STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345097	A. BUILDING _____ B. WING _____	10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JESSE HELMS NURSING CENTER	1411 DOVE STREET MONROE, NC 28111

(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 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and interviews the facility failed to implement standing orders for constipation for two (2) of nine (9) sampled residents. (Resident #3 and #6) The findings are: A. Resident #6 was re-admitted to the facility on 09/14/11 with diagnoses including Anemia, Muscle Weakness and Dementia. The latest Minimum Data Set (MDS) dated 09/21/11 revealed Resident #6 required extensive assistance from staff for activities of daily living (ADL), including toilet use. The MDS further revealed the resident was incontinent of bowel and bladder. Review of a nursing plan of care for Resident #6 dated 09/27/11 revealed the resident was at risk for discomfort related to constipation with a stated goal resident will have regular BMs at least every three days through next review. Interventions included monitor frequency of BMs and implement bowel protocol as needed.	F 309	Disclaimer: 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 this 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 309 A. Immediate correction was accomplished by: a) The bowel protocol was immediately implemented on Resident #6 on 10/19/2011. One on one re-education on the Bowel protocol was completed on 4 identified nurses that failed to follow the facility bowel movement (BM) protocol and this was completed by the DON on 10/31/2011. b) The bowel protocol was immediately implemented on Resident #3 on 10/19/2011. One on one re-education on the Bowel protocol was completed on 4 identified nurses that failed to follow the BM protocol and this was completed by the DON on 10/31/2011. Administrator conducted an in-service on bowel protocol, expectations with nursing staff on 10/21/2011. A facility report on BM record has been printed and audited to ensure that each resident has had regular BM at least in the last 3 days. This was completed by the DON and RN Supervisor on 10/21/2011. B. The bowel records of all current residents were reviewed and DON will ensure that the bowel protocol will be appropriately implemented per facility BM protocol with positive result. This will be completed by the DON by 11/17/2011. The resident care plan on each resident with BM intervention will be reviewed and updated accordingly by the MDS Coordinator and completed by 11/17/2011. C. Systemic changes made include review and revision of the facility's current BM protocol by the Medical	11/17/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] RN, NHA | TITLE: Administrator | (X6) DATE: 11/11/11

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

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F 309	Continued From page 1 A review of the medical record for Resident #6 revealed physician standing orders for constipation and bowel management. The orders specified if no bowel movement (BM) in past two days the resident should be given Milk of Magnesia (MOM) times one dose and if ineffective, use one Dulcolax suppository. If Dulcolax suppository is ineffective, give one fleets enema. Review of Resident #6's Bowel and Bladder Report for October, 2011, utilized by the facility to monitor residents' BMs, revealed from 10/10/11 through 10/14/11, no BMs were documented. Review of a facility form titled; "No BM in last 9 Shifts Report" revealed documentation of Resident #6 not having a recorded BM for thirteen (13) shifts. A review of the Medication Administration Record (MAR) revealed Resident #6 received Colace (stool softener) syrup daily on a routine basis beginning 10/07/11. No additional medications were administered for constipation. An interview with Licensed Nurse (LN) # 2 on 10/19/11 at 10:30 AM revealed BMs are documented in the resident's care tracker by the staff member who noted the BM. LN #2 indicated a report is printed by the second shift for residents who have not had a documented BM in nine (9) shifts to alert the LN of a potential constipation problem. LN #2 acknowledged Resident #6's name was on the list from 10/10/11 through 10/14/11 for no BMs and standing orders should have been implemented on the third day.	F 309	Director and Administrator and this was completed on 10/26/2011. The DON/ designee will continue to educate appropriate nursing staff on this new protocol and will be completed on 11/17/2011. Evening shift's RN Supervisor or designee will print out BM record at the beginning and review at the end of each shift for compliance with protocol. This BM report will be used by RN supervisor/ charge nurse for proper and complete hand-off from shift to shift to verify BM record, appropriate treatment and results. RN Supervisor will ensure each shift positive result from each treatment or until BM irregularity is resolved. All nursing staff will be educated during orientation, annually and as needed on this protocol. D. The facility will monitor and ensure that solutions are maintained through weekly report given by RN Supervisor to DON. DON will report to Administration and QAA committee monthly compliance to this PoC and facility protocol for 90 days and ongoing thereafter by the DON.	

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F 309	Continued From page 2 An interview with the Director of Nursing (DON) on 10/19/11 at 3:30 PM revealed if the resident is identified as no BM in nine shifts, the BM protocol would be implemented on the third day. The DON further indicated the LN would start with MOM and if not effective, then follows the rest of the standing orders. B. Resident #3 was re-admitted to the facility on 09/27/11 with diagnoses including fractured femur, muscle weakness and difficulty walking. The latest Minimum Data Set (MDS) dated 10/09/11 revealed the resident required extensive assistance with Activities of Daily Living (ADLs), including toilet use. The MDS further triggered Resident #3 for constipation. Review of a nursing plan of care for Resident #3 dated 10/10/11 revealed the resident was at risk for further constipation with a stated goal resident will have regular BMs at least every three days through next review. Interventions included monitor frequency of BMs and implement bowel protocol as needed. A review of the medical record for Resident #3 revealed physician standing orders for constipation and bowel management. The orders specified if no bowel movement in past two days the resident should be given Milk of Magnesia (MOM) times one dose and if ineffective, use one Dulcolax suppository. If Dulcolax suppository is ineffective, give one fleets enema. Review of Resident #3's Bowel and Bladder Report for October, 2011, utilized by the facility to monitor residents' BMs revealed from 10/15/11	F 309		

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F 309	Continued From page 3 through 10/19/11, no BMs were documented. Review of a facility form titled; "No BM in last 9 Shifts Report" revealed documentation of Resident #3 not having a recorded BM for thirteen (13) shifts. A review of the Medication Administration Record (MAR) revealed Resident #3 received Senna-S (stool softener) one tablet daily on a routine basis beginning 10/07/11. No additional medications were administered for constipation from 10/15/11 through the day shift of 10/19/11. The MAR revealed documentation of Resident #3 receiving Milk of Magnesia during the evening shift of 10/19/11. An interview with Licensed Nurse (LN) # 2 on 10/19/11 at 10:30 AM revealed BM's are documented in the resident's care tracker by the staff member who noted the BM. LN #2 indicated a report is printed by the second shift for residents who have not had a documented BM in nine (9) shifts to alert the LN of a potential constipation problem. LN #2 acknowledged Resident #3's name was on the list for no BMs and standing orders should have been implemented on the third day. An interview with the Director of Nursing (DON) on 10/19/11 at 3:30 PM revealed if the resident is identified as no BM in nine shifts, the BM protocol would be implemented on the third day. The DON further indicated the LN would start with MOM and if not effective, then follows the rest of the standing orders.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

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F 312	Continued From page 4 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and product manufacturer directions facility staff failed to rinse the perineal area of one (1) of five (5) residents observed for incontinence care. (Resident #6) The findings are: Review of the manufacturer's label for a commercial hair and body wash utilized during incontinence care for Resident #6 included the following directions for use: "Rinse well and dry completely." Resident #6 was re-admitted to the facility on 09/14/11 with diagnoses including Anemia, Muscle Weakness and Dementia. The latest Minimum Data Set (MDS) dated 09/21/11 revealed Resident #6 required extensive assistance from staff for activities of daily living (ADL), including personal hygiene and toilet use. The MDS further revealed the resident was incontinent of bowel and bladder. On 10/19/11 at 10:20 AM, Nursing Assistant (NA) #1 was observed providing incontinence care to Resident #6. NA #1 prepared a basin of water with the hair and body wash, washed and dried the resident without rinsing Resident #6's skin.	F 312	F 312 A. Immediate correction was done by rinsing Resident #6's peri-area skin with plain water after the use of the body/peri-wash on 10/19/2011. Verbal re-education was done by DON with C.N.A. #1 on 10/19/2011. There was no negative outcome noted for Resident #6. DON held a one-on-one return demonstration with C.N.A #1 on 10/24/2011 regarding need to rinse current body/ peri-wash soap product. Administrator conducted an in-service on peri-care, use of commercial hair and body wash based on manufacturer's directions, expectations, and action planning with nursing staff on 10/21/2011. B. C.N.A.s have been observed and evaluated during incontinence care to ensure that peri-care is appropriate and that the body/ peri-wash product is properly rinsed off on all residents requiring peri-care. The DON and PI/Nurse Educator re-educated C.N.A.s on the proper rinsing of this current body/peri-wash product with plain water after each use- this was accomplished from 10/25/2011 to 11/8/2011. Nursing staff will continue to be educated and this will be completed as of 11/17/2011. C. To ensure compliance, staff education on following manufacturer's directions for commercial hair and body wash was ensured on 10/20/2011 and 10/21/2011. Education of the staff will continue and be done during orientation, annually, and as needed with each new product purchase or change. D. To monitor the measure to make sure that solutions are sustained, the DON/ RN Supervisors/ designee will observe and/ or require return demonstration from nursing staff on all shifts providing incontinent care at least 2x/week ensuring staff's proper rinsing of the soap product with each incontinent care and/ or bed bath procedure. The DON will report to Administrator compliance weekly and to QAA committee monthly x 90 days. Then the DON will monitor compliance thereafter.	11/17/11

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F 312	Continued From page 5 An interview on 10/19/11 at 10:50 AM with NA #1 revealed body wash from the dispenser in the resident's bathroom was used in the basin of water. NA #1 further revealed she understood the body wash was a no rinse product. On 10/19/11 at 3:50 PM the Director of Nursing (DON) was interviewed and revealed she would have expected the NA to rinse the hair and body wash product off of the resident's skin prior to drying and placing a clean brief.	F 312		
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 This REQUIREMENT is not met as evidenced by: Based on observation and interviews the facility failed to ensure cups were properly cleaned prior to planned use for the lunch meal service on 10/18/11. The findings are: An initial tour of the facility's kitchen and dining area was made with the Director of Dietary Services on 10/18/11 at 10:10 AM. Plastic cups,	F 371	F 371 A. Immediate correction accomplished by immediate removal and replacement of the 9 plastic coffee cups identified not to have been properly cleaned on 10/18/2011. The Director of Dietary also immediately requested inspection and repair of the existing dishwasher; this was completed on 10/18/2011 by Ecolab (contracted service). Consistent and acceptable cleaning standard of dining tools, utensils, and equipment immediate correction, expectations, and action planning in-service held by Administrator on 10/21/2011. B. To correct those that have potential to be affected, the kitchen director and supervisor inspected all existing coffee cups and dining tools /utensils to ensure cleanliness on 10/18/2011 and ongoing by Director and Chef. The Production Supervisor will verify proper function of current kitchen equipment and report to Director for repair as needed. The Director of Dietary and Assistant will continue to educate the kitchen staff on ensuring proper washing of every dining cup, glass, plate, other tools/ utensils and to report any problems immediately for correction , this will be completed by 11/17/2011. C. Systemic changes implemented include Preventive Maintenance check of kitchen equipment to be	11/17/11

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F 371	Continued From page 6 identified by the Director of Dietary Services as clean and ready for use by the residents for the lunch meal, were observed. The interior of nine (9) of twenty-six (26) cups contained dried food particles and one (1) of the 26 cups revealed a thick brown matter on the inside of the cup. The Director of Dietary Services was interviewed on 10/18/11 at 10:30 AM and reported he expected the staff member at the end of the dish line to inspect dishware for cleanliness before the dishware is stored ready for use. The Director of Dietary Services offered no explanation why the dirty cups were stored ready for resident use. During a group interview on 10/19/11 at 3:30 PM, three (3) of seven (7) residents identified as interviewable by the facility revealed they have received dirty cups with their meals. The residents further revealed the dirty cups were returned and replaced with clean cups.	F 371	overseen by Director of Dietary. Kitchen Supervisor will inspect equipment and status of coffee cups, glasses, plates, other dining tools/ utensils daily prior to each meal. Food Service staff will continue to be educated to report to Supervisor and Director any equipment identified not appearing to be working properly. No cup, glass, plate, dining tool, or utensil will be delivered from the main kitchen to the facility without passing the inspection of the Kitchen Supervisor or Director/ designee. D. Facility will monitor measures to ensure solutions are sustained by routine PM (preventive maintenance) reports, checklist on kitchen routine sanitation inspection report specifically on coffee cups and tumblers will be submitted weekly or monthly by Director of Dietary to Administrator and report compliance monthly to the QAA committee x 90 days and then ongoing by the Director of Dietary thereafter through Leadership Meeting report and updates.	
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	F 431	F431 A. Immediate correction accomplished by Pharmacy consultant discarding and replacing the Forteo injectable that was identified not to have been properly stored in the refrigerator on 10/18/2011. One on one education of LN#1 was completed on 10/18/2011 & again one on one education by the DON on 10/20/2011 was completed. Labeling and storage of medication immediate correction, expectations, and action planning in-service held by Administrator on 10/21/2011. B. The Pharmacy manager and Pharmacy consultant reviewed and ensured that all medications that require special storage procedures on all places where they are stored including medication carts, refrigerators,	11/17/11

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F 431	Continued From page 7 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. This REQUIREMENT is not met as evidenced by: Based on observations, medical record reviews and staff interviews the facility failed to accurately store and date a r-DNA (Recombinant DNA) injection product 'Forteo' (Teriparatide) a pre-filled delivery device injector, as per the manufacturer instructions observed in one (1) of four (4) medication storage carts used for a current resident. (Resident #14) The findings include: A review of the manufacturer product insert, product container label and the pharmacy label for Forteo had a black box warning to store the product in refrigerator (36-46 degree F) and to discard the delivery device after 28 days from	F 431	and bulk storage areas were identified and currently stored and labeled correctly on 10/18/2011 and 10/19/2011. No additional medications were found. Nurses were educated on proper storage and reading of labels by RN Nurse Educator on 10/25/2011. C. To ensure that compliance is sustained, the Pharmacy Consultant and Manager reviewed the current Policy regarding medication Labeling and Storage with nurses. The Pharmacy will affix a label on specific medications to indicate and highlight special storage or handling procedures of specific medications. The Consultant Pharmacist will inspect special storage procedures of specific medications twice monthly during med pass observations. Inspection will include ensuring proper labeling and knowledge of nurses. Also, education of licensed nursing staff on this policy on orientation, annually, and as needed of this policy. D. Measures to make sure that this solution is sustained will be through weekly compliance report by the DON/designee and report monthly of compliance by pharmacy to administration and QAA committee x 90 days and ongoing by pharmacy and DON during monthly and/ or quarterly med management meetings.	

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F 431	Continued From page 8 opening. Resident # 14 was admitted to the facility on 10/6/11 with diagnoses that included low calcium, difficulty walking, unspecified muscle weakness and other rehabilitation. A review of the physician orders dated 10/6/11 included an order to inject 20 mcg (Microgram) Forteo subcutaneously every day at 8:00 AM. Observation of the Union hall medication cart on 10/18/2011 at 10:15 AM revealed the following: · A box of Forteo injection device opened and not dated. Further, the product label disclosed a warning to discard the delivery device in 28 days after opening. · The box of Forteo was located in a top storage drawer of the medication cart. The box was at room temperature. The product label on the box disclosed the information to store Forteo in the refrigerator and the pharmacy label had an auxiliary label 'Keep Refrigerated' . An interview with Licensed Nurse (LN) #1 on 10/18/2011 at 2:55 PM revealed that she was not aware that Forteo became outdated in 28 days after opening and was not aware why the injection device was not dated when opened. In addition, she was not aware that Forteo was to be kept in the refrigerator and stated that the medication was in the medication cart when she arrived this morning. LN #1 was unsure how long Forteo had been stored in the medication cart. An interview with the Director of Nursing (DON) on 10/18/2011 at 2:55 PM revealed that it was her expectation that all medications were checked for	F 431		

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F 431	Continued From page 9 expiration and stored per manufacturer guidelines. An interview with an onsite consultant Pharmacist on 10/18/2011 at 2:57 PM revealed that the 'refrigerate' label is a part of the instructions on the pharmacy label for Forteo and the medication is delivered to the facility with a cold pack when black box instructions require refrigeration.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441	F441 A. Immediate correction was completed by C.N.A. #1 cleaning all the personal items held with dirty gloves during the peri-care with sani-wipes including the night stand drawer on 10/19/2011. C.N.A. #1 was verbally counseled and re-educated by DON on 10/19/2011. The DON also held a one on one re-education and return demonstration with C.N.A. #1 on 10/24/2011 regarding consistent practice of infection control procedure during peri-care. B. Administrator held an in-service on Infection Control Standards and expectations on 10/21/2011. C.N.A.s were observed and each performed return demonstration on infection control practice during peri-care held by the DON and Nurse Educator from 10/25/2011 to 11/8/2011. C. To ensure compliance to this policy, review of the Incontinent Care and Infection Control Policy and Procedure with staff was held on 10/20/2011 and 10/21/2011 by Administrator, DON and RN Nurse Educator. The DON/ designee and RN supervisors will observe at least 2 C.N.A.s each week on different shifts during incontinent care and ensure infection control practice during entire procedure. Infection Control Nurse/ designee will observe hand washing and changing of gloves procedure and compliance at least monthly to at least 10% of current working staff on every shift. Education on Infection Control P&P specifically with peri-care procedure will be held on	11/17/11

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(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 441	Continued From page 10 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to change gloves after the provision of incontinence care and prior to retrieving personal care products from a bedside table for one (1) of five (5) residents observed for incontinence care. (Resident #9) The findings are: Resident #9 was re-admitted to the facility on 08/22/11 with diagnoses including Urinary Tract Infections (UTI). Review of the most recent Minimum Data Set (MDS) dated 10/04/11 revealed Resident #9 required extensive assistance with activities of daily living including toilet use. On 10/19/11 at 9:55 AM, Nursing Assistant (NA) #1 was observed providing incontinence care to Resident #9. After providing care and without changing gloves, NA #1 opened the resident's bedside table and removed a tube of moisture barrier ointment and a container of powder. After applying ointment to the resident's groin and without changing gloves, NA #1 returned the	F 441	with staff on orientation, annually, and as needed. D. To monitor the measures and ensure that solutions are sustained, the RN Supervisors will report compliance to DON at least weekly and then the DON and Infection Control Nurse will report to Administration and QAA committee compliance monthly for 90 days and then to DON ongoing thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345097	A. BUILDING _____ B. WING _____	10/20/2011

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F 441	Continued From page 11 personal care products to the drawer of Resident #9's bedside table. On 10/19/11 at 10:05 AM, NA #1 was interviewed. NA #1 indicated she should have changed her gloves after providing incontinence care and prior to removing the personal care products from the resident's drawer and applying the products to the resident's skin. The Director of Nursing (DON) was interviewed on 10/19/11 at 4:00 PM. The DON indicated it is her expectation to set up supplies prior to beginning care. The DON further indicated if supplies are not assembled prior to beginning the procedure she would expect the NA to change gloves after providing incontinence care and before removing the supplies from a resident's drawer.	F 441		