Federal or State surveyors."</p> <p>On 2/9/12 at 2:00pm, Resident # 82, the Resident Council President was interviewed. He shared that the council meets monthly, discussing concerns as well as reviewing resident rights. He stated that he couldn't remember seeing a "Survey Results" book in the facility. He also commented that he didn ' t recall seeing any sign, where the book was located.</p> <p>The Administrative Staff #2 was interviewed on 2/9/12 at 3:20pm. She relayed that the "Survey Results" were located on both floors of the facility. She was unaware that residents did not have to request to examine the Survey Book and stated that she would make changes to the language in the Resident Handbook as well as</p>	F 167	<p>The Administrator will document the monitoring accessibility of the survey book daily for one week and then once a month for three months.</p> <p>Tracking and trending of the monitoring results will be reported to the quarterly Performance Improvement Meeting by the Administrator for recommendations and suggestions.</p>	3-6-12	

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F 167	Continued From page 12 make the book at the 2nd floor nurses' station, easily accessible for residents.	F 167			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to follow the treatment for pressure ulcer as ordered and failed to turn and reposition 1 (Resident #49) of 3 sampled residents with pressure ulcers. The findings include:	F 314	F 314  Resident #49 was turned and repositioned on 2/8/2012.  Resident #49's physician was notified on 2/8/12 related to the discontinued treatment medication being used and no additional orders or treatments were given.  All Residents with pressure ulcers have the potential of being affected by the same deficient practice and this will be prevented by the education and monitoring measures listed below:  The Director of Health Services will in-service licensed nurses and nursing assistants on turning and repositioning Residents for proper pressure redistribution. Education began on 3/5/2012 and was completed 3/8/12.	2-8-12  2-8-12  3-8-12	

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F 314	<p>Continued From page 13</p> <p>Resident # 49 was re-admitted to the facility on 09/11/11 with multiple diagnoses including Stage IV pressure ulcer on the sacrum and left hip. The quarterly Minimum Data Set (MDS) assessment dated 11/20/11 indicated that Resident #49 had memory and decision making problems and had stage IV and unstageable pressure ulcers.</p> <p>The care plan for pressure ulcer dated 11/16/11 included (problem) admitted with pressure ulcers on left hip and sacrum. The goals were for the wounds to be free of drainage and will exhibit signs of healing and will not show signs of infection by next review. The approaches included to use pillows, pressure reducing product to bed and chair as well as other supportive/protective devices to assist with positioning and to turn and reposition at least on routine rounds.</p> <p>The Braden scale was completed on 01/31/12 and Resident #49 scored 12 which represented as high risk for pressure ulcer.</p> <p>The doctor's orders were reviewed. On 11/16/11, there was a doctor's order to "change coccyx/sacral wound care to cleanse with wound cleanser daily, pat dry, pack wound with Maxorb AG gauze and cover with dry dressing." On 01/04/12, there was a doctor's order to turn resident every 2 hours.</p> <p>The doctor's progress notes were reviewed. The notes dated 01/04/12 indicated "concerned new dark areas (on sacrum/left hip) are from laying on it, on air mattress, pt (patient) unable to move at all "frozen body", turn every 2 hours".</p>	F 314	<p>Documented monitoring of turning and repositioning of Residents will be documented by the RN supervisor on all three shifts for two weeks and then monthly for three months.</p> <p>The Skin Integrity Supervisor will in-service the treatment nurses on reviewing the treatment administration record of each resident with treatment orders at least 3 times before administering the treatment to ensure correct and proper treatment is delivered as ordered. Education completed 3/6/2012.</p> <p>The Director of Health Services and the Skin Integrity Supervisor will observe 100% pressure ulcer treatments for five days, then 50% of pressure ulcer treatments for two weeks for three months.</p> <p>Tracking and trending of the documented results of turning and repositioning and documented results of treatment delivery will be reported by the Director of Health Services to the quarterly Quality Assurance Committee for suggestions and recommendations.</p>	3-6-12

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F 314	Continued From page 14 Resident #49 was observed on 02/08/12 at 8:10 AM, 10:46 AM and 12:13 PM. He was in bed turned to his right side.  On 02/08/12 at 12:14 PM, Nurse # 3 was interviewed. She stated that Resident #49 needed to be turned every 2 hours due to his pressure ulcers. She acknowledged that the resident was turned to his right side during the morning medication pass.  On 02/08/12 at 12:15 PM, NA # 3 was interviewed. She stated that she was new to the resident and she did not know that the resident needed to be turned. She stated that she had not turned him since she came in this morning.  On 02/08/12 at 2:22 PM, Resident #49 was observed during the dressing change. The sacral pressure ulcer has a red wound bed, with no eschar/necrosis noted. The treatment nurse was observed to cleanse the sacral wound with wound cleanser, Santyl ointment was applied, covered with Maxorb AG gauze and secured with dry dressing.  On 02/08/12 at 4:07 PM, the treatment nurse was interviewed. The treatment nurse reviewed the doctor's orders and the treatment book and acknowledged that she did not follow the treatment order for the sacral pressure ulcer. She stated that she was not supposed to apply Santyl ointment to the sacral pressure ulcer but she did.	F 314			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive	F 315			

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F 315	<p>Continued From page 15</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and staff interview, the facility failed to secure the indwelling catheter tubing to prevent catheter removal or tissue injury from dislodging the catheter for 2 (Residents # 49 &amp; # 81) of 3 sampled residents with indwelling catheters. The findings include:</p> <p>1. Resident # 49 was re-admitted to the facility on 09/11/11 with multiple diagnoses including Stage IV pressure ulcer on the sacrum. The quarterly Minimum Data Set (MDS) assessment dated 11/20/11 indicated that Resident #49 had memory and decision making problems and had an indwelling catheter.</p> <p>The care plan dated 11/20/11 included (problem) risk for Urinary Tract Infection (UTI) due to history of UTI and has an indwelling catheter due to wounds. The goals were to remain free from UTI and will have no injury related to the use of the catheter in 90 days. One of the approaches was "to utilize a leg strap to keep the catheter in place and preventing tug or injury".</p>	F 315	<p>F315</p> <p>Resident #49 and Resident #81 had their indwelling catheters secured by anchoring straps by the RN supervisor on 2/9/2012.</p> <p>All other Residents with indwelling catheters were checked by the RN Supervisor to ensure their indwelling catheters were secured by anchoring straps. Completed 2/9/2012.</p> <p>The Director of Health Services will in-service licensed and unlicensed staff on catheter care and anchoring, which include demonstration of positioning and usage of leg strap to keep catheter in place to prevent tugging and injury. Education began on 3/1/2012 and was completed 3/8/2012.</p> <p>RN supervisors will have documented monitoring of catheter strap placement daily each shift for two weeks, then weekly each shift for one week and then monthly each shift for two months.</p> <p>The Director of Health Services will report the documented tracking and trending of the monitoring to the quarterly Performance Improvement Committee for any recommendation and suggestions.</p>	2-9-12	2-9-12
				3-8-12	



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F 315	<p>Continued From page 16</p> <p>On 02/08/12 at 2:23 PM, Resident #49 was observed during the dressing change. He was observed to have an indwelling catheter which was not secured to his thigh. He was turned from side to side during the dressing change.</p> <p>On 02/09/12 at 11:01 AM, Resident #49 was observed in bed. NA #1 was observed to turn the resident to his right side. His indwelling catheter was not secured to his thigh.</p> <p>On 02/09/12 at 11:03 AM, NA #1 was interviewed. She stated that she had not seen Resident #49 having a leg strap on. She further stated that she did not know why he did not have a leg strap on but she would tell the nurse.</p> <p>On 02/09/12 at 11:04 AM, Nurse #3 was interviewed. She stated that Resident #49 should have a leg strap on. She further stated that maybe it got soiled and was never replaced.</p> <p>2. Resident # 81 was admitted to the facility on 01/06/11 with multiple diagnoses including Benign Prostatic Hypertrophy (BPH) with urinary obstruction and Urinary Retention. The annual MDS assessment dated 12/22/11 indicated that Resident #81 had intact cognition and has an indwelling catheter.</p> <p>The care plan dated 10/04/11 included (problem) potential for injury related to presence of indwelling catheter for diagnosis of urinary retention. The goals were for the veteran to have no injury related to use of the catheter and to have no signs/symptoms of UTI in 90 days. One</p>	F 315			

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F 315	Continued From page 17 of the approaches was to secure the catheter to thigh with a leg strap to prevent pulling on tubing.  Review of the Physician's order for February, 2012 revealed an order to secure tubing with a leg strap.  The nurse's notes dated 02/07/12 at 9:30 AM indicated that the charge nurse reported to the writer that the resident's catheter came out. The catheter was reinserted.  On 02/08/12 at 11:10 AM and 2:30 PM, tried to observe Resident #81 but he was out of the facility.  On 02/08/12 at 2:35 PM, Nurse #3 was interviewed. She stated that Resident #81 was out of the facility for eye surgery.  On 02/09/12 at 11:09 AM, Resident #81 was observed with NA #2. He was observed to have no leg strap to secure the catheter.  On 02/09/12 at 11:10 AM, NA #2 was interviewed. She stated that Resident #81 should have a leg strap on but did not know why he did not have one on. She stated that she would inform the nurse about it. NA #2 revealed that the resident just came back from a doctor's appointment this morning.  On 02/09/12 at 11:30 AM, tried to interview Resident #81 but he was too sleepy to answer questions.	F 315			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332			

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F 332	<p>Continued From page 18</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure that medication error rate was 5% or below by not following the physician's orders and the manufacturer's specifications. There were three (3) errors (Resident # 5, #122, #127) of fifty-eight (58) opportunities resulting in a 5.17% error rate. The findings include:</p> <p>1. Resident #5 was readmitted to the facility 3/22/2011. Cumulative diagnoses included: BPH (benign prostatic hyperplasia). Resident #5's clinical record was reviewed. Physician orders for February 2012 stated Tamsulosin cap 0.4 milligrams (mg.) one (1) cap by mouth daily (Flomax) with the time to be administered as 6:00 PM. Flomax is used for the treatment of signs and symptoms of BPH.</p> <p>Lexi-Comps Geriatric Dosage Handbook 12th edition stated, in part, "Take approximately thirty (30) minutes after the same meal each day."</p> <p>On 2/7/2012 at 4:35 PM., Nurse #1 was observed during the medication pass. Nurse #1 was observed to obtain one cap of Flomax 0.4 mg and administered the medication to resident #5.</p> <p>On 2/7/2012 at 5:10 PM., Nurse #1 stated that flomax was supposed to be given on an empty stomach and she administered the medication at</p>	F 332	<p>F332</p> <p>Resident #5 will receive medicine at the correct time. Resident #127 will receive the correct dosages. Resident #122 did and will continue to receive the correct medication.</p> <p>All Resident receiving medication has the potential of being affected by the same deficient practice and this will be prevented by the measures and education listed below:</p> <p>Nurse #1 and #4 completed a competency checklist on 2/14/12. All licensed nurses who pass medications will complete the same competency check list which will include reviewing medication and administration power point and taking the medication administration written examination with a passing score of 90. Educated completed 3/8/2012</p> <p>All licensed nurses who pass medications will have a medication pass observation conducted by the Director of Health Services including weekend license nurses who pass medications. Completed 3/8/2012.</p>	<p>2-14-12</p> <p>3-8-12</p> <p>3-8-12</p>	

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F 332	<p>Continued From page 19</p> <p>4:30 PM. because supper was served around 6 PM. Nurse #1 checked the Medication Administration Record and acknowledged the time stated 6:00 PM.</p> <p>On 2/8/2012 at 8:30 AM., Administrative Nurse #1 stated she expected for the medication to be given as ordered at 6 PM.</p> <p>2. Resident #127 had a doctor's order dated 01/27/12 for Hydralazine 50 mgs.1 tablet by mouth every 12 hours for Hypertension.</p> <p>On 02/08/12 at 8:30 AM, Nurse #4 was observed to prepare the resident's medications including Hydralazine 25 mgs.1 tablet. Before Nurse #4 entered the resident's room to administer the medications, she was questioned regarding the Hydralazine. She checked the Medication Administration Record (MAR) and acknowledged that the order was 50 mgs. and she should have prepared 2 tablets instead of 1 tablet.</p> <p>3. Resident #122 had a doctor's order dated 07/22/11 for Aspirin 325 mgs (milligram) 1 tablet by mouth daily for Ischemic Heard Disease.</p> <p>On 02/08/12 at 8:41 AM, Nurse # 4 was observed to prepare the resident's medications including (ECASA) Enteric Coated Aspirin 325 mgs. 1 tablet. Before Nurse #4 entered the resident's room to administer the medications, she was questioned regarding the ECASA. She stated that she always administered the ECASA to the resident. She further stated that she has available regular ASA 325 mgs in the drawer but she always administers the ECASA. Nurse #4 went</p>	F 332	<p>Continued monitoring of licensed medication nurses will occur monthly with the consultant pharmacy visits.</p> <p>Tracking and trending of the documented medication pass observation results will be reported by the Director of Health Services to the quarterly Performance Improvement Committee for recommendation and suggestions.</p>	3812	

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F 332	Continued From page 20 to clarify the order with the administrative staff #1 who advised her to administer the regular ASA as ordered.	F 332			
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS  The facility must assist residents in obtaining routine and 24-hour emergency dental care.  A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist.  This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review the facility failed to provide timely referral for dental services for 1 of 2 residents (Resident # 59) and failed to follow up with the dentist for 1 of 2 residents (Resident #22) whose reason for referral to the Dentist was not addressed at the dental visit.  1. Resident # 59 was admitted to the facility on 6/6/11. His diagnoses included: diabetes mellitus type II, chronic kidney disease and hypertension. On the most recent Minimum Data Set (MDS) dated 11/22/11 where it was noted that he had a significant change, Resident	F 411	F411  Resident #59 received a new upper denture on 2/23/2012.  Resident #22 has a dental consult scheduled for 3/20/12 for a crown placement.  All Residents have the potential of being affected by the same deficient practice that will be prevented by education and monitoring listed below:  The Director of Health services educated all licensed nurses, nursing assistants and social worker on reporting timely referrals for dental services. Education completed on 3/8/2012.  The Licensed nurses will notify the social worker of referrals made by the physician in morning clinical meetings.  The Social Worker will then obtain dental appointments and arrange transportation to and from the dental appointment timely.  The Social Service Director will monitor by documenting referrals for all dental consults weekly for four weeks and then monthly for three months.  Tracking and trending of the documented monitoring will be reported by the Social Worker to the quarterly Performance Improvement Committee for recommendations and suggestions.	2-23-12  3-8-12	

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F 411	<p>Continued From page 21</p> <p>#59 were assessed as having no memory problems and being cognitively intact. He needed set up help for personal hygiene, with some cueing from staff.</p> <p>On the Inventory of Personal Effects Form, dated 6/8/11 contained within his medical chart, listed upper denture.</p> <p>On 2/7/12, a chart review revealed the following details. On 1/21/12 at 11:00am, the nurse's Notes recorded that Resident #59 informed Nurse #8, that when he vomited last night, his upper denture fell out of his mouth, into the toilet and was flushed by staff. Nurse #8 wrote a note, that the Administrative Staff #4 was made aware of the dentures.</p> <p>On 2/7/12, the Grievance Log was reviewed. On 1/26/12, the Responsible Party (RP) for Resident #59 had complained that no arrangements had been made by the facility to schedule a dentist appointment for Resident #59. The grievance investigation revealed that Resident #59 was witnessed by Nurse Aide # 5, reporting to staff at the nurse's station, that he lost his dentures on 1/20/12.</p> <p>On 2/8/12 at 10:38am, Administrative Staff #3 was interviewed. She shared that she began employment at the facility on 1/25/12. She stated that normally, staffs convey grievances and missing property reports verbally to the social work office. She stated that she was unaware that Resident #59 lost his denture, until the RP met with the former social worker (Administrative Staff #4) on 1/26/12.</p>	F 411			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345531	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  C 02/09/2012
NAME OF PROVIDER OR SUPPLIER  NORTH CAROLINA STATE VETERANS NURSING HOME SALISBU			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 BRENNER AVE, BLDNG #10, PO BOX 699 SALISBURY, NC 28145		
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F 411	<p>Continued From page 22</p> <p>She reported that the facility uses two dental services. One was used for in-patient appointments, whereas the other practice was in the community. She scheduled an appointment for Resident #59 to see the dentist in the community, on 1/30/12 for a new upper denture.</p> <p>Administrative Staff #2 was interviewed on 2/8/12 at 10:55am. She stated that on 1/23/12, the facility learned, through their morning meeting, that Nurse #8, reported that Resident #59 lost his dentures on 1/20/12, while vomiting. She shared that no one wrote up the incident as a grievance or missing property, until the RP arrived at the facility on 1/26/12 and learned that the denture was missing. The facility was unable to determine if staff flushed the denture down the toilet, but absorbed the cost to replace it. The chart reflected that on 2/6/12, Resident #59 received his replacement denture.</p> <p>2. Resident #22 was admitted on 11/10/08 and last readmitted on 12/19/11 with diagnoses including diabetes and chronic airway obstruction.</p> <p>Review of the Goods and Services agreement between (name of dental provider company) and the facility dated 9/2/04 read, in part, "2.8 Provide provider with essential medical and nursing assessments and recommendations which enable Provider ' s dental staff to plan appropriate oral health care."</p> <p>Review of the Consent for Dental Services signed by the Responsible Party on 6/17/11 revealed, in part, "I authorize (name of Dental Service) to</p>	F 411			

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F 411	<p>Continued From page 23</p> <p>provide routine preventative diagnostic services which consist of an exam, x-rays and cleaning every 6 - 12 months. If any additional treatment is recommended, I understand I will be provided with a treatment plan, written information about the treatment, and a consent form."</p> <p>Review of the 4/5/11 dental provider Oral Assessment revealed Resident #22 had six remaining upper teeth and six remaining lower teeth.</p> <p>The Quarterly Minimum Data Set dated 12/22/11 revealed Resident #22 had short and long term memory problems and was severely impaired in decision making. He also required extensive assistance of one person for personal hygiene including oral care.</p> <p>Review of the Summary Assessment dated 12/22/11 revealed Resident #22 had broken or loose teeth.</p> <p>Review of the Nursing Notes on 1/12/12 revealed the resident complained of tooth pain and was given pain relieving medication with effect.</p> <p>Review of the physician's orders dated 1/14/11 revealed an order for a dental consult secondary to a broken tooth and tooth decay.</p> <p>Review of the Nursing Notes on 1/16/12 revealed the resident complained of tooth pain and was given pain relieving medication with effect.</p> <p>Review of the dental provider Oral Assessment dated 2/1/12 revealed there were no dental concerns noted on examination and no further</p>	F 411			



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F 411	<p>Continued From page 24</p> <p>actions to be taken. There was no documentation that the broken tooth had been assessed or treated or that a treatment plan had been developed.</p> <p>Observation of Resident #22 on 2/6/12 at 5 PM revealed he was missing some teeth and had one tooth that appeared broken.</p> <p>Interview with the Responsible Party on 2/7/12 at 12:57 PM revealed she was aware that the resident had been seen by a dentist for a broken cap but she stated that there had not been any treatment and she had not been informed of any treatment plans.</p> <p>Interview with Administrative Staff #3 on 2/9/12 at 2:45 PM revealed that she ensured referred residents got on the list to see the dentist. She also stated that she received a copy of the dental provider Oral Assessment after the appointment and filed this in the Medical Record, but indicated that she did not review it and did not discuss it with other staff members.</p> <p>Interview with Nurse #6 on 2/9/12 at 3 PM revealed she thought Resident #22 had a dental cleaning recently and stated he had no further dental complaints. She was not aware of a broken tooth.</p> <p>Interview with Administrative Staff #2 on 2/9/12 at 4 PM revealed she expected that the Dentist would have addressed the resident's broken tooth on the 2/1/12 visit but she acknowledged that the documentation showed it had not been addressed. She then had another staff member contact the dental provider and upon hearing the</p>	F 411			

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F 411	Continued From page 25 results revealed that the dental provider confirmed no treatment had been done at the 2/1/12 dental visit. She indicated that further follow-up with the Dentist was required.	F 411			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	F431  There were no identified Residents in this practice statement.  The RN Supervisor checked all medication carts and medication rooms for expired medications on 2/10/2012.  Education by the Director of Health Services was provided on discarding of expired medications to all licensed nurses and was completed on 3/8/2012.  The RN Supervisor will document results of monitoring for expired medications on each medication cart and medication rooms 2 times weekly for 4 weeks and then monthly for 2 months.	2-10-12  3-8-12	

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F 431	Continued From page 26  This REQUIREMENT is not met as evidenced by: Based on review of facility policy, observation and staff interview, the facility failed to discard expired medications from 1 (1C medication cart) of 4 medication carts. The findings include:  The facility's policy on " Medications with Shortened Expiration Dates " (undated) was reviewed. The policy stated that Advair Diskus (used for people with Asthma and COPD (Chronic Obstructive Pulmonary Disease) "should be discarded 30 days after removal from the moisture protective wrapper or after all blisters have been used, whichever comes first".  The manufacturer's instruction written on the wrapper of the Advair Diskus read "Discard the diskus one month after removal from the overwrap. Fill in the dates on the diskus appropriately".  On 02/09/12 at 2:20 PM, the medication cart on 1C hall was observed. There were 2 Advair Diskus inhalers observed that were removed from the wrapper. The dates listed on the inhalers were 01/01/12 and 01/05/12.  On 02/09/12 at 2:25 PM, Nurse #2 was interviewed. She stated that Advair Diskus was good for 2 months after opening. She also stated that nurses were responsible for checking the medication carts for expired medications.  On 02/09/12 at 3:10 PM, Administrative staff #1	F 431	Medications carts and medication rooms will be checked by the pharmacy consultant on monthly visits thereafter.  Tracking and trending results of the documented monitoring will be reported by the Director of Health Services to the quarterly Performance Improvement Committee for recommendations and suggestions.	3-8-12	

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F 431	Continued From page 27 was interviewed. She stated that Advair Diskus was good for 30 days after opening. She further stated that the 2 expired Advair inhalers were already discarded by Nurse #2 after it was brought to her attention.	F 431			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345531	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NORTH CAROLINA STATE B. WING _____		(X3) DATE SURVEY COMPLETED  03/21/2012
NAME OF PROVIDER OR SUPPLIER  NORTH CAROLINA STATE VETERANS NURSING HOME SALISBU			STREET ADDRESS, CITY, STATE, ZIP CODE 1601 BRENNER AVE, BLDNG #10, PO BOX 599 SALISBURY, NC 28145		
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K 000	INITIAL COMMENTS  This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type 1 fire resistive construction, two stories above ground with a basement area. The facility is equipped with a complete automatic sprinkler system.	K 000			
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1  This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 3/21/2012 the following means of egress Life Safety Item was observed as noncompliant with the North Carolina Special Locking system for the facility, specific findings include:  The two required exits from the therapy wing on the ground floor has North Carolina Special locking devices at each exit. During the testing of the alarm system these two doors did not release with activation of the fire alarm system.  NOTE: The door release mechanism at the door did release the each door.  CFR#: 42 CFR 483.70 (a)	K 038	K38 NC State Veterans Home of Salisbury will ensure that all means of egress will be unlocked automatically upon activation of the fire alarm. The facility will have the two faulty maglock devices connected to the fire alarm panel which will release doors upon activation of the fire alarm.  A complete inspection of the facilities egress doors releasing upon fire alarm activation has been completed by the facility without any other failure found. The facility will continually inspect that all egress doors will release upon fire alarm activation. A new specific PM has been created and will document the egress door inspections once each month for 3 months and once a quarter there after.  The Maintenance Director will be responsible to have the two doors in Therapy hooked up to the fire alarm and to maintain the documentation of the PM inspections.	May 4, 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*[Handwritten Signature]*

TITLE

*Administrator*

(X6) DATE:

4-5-12

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.