STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____ MAY 04 2012	C 04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH RD BOX 38 ALBEMARLE, NC 28001

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F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff and resident interviews, the facility's interdisciplinary team failed to assess 1 (Resident # 126) of 1 sampled resident if safe to self administer medication. The finding includes: The facility's policy on Self-Administration of Medication dated 2/12 was reviewed. The policy read in part " Each resident has the right to self-administer medications, unless the facility's IDCP (interdisciplinary care plan) team has determined for each resident that this practice is unsafe. The facility will assume responsibility of documenting the administration of medications as well as proper storage. The admitting nurse will ask each resident if he/she wishes to self-administer medications and complete " Self-Administration of Drugs " initial assessment. Initial assessment will be forwarded to the IDCP to be reviewed at initial IDCP team conference. IDCP team will complete the " Resident Assessment for Self-Administering Medication " . Resident # 126 was admitted to the facility on 01/14/12 with multiple diagnoses including Dry Eyes. The MDS (Minimum Data Set) assessment dated 01/26/12 indicated that Resident #126's cognition was intact.	F 176	Resident #126 had IDCP review for self administer medication on 4/12/12. Evaluation of residents demonstration of self administering was completed by IDCP. Resident was found to be competent of this task per IDCP. Other residents identified as desiring to self medicate were assessed by the IDCP for self medication administration determination. For current residents who self administer and future admissions, this assessment will be reviewed annually and upon changes in residents status. A monthly audit of all physician orders will be reviewed by the ADON and SDC RN to ensure any self administration orders have an approved assessment by the IDCP team. An audit tool will be used during this process. An in-service will be held with all licensed nursing staff and Medication Aides on the facility's self administration medication policy. In-service held on 4/29,4/30, 5/1, 5/2,5/9. This in-service was conducted by the DON , SDC RN and Pharmacist. This monthly self administration medication audit will continue until compliance is sustained for at least for 3 consecutive months. During this audit period all results will be shared monthly at the Facility's QA meeting.	4/12/12 5/9/12 5/9/12 5/9/12 5/10/12

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

Stephanie Hunnycutt | Administrator | May 3, 2012

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 176	Continued From page 1 A Self-Administration of Medication form dated 01/14/12 was reviewed. The form indicated that Resident #126 did not wish to self-administer medications. Review of the Physician's orders revealed that Resident #126 was on Artificial Tears 2 drops to both eyes twice a day for Dry Eyes. On 03/05/12, there was a doctor's order " may keep Artificial tears at bedside " . The initial assessment form and the Medication Self-Administration Assessment form dated 03/06/12 were completed by Nurse #2. The form indicated that Resident #126 can safely self-administer medications. On 04/10/12 at 8:14 AM and 04/12/12 at 10:05 AM, Resident #126 was observed in her room. A bottle of Artificial Tears was observed on top of her over the bed table. When interviewed, she stated that she instilled 1 big drop of Artificial Tears to both eyes once a day in the morning. On 04/11/12 at 11:34 AM, Nurse #2 was interviewed. She stated that Resident #126 was alert and oriented. She further stated that the bottle of Artificial tears was left at bedside and the resident has been administering it to herself. She added that she had assessed the resident for self administration and was informed that she had to instill 2 drops to each eye 2 times a day. On 04/12/12 at 8:46 AM, the MDS Nurse was interviewed. She stated that the IDCP team did not assess Resident #126 for self administration	F 176		

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F 176	Continued From page 2 of medication. She indicated that the admitting nurse and Nurse #2 had completed the initial assessment form for self administration but the form was not forwarded to the IDCP team. The IDCP was not able to assess the resident and therefore care plan for self administration was not initiated.	F 176		
F 334 SS=C	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures	F 334	Resident and Responsible Parties of #2, #14, #27, #10, and #76 were provided with the CDC's 2011-2012 on 4-26-12 by the Admission RN (due to the 2012-2013 flu season information has not been made available at this time). Also Pneumococcal fact sheets from the CDC were sent to the above residents and responsible parties. The information was documented in resident's medical charts. New residents upon admission will receive the current years CDC Influenza risk versus benefits, and the Pneumococcal vaccine. This information will be provided by the Facility's Resident Liaison or Admission RN. Stanly Manor's release for Flu and Pneumonia vaccine will also be provided, giving the right to refuse at time of admission. All current residents will receive, when available the CDC 2012-2013 influenza information fact sheet that shares risk versus benefits, opportunity to decline vaccine will be given and this information will be documented in resident chart. This information will be sent by the Resident Liaison.	5/9/12 5/9/12

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

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F 334	Continued From page 3 that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the	F 334	The facility will update the quarterly medical record chart audits tool, including annual documentation requirements for annual influenza vaccine, CDC risk versus benefits and right to refuse. Along with ensuring information regarding the Pneumococcal vaccine, CDC risk versus benefits and right to refuse was documented in residents medical record. These medical record chart audits for documentation supporting CDC education of risk versus benefits and opportunity to refuse the Influenza and Pneumococcal vaccine will be conducted for new admissions within 7 days of admission and then on-going audited quarterly. The audit will be conducted by the Medical Record's Director. An audit tool has been created to monitor this compliance. This audit will continue until compliance is sustained for at least for 3 consecutive months. During this audit period all results will be shared monthly at the Facility's Quality Assurance meeting.	5/9/12 5/10/12

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F 334	Continued From page 4 facility failed to document in the resident's medical record that education regarding the benefits and potential side effects of the influenza immunization was provided to the resident or family prior to offering the vaccine for 5 (Resident # 2, #14, #27, #10 & #76) of 5 sampled residents. The findings include: The facility's policy on Influenza Immunization dated 08/09 was reviewed. The policy read in part " Before offering the influenza immunization, the facility will provide to each resident or the legal representative education regarding the benefits and potential side effects of the immunization and assess each resident for possible medical contraindications. Documentation in the resident's medical record will include at a minimum that the resident or legal representative was provided education regarding the benefits and potential side effects of influenza immunization " . 1. Resident #2 was admitted to the facility on 11/29/10. The immunization record indicated that Resident #2 had received the influenza immunization on 10/07/11. There was no documentation found in the resident's medical record that the resident or the legal representative was provided education regarding benefits and potential side effects of the influenza vaccine prior to offering the vaccine. On 04/12/12 at 8:20 AM, Administrative Staff #2 was interviewed. She stated that on admission the resident or the family member was provided education regarding benefits and potential side effects of influenza and pneumonia immunization.	F 334		

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

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F 334	Continued From page 5 She added that the education was mailed to family with their financial statements yearly prior to immunization time but she did not document it on the resident's medical records. On 04/12/12 at 8:25 AM, administrative staff #4 was interviewed. She stated that nurses working on the floor administered the influenza vaccine to the residents. She further stated that there was no documentation in the records that the education was provided yearly before the vaccine was offered. 2. Resident # 14 was admitted to the facility on 06/29/10. The immunization record indicated that Resident #14 had received the influenza immunization on 10/07/11. There was no documentation found in the resident's medical record that the resident or the legal representative was provided education regarding benefits and potential side effects of the influenza vaccine prior to offering the vaccine. On 04/12/12 at 8:20 AM, Administrative Staff #2 was interviewed. She stated that on admission the resident or the family member was provided education regarding benefits and potential side effects of influenza and pneumonia immunization. She added that the education was mailed to family with their financial statements yearly prior to immunization time but she did not document it on the resident's medical records. On 04/12/12 at 8:25 AM, administrative staff #4 was interviewed. She stated that nurses working on the floor administered the influenza vaccine to the residents. She further stated that there was	F 334		

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

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F 334	Continued From page 6 no documentation in the records that the education was provided yearly before the vaccine was offered. 3. Resident # 27 was admitted to the facility on 12/04/09. The immunization record indicated that Resident #27 had received the influenza immunization on 10/07/11. There was no documentation found in the resident's medical record that the resident or the legal representative was provided education regarding benefits and potential side effects of the influenza vaccine prior to offering the vaccine. On 04/12/12 at 8:20 AM, Administrative Staff #2 was interviewed. She stated that on admission the resident or the family member was provided education regarding benefits and potential side effects of influenza and pneumonia immunization. She added that the education was mailed to family with their financial statements yearly prior to immunization time but she did not document it on the resident's medical records. On 04/12/12 at 8:25 AM, administrative staff #4 was interviewed. She stated that nurses working on the floor administered the influenza vaccine to the residents. She further stated that there was no documentation in the records that the education was provided yearly before the vaccine was offered. 4. Resident # 10 was admitted to the facility on 10/03/06. The immunization record indicated that Resident #10 had received the influenza immunization on 10/07/11. There was no documentation found in the resident's medical	F 334		

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

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F 334	Continued From page 7 record that the resident or the legal representative was provided education regarding benefits and potential side effects of the influenza vaccine prior to offering the vaccine. On 04/12/12 at 8:20 AM, Administrative Staff #2 was interviewed. She stated that on admission the resident or the family member was provided education regarding benefits and potential side effects of influenza and pneumonia immunization. She added that the education was mailed to family with their financial statements yearly prior to immunization time but she did not document it on the resident's medical records. On 04/12/12 at 8:25 AM, administrative staff #4 was interviewed. She stated that nurses working on the floor administered the influenza vaccine to the residents. She further stated that there was no documentation in the records that the education was provided yearly before the vaccine was offered. 5. Resident # 76 was admitted to the facility on 09/28/09. The immunization record indicated that Resident #76 had received the influenza immunization on 10/07/11. There was no documentation found in the resident's medical record that the resident or the legal representative was provided education regarding benefits and potential side effects of the influenza vaccine prior to offering the vaccine. On 04/12/12 at 8:20 AM, Administrative Staff #2 was interviewed. She stated that on admission the resident or the family member was provided education regarding benefits and potential side	F 334		

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

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F 334	Continued From page 8 effects of influenza and pneumonia immunization. She added that the education was mailed to family with their financial statements yearly prior to immunization time but she did not document it on the resident's medical records. On 04/12/12 at 8:25 AM, administrative staff #4 was interviewed. She stated that nurses working on the floor administered the influenza vaccine to the residents. She further stated that there was no documentation in the records that the education was provided yearly before the vaccine was offered.	F 334		
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 staff interviews, the facility failed to store the trash can away from cooking utensils, air dry cooking utensils, and make sure staff does not allow their clothing to make contact with plated foods and store dishes that are clean. Findings included: 1. Accompanied by the Dietary Manager the first observation of the facility kitchen was conducted	F 371	Facility has designated area in the kitchen for trash can container which is away from cooking utensils, air drying cooking utensils and clean dishes. In-service will be held with all dietary staff ensuring awareness of trash can container placement and how to properly dispose of discarded items. In-service held on April 30,2012 by the Dietary Manager. Daily Dietary Manager, Assistant Manager or Cook will review trash container location in kitchen area ensuring proper placement through walk through audit. Weekly the Dietary Manager will also complete a walk through audit ensuring proper placement of the trash container. An audit tool has been created to monitor compliance.	5/9/12 5/9/12 5/9/12

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

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F 371	Continued From page 9 on April 9, 2012 at 11:15am. It was observed that a trash can was pushed up against and touching the metal wire rack that was holding clean cooking utensils. The cooking utensils looked like a variety of steam table pans. The pans were stacked upside down on the wire rack. Trash and empty boxes were also observed to be stacked up against the rack holding the clean pans. Five loaf pans were observed to be stacked upright on the rack and were touching the side of the trash can. When the Dietary Manager pulled the trash and the trash can away from the rack a metal cookie sheet was observed lying on the floor. In an interview with the Dietary Manager on 4/09/2012 at 11:20 am she reported that the trash can needed to be stored in another area away from the wire rack holding the clean pans. During the second observation of the facility kitchen accompanied by the Dietary Manager on 4/10/2012 at 10:50am it was observed that a trash can was pushed up against and touching the wire rack of clean cooking utensils. A staff was observed to toss scraps of vegetable trimmings toward the trash can from a preparation table. In an interview with the Dietary Manager on 4/10/2012 at 10:55 pm she stated that the trash can could not remain up against the clean cooking utensil rack and would be moved to another location. 2. Further observation of facility kitchen on 4/09/2012 it was observed at 11:25am that several items had been stored on a wire rack. Eight of 10 bowls were observed to be stacked	F 371	Walk through audits for trash container placement, will be held at least 3 consecutive months. During this audit period all results of the audit tool will be shared monthly at the Facility's Quality Assurance meeting. The Dietary dress code in-service will be reviewed on what is properly fitting dietary attire to ensure scrub tops do not come in to contact with plated food. In-service held by the Dietary Manager on 4-30-12 to all dietary staff. Daily Dietary Manager, Assistant Manager or Cook will review during daily walk through dietary staffs attire to ensure clothing is properly fitting dietary attire to ensure scrub tops do not come in to contact with plated food. Weekly the Dietary Manager will also complete a walk through auditing employee's attire. An audit tool has been created to monitor compliance. Walk through audits for employee's attire , will be reviewed for at least 3 consecutive months. During this audit period all results from audit tool will be shared monthly at the Facility's Quality Assurance meeting. Dishes have been reviewed any dishes having stains were discarded. Any dishes having debris were re-washed. Any dishes or cooking utensils with water droplets were re-washed unless in drying area. In-services will be held with all dietary staff ensuring compliance with removing any stained dishes, rewashing any dishes that have (cont.)	5/9/12 5/9/12 5/9/12 5/9/12 5/9/12 5/9/12

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F 371	Continued From page 10 while wet. There were 5 of 7 plates observed to be stacked while wet. On 4/09/2012 at 11:30am the Dietary Manager said that the staff was aware that all items that come through the dish machine should be air dried. The Dietary Manager stated that usually staff allowed items to be air dried. It was observed on 4/10/2012 at 12:30 pm that a variety of dipping utensils were lying in a basket that had dried circles located at the bottom similar to those found in utensils that were not air dried. On 4/10/2012 at 12:45 pm the Dietary Manager demonstrated to the staff how to hang the dipping utensils for air drying. 3. During the noon meal observation on 4/10/2012 at 11:45 am a dietary staff plating foods for the residents was observed on 3 occasions to be reaching over the plated food for items allowing a loose fitting scrub top to come in direct contact with the plated foods. When it was brought to the Dietary Managers ' attention the employee was provided an apron. 4. Further observation of the facility kitchen accompanied by the Dietary Manager on 4/10/2012 at 12:20 pm it was observed that the partitioned plates stacked up on a wire rack had stains or food particles in 3 of 5 plates. On 4/10/2012 at 12:25 pm the Dietary Manager said that the partitioned plates would be rewashed and if stained the partitioned plates would be discarded.	F 371	debris, and re-washing any dishes or cooking utensils that haven't properly air dried. In-service was held on April 30 by Dietary Manager to all dietary staff. Daily Dietary Manager, Assistant Manager or Cook will review during daily walk through appearance of plates and cooking utensils in drying area and on storage racks ensuring plates do not look stained, have debris, or water droplets. An audit tool has been completed to monitor task. This audit tool will also be reviewed weekly by the Dietary Manager. Walk through audits for dish inspection , will be held at least 3 consecutive months. During this audit period all results of the audit tool will be shared monthly at the Facility's Quality Assurance meeting.	5/9/12 5/9/12 5/9/12
F 425	483.60(a),(b) PHARMACEUTICAL SVC -	F 425		

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F 425 SS=D	Continued From page 11 ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on facility policy, observation and staff interview, the facility failed to discard an expired medication (one 20 ml. (milliliter) bottle of sterile water for injection dated 4/7/12) on one (1) of five (5) medication carts (500 hall) and failed to discard six (6) Acetaminophen 650 mg. (milligrams) suppositories with an expiration date 3/12) located in the stock medication supply. The findings include: An undated facility policy entitled Storage of Medications stated, in part, "7. Outdated,	F 425	The bottle of sterile water for injection dated 4/7/12 and the 6) Acetaminophen 650 mg. suppositories was returned to the pharmacy. In-services to all licensed staff and medication Aides will be held on 4/11, 4/14, 4/29, 4/30, 5/1, 5/2 educating on the importance of discarding medication in timely and appropriate manner. These in-services will be held by the DON, Pharmacist and SDC.	5/9/12 5/9/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	C 04/12/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH RD BOX 38 ALBEMARLE, NC 28001

(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 425	Continued From page 12 contaminated, or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from use; disposed of according to procedures for medication disposal; and reordered from the pharmacy, if a current order exists." 1. On 4/11/12 at 10:30 AM., the medication cart on 500 hall was observed. One 20 ml. bottle of sterile water for injection was observed opened and dated 4/7/12. On 4/11/12 at 10:30 AM., Nurse #1 stated she was not sure of the facility policy but would discard the vial if it was still in the cart on 4/13/12. On 4/11/12 at 1:00 PM., Administrative staff #3 stated the 20 ml. bottle of sterile water for injection should have been discarded after use. On 4/11/12 at 2:23 PM., the pharmacy consultant stated the 20 ml. bottle of sterile water for injection was for one time use only and should have been discarded after use. 2. On 4/11/12 at 11:00 AM., an observation revealed six (6) Acetaminophen 650 mg. (milligrams) suppositories with an expiration date 3/12) located in the stock medication supply. On 4/11/12 at 2:25 PM., Administrative staff #3 stated there was a schedule for the night shift nursing staff to check the medication carts and medication room for expired or discontinued medications and remove them from use.	F 425	The medication carts and storage areas will be reviewed at least quarterly by pharmacy services. All medication carts, and storage areas will be audited by floor nursing staff weekly(11p-7am RN/ LPN/Med Aide). A tool audit was created and will be turned into the Director of Nursing or Assistant Director of Nursing weekly for review. All medication tool audits will be reviewed for sustained compliance for at least 3 consecutive months. During this audit period all results will be shared monthly at the Facility's Quality Assurance meeting.	5/9/12 5/9/12 5/9/12

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MAY 10 2012
CONSTRUCTION SECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING 01 - MAIN BUILDING B. WING	04/24/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	625 BETHANY CHURCH RD BOX 38 ALBEMARLE, NC 28001

(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 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 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type V construction, and is equipped with an automatic sprinkler system. CFR#: 42 CFR 483.70 (a)	K 000		
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 4/24/2012 the clean linen closets double doors on the 300 and 400 hallways opened into the corridor less than 180 degrees as there were handrails installed. With this condition the doors must have a device installed to bring the door back to the closed and latched position after being opened. CFR#: 42 CFR 483.70 (a)	K 072	Self closure was installed on linen closet door on 300/400 hall. A walk through of facility was conducted on 4-24-12 no other doors were found to be deficient for self closures. A monthly walk through of facility will be conducted and an audit tool will be implemented to ensure proper hardware is present on doors that are determined to need self-closure devices. Monthly walk through audits will be reviewed at QA meetings. This audit will continue until three months of compliance is sustained.	5-1-12 4-24-12 4-24-12 5/10/12

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

Stephanie Richardson — Administrator — 5-8-12

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.