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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	08/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON ST CHERRYVILLE, NC 28021

(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 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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 observations, resident and staff interviews, the facility failed to remove chin hairs on two (2) of five(5) dependent residents (Resident # 90 and Resident # 58). The findings are: 1. Resident #90 was admitted to the facility with diagnoses of heart failure, hypertension, diabetes, depression, and chronic pain. The most recent quarterly Minimum Data Set (MDS) assessment dated 5/18/2012 indicated Resident #90 was moderately impaired for decision making skills and required extensive assistance from staff for activities of daily living, bathing and personal hygiene. The MDS also indicated Resident #90 had impaired range of motion of one upper extremity as well as both lower extremities. Care plan dated 6/13/12 revealed Resident #90 was scheduled for showers on Mondays and Wednesdays. On 8/6/12 at 2:39 PM Resident #90 was observed sitting in a chair with multiple ¼ inch	F 312	Carolina Care Center provides necessary services to maintain good nutrition, grooming, and personal and oral hygiene *Corrective action was taken immediately for residents #90 and #58 on 08/09/12 when Director of Nursing (DON) was notified and asked Certified Nursing Assistants (CNAs) to shave each females 1/4 inch chin hairs. *No other residents reviewed by the Surveyors had facial hair in need of shaving. The other residents having potential to be affected by the alleged deficient practice were reviewed by facility staff and did not have facial hair on 8/09/12. *Measures put into place to ensure the alleged deficient practice does not recur included the following: -Re-education of shower team CNAs as to grooming responsibilities to be completed during shower of residents by 8/28/12. -Re-education of all CNAs to provide shaving to residents as needed daily during care or grooming as 8/28/12. *Monitors put into place to ensure corrective actions are sustained include weekly reviews by Restorative Nursing on each hall to ensure residents are being shaved. The monitors are documented and submitted to the DON.	9/05/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Judy B Bean WHA | TITLE: President | (X6) DATE: 8/28/12

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.

RECEIVED
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BY:

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F 312	Continued From page 1 long chin hairs noted. On 8/6/12 at 2:39 PM Resident #90 was interviewed. She stated she disliked having chin hairs. On 8/8/12 at 8:56 AM Resident #90 was observed sitting up in a chair. The resident was observed to have facial hair approximately ¼ inch long covering her chin. On 8/9/12 at 8:28 AM Resident was observed sitting up in wheelchair. The resident was observed to have facial hair approximately ¼ inch long covering her chin. On 8/9/12 at 8:42 AM Nursing Assistant #2 was interviewed. She stated it was the responsibility of the nursing assistants working on the floor to trim chin hairs. NA #2 stated that she showered Resident # 90 early this morning. She offered no explanation as to why the chin hairs were not removed while resident was in the shower. On 8/9/12 at 9:28 AM NA #3 was interviewed. She stated she would shave chin hairs on females when she noticed them. She stated she had not noticed multiple chin hairs on Resident #90 while she was assigned to her 7AM-3PM on 8/9/12. On 8/9/12 at 9:50 AM the Director of Nursing (DON) was interviewed. She stated it was her expectation that the nursing assistants check chin hair on females daily and remove the hair.	F 312	The DON reviews monitoring in the weekly Tracking Committee meeting and tracking reports are submitted by the DON to the Administrator in the monthly Quality Assurance and Assessment (QA&A) Committee meeting. The committe reviews the reports for the effectiveness of the plan and will recommend changes as needed on an on-going basis for a minimum of one year.	9/05/12

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F 312	Continued From page 2	F 312		

On 8/9/12 at 9:58 AM the DON confirmed the presence of multiple ¼ inch long chin hairs on Resident #48.

2. Resident #48 was admitted to the facility with diagnoses of hip fracture and Non-Alzheimer's dementia.

The admission Minimum Data Set (MDS) dated 6/14/12 indicated Resident # 48 had short and long term memory impairment and had severely impaired skills for decision making. The MDS also indicated Resident #48 required extensive assistance from staff for activities of daily living, bathing and personal hygiene.

Review of the current Care Plan dated of 6/19/12 indicated Resident #48 was scheduled for showers on Mondays and Fridays.

On 8/6/12 at 11:15 AM Resident #48 was observed sitting up in a chair in her room. The resident was observed to have facial hair approximately ¼ inch long covering her chin.

On 8/8/12 at 10:43 AM Resident #48 was observed sitting up in a chair. The resident was observed to have facial hair approximately ¼ inch long covering her chin.

On 8/8/12 at 4:03 PM 3 The resident was observed to have facial hair approximately ¼ inch long covering her chin.

On 8/9/12 at 8:25 AM Resident #48 was observed up in a chair. The resident was observed to have facial hair approximately ¼ inch long covering her chin.

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F 312	Continued From page 3 On 8/9/12 at 8:42 AM Nursing Assistant #2 was interviewed. She stated it was the responsibility of the nursing assistants working on the floor to trim chin hairs. NA #2 stated if the resident was not diabetic, she would trim the chin hair while the resident was in the shower. NA #2 stated that she showered Resident # 48 on Monday 8/6/12. She offered no explanation as to why the chin hairs were not removed during the shower on 8/6/12. On 8/9/12 at 9:28 AM Nursing Assistant #3 was interviewed. She stated she shaved a female resident's chin hairs when they are noticed. NA #3 was assigned to Resident #48 7AM - 3PM on 8/9/12. She also stated that she had not noticed the chin hairs on Resident #48 during her shift. On 8/9/12 at 9:50 AM the Director of Nursing (DON) was interviewed. She stated it was her expectation that the nursing assistants checked chin hairs on females daily and removed them. On 8/9/12 at 9:58 AM the DON confirmed the presence of multiple ¼ inch long chin hairs on Resident #48.	F 312		
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	F 314	Carolina Care Center provides necessary care and treatment to prevent pressure sores, promote healing, and prevent infection unless the resident's clinical condition demonstrates pressure sores were unavoidable.	9/05/12

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F 314	Continued From page 4 prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review the facility failed to provide a physician ordered nutritional supplement to promote wound healing for a resident with a stage III pressure ulcer for one (1) of three (3) residents with pressure ulcers, Resident #64. The findings are: Resident #64 was admitted to the facility with the diagnosis anemia, chronic pain, hypertension, and pressure ulcers. Review of Resident #64's most recent Significant Change Minimum Data Set (MDS) dated 07/23/12 revealed she had moderate cognitive impairment. Review of her Care Area Assessment dated 07/23/12 pressure ulcers revealed she had a stage III pressure ulcer to her coccyx, an unstageable pressure ulcer to her right heel and a suspected deep tissue injury to her on her right toe. The resident had weight loss and a poor appetite. She was incontinent of bowel. She wore heel boots at all times and had an air mattress to relieve pressure. Review of Resident #64's weights revealed she had a recent weight loss of eight pounds. On 07/17/12 Resident #64 weighed 154 pounds and on 07/25/12 she weighed 146 pounds. A review of physician's orders revealed an order dated 07/18/12 for a nutritional supplement to be	F 314	*The need for nutritional supplement for resident #64 was corrected immediately by DON on 8/08/12 by obtaining a clarification order from the physician for nutritional supplement and placing order on Medication Administration Record (MAR). *Corrective action for other residents having potential to be affected by the alleged deficient practice was accomplished by DON reviewing wound care log, supplement orders and MARs to ensure all other supplements for skin care were being administered as ordered (8/12/12). All residents were receiving supplements as ordered. *Measures put into place to ensure alleged deficient practice does not recur included the following: -Re-inservice of all licensed staff by 8/28/12 regarding physician entry into the electronic record and submission of order to transfer to MAR. -Re-inservice of all licensed staff on completion of hard copy of "Diet Sheets" on the date the supplement is ordered to communicate to Food Service Director (FSD) the type of supplement needed on medication cart.	9/05/12

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F 314	Continued From page 5 given with medication pass, to add calories. The order specified it was to be offered if she did not eat her meals. Meal intake records dated from 07/18/12 thru 08/05/12 were reviewed. It was documented Resident #64 ate between 1 -25% of her meal twenty-three (23) times during that period. On 07/12/12 it was documented the resident ate none of her morning meal. Further review of Resident #64's medical record revealed a note written by the facility's Registered Dietician (RD) dated 07/31/12. The RD reviewed the resident's skin impairments to her coccyx and right heal/foot. She noted that the resident's weight for July reflected a greater than five (5) percent weight loss. She further noted Resident #64's protein need for healing support had increased and she requested a nutritional supplement.. Review of Resident #64's July and August Medication Administration Record (MAR) revealed there were no an orders for the nutritional supplements to be given by nursing if the resident did not eat her meals. Resident #64's skin assessment dated 08/01/12 revealed she had a stage III pressure ulcer on her coccyx area and an unstageable pressure ulcer on her right heel. During an interview on 08/08/12 at 12:03 PM, with Licensed Nurse (LN) #1 she stated she had never given Resident #64 a nutritional supplement. She stated she would have given the supplement when the resident ate less than twenty-five (25)	F 314	-FSD meets monthly with Registered Dietary Consultant to review supplements recommended and provides supplement recommendations to Licensed Nurse and Minimum Data Set (MDS) nurse to ensure recommendations are Faxed to the attending physician for orders. -New orders for supplements are reviewed at daily stand up meeting by wound nurse or MDS nurse. *Monitoring put into place to ensure solutions are sustained include review of wound care sheets by MDS nurses each week to ensure supplements ordered are on MARs and being documented. New orders for supplements are also reviewed following stand up meeting by MDS nurses to ensure orders are entered into the electronic record and submitted to MAR. Weekly monitoring is submitted to DON. The DON reports weekly monitoring to the Tracking Committee. Reports from Tracking Committee are reviewed with Administrator at the monthly QA&A committee meeting. The Committee reviews the report for effectiveness of the plan and changes needed on an ongoing basis for a minimum of one year.	9/05/12

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F 314	Continued From page 6 percent of her meal. She reported there was not an order on the MAR for the resident to be given a nutritional supplement. An interview was conducted on 08/08/12 at 1:49 PM with the Director of Nursing (DON). She stated the nutritional supplement should have been put on the MAR and should have been given when the resident did not eat her meals.	F 314		
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	F 431	Carolina Care Center maintains drugs used in the facility in accordance with accepted professional principles including medication instructions and expiration dates which are in compliance with dates administered. *Corrective action taken for medication with expired dates observed by the surveyor were taken immediately by DON on 8/09/12 by returning expired medication to pharmacy for destruction and obtaining replacement medications from the pharmacy. *No other residents were affected by the alleged deficient practice due to immediate corrective action by Licensed nurses to review all medication carts for expired drugs on 8/09/12 and no expired drugs were found.	9/05/12

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F 431	Continued From page 7 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 and staff interviews, the facility failed to discard expired medications on two (2) of four (4) medication carts. The findings are: Observation of the Back Hall Medication Cart on 8/9/12 at 11:15 AM revealed a bottle of stock Ferrous Sulfate 325mg which had an expiration date of 7/12 and a bottle of stock Senna 8.6mg with an expiration date of 7/12. Observation of the Front Hall Medication Cart on 8/9/12 at 11:30 AM revealed unit dose containers of the following medications which had expired: Cymbalta 60mg with expiration date of 4/12; Levothyroxine 50mcg with expiration date of 2/12; and Simvastatin 20mg with expiration date of 6/12. Interview on 8/9/12 at 11:15 with LN #2 stated that expired medications are discarded by the Staff Development Nurse every 2 weeks. Interview on 8/9/12 at 11:30AM with LN #3 stated that expired medications are discarded by the third shift staff every two weeks when they receive the refills.	F 431	*Measures put into place to ensure alleged deficient practice does not recur included: -Re-inservice of all Licensed Nurses on 5 rights of medication administration by 8/28/12. Inservice included the review of drug prior to administration for expiration date. -Inservice of all licensed staff on monitoring sheets for expired medications, with procedures for return and reporting expired medications by 8/28/12. *Monitoring put into place to ensure solutions are sustained include: -Medication Nurse will check all medications upon administration for expired dates. Expired medication sheets maintained on medication cart are given to DON after completion, if expired drugs are found. -Nurse checking in medication from pharmacy on daily delivery completes expired medication audit sheet at time drugs delivered and returns any expired drugs delivered for replacement. Sheets are reviewed by DON weekly.	9/05/12

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F 431	Continued From page 8 Interview on 8/9/12 at 12:10 PM with the Director of Nursing (DON). She stated that her expectation is that expired medications be discarded daily by nursing staff. The DON stated that the pharmacy had been notified and all expired medications had been replaced.	F 431	-Third shift nurses review all medications on all carts each week and submit a weekly report to the DON as to any expired medications found and to be returned to pharmacy. -All reports are submitted at the weekly Tracking Committee. Reports from Tracking Committee are reviewed with the Administrator and the QA&A Committee monthly for review and effectiveness of the plan. The committee reviews the reports and recommends any changes needed to the plan on an ongoing basis for a minimum of one year.	9/05/12

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