

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

AUG 14 2012

PRINTED: 08/02/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345004	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/19/2012
NAME OF PROVIDER OR SUPPLIER PERSON MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE RD ROXBORO, NC 27573	
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F 164 SS=D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to provide privacy during care by failing to drape a resident to prevent unnecessary exposure of body parts for 1 of 2 (Resident # 3)</p>	F 164	<p>Based on the state survey ending on 7/19/2012 the surveyor noted that the facility failed to provide privacy during care by failing to drape a resident to prevent unnecessary exposure of body parts for 1 of 2 residents. The Director of Nursing provided inservice education to all staff on residents rights with an emphasis on privacy during care with a return demonstration on bathing, peri-care, and catheter care. New employees will be required to demonstrate competency as a part of orientation. Random observations will be done 2xs a week for six months, then monthly to ensure compliance. Observation results will be reported to ECU's QA committee as well as Clinical Care and Quality Services committee. This will be incorporated into the annual training for ECU employees.</p>	8/16/12

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

TITLE

(X6) DATE

Spence Thomas

Interim DON

8/11/12

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 164	<p>Continued From page 1</p> <p>Resident was admitted to the facility on 6/22/09 ,with traumatic brain injury, dysphasia and dementia.</p> <p>Review of the resident's most recent annual Minimum Data set (MDS) dated 6/13/12 revealed Resident # 3 was severely impaired in cognitive skills for daily decision making. Resident #3 was unable to voice her needs and was coded as needing extensive care for personal hygiene, incontinence care and totally dependent on staff for bathing.</p> <p>On 7/18/12 at 10:00 am Resident # 3 was observed receiving a bed bath. Aide #1 was observed pulling the bed linens and all clothing completely off Resident #3 . She was left nude with out any covering during the bath observation . A fan was blowing on her and the air condition was on. During an interview with aide #1, she was asked was she going to cover Resident #3 and she indicated a family member had bathed Resident #3 that way and she did not feel the resident was uncomfortable. Aide # 1 failed to prevent unnecessary exposure of body parts. After completing the bed bath, Aide #1 put clothing on Resident #3 and placed the blankets over her.</p> <p>During an interview on 7/19/12 at 8:51 am, aide # 3 indicated during bathing a resident was to be kept covered except for the body part that was being cleaned.</p> <p>During an interview on 7/19/12 at 11:24 AM, the director of nursing stated her expectations would be for the aide to prevent a resident from</p>	F 164			

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F 164	Continued From page 2	F 164		
F 279 SS=D	<p>becoming chilled and to cover the resident and only expose the area that needed to be cleaned.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to develop a comprehensive care plan for each resident that includes measurable objectives and timetables in 6 out of 14 sampled residents (Residents #4, #8, #21, #31, #32 and #35). Findings included:</p> <p>1. Resident #31 was admitted to the facility on 2/18/10 with cumulative diagnoses that included</p>	F 279	<p>Based in the state survey ending on 7/19/2012 the surveyor noted that 6 out of 14 sampled residents did not have a comprehensive care plan that included measurable objectives and timetables. As a plan of correction to this issue, the Director of Nursing (former MDSC) updated care plans for all residents to reflect the date of onset as well as the next evaluation date. All care plans at that time were evaluated and revised according to nursing notes, charts, and assessments. The Director of Nursing reviewed the care plan policy with the MDSC. 10 charts per month Will be audited to identify issues with non-compliant careplans. The process for care-planning will be to put in a note to reflect the previous revision. The monitoring results will be reported to ECU's QA committee every other month as well as Clinical Care and Quality committee. This monitoring tool will be used for six months.</p>	8/16/12

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F 279	<p>Continued From page 3</p> <p>failure to thrive, osteoporosis, hypertension and dementia. The facility had developed a care plan for the resident but had no initiation dates and incomplete review dates on the care plan.</p> <p>In an interview on 7/19/12 at 10:10AM, the facility's MDS coordinator who develops the resident care plans revealed she failed to put an initial date and review date on Resident #31's care plan. In an interview on 7/19/12 at 10:10AM, the facility's Director of Nursing stated that her expectation was that the resident care plans would have the date they were initiated and a review date 90 days later, or whatever the facility assessed the date of review needed to be.</p> <p>2. Resident #32 was admitted to the facility on 3/9/12 and discharged on 5/30/12. The resident has cumulative diagnoses that included end-stage chronic obstructive pulmonary disease, congestive heart failure, atrial fibrillation, depression, osteoarthritis, neuropathy, anxiety, anemia, and atherosclerotic coronary vascular disease. Review of the resident's record showed there was no care plan developed for the resident.</p> <p>In an interview on 7/19/12 at 10:02AM, the facility's MDS coordinator who develops the resident care plans revealed she could not find a care plan for this resident. The MDS coordinator further stated that the facility uses an online care plan website. She called the care plan website support service 7/16/12 and they indicated that when the MDS coordinator went into the site to discharge a resident, she may have deleted that resident's care plan. The MDS coordinator further stated that she thought when she discharged the</p>	F 279			

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F 279	<p>Continued From page 4</p> <p>resident at the online site, the resident 's care plan went to an archive but was informed they would not archive. The website could not retrieve Resident #32's care plan.</p> <p>In an interview on 7/19/12 at 10:02AM, the facility's Director of Nursing stated that their computer system is more for acute care since the facility is hospital based. She further stated that the acute care system did not individualize care plans so the facility started using the online care plan site.</p> <p>3. Resident #35 was admitted to the facility on 8/9/11 with cumulative diagnoses that included Alzheimer's disease, chronic obstructive pulmonary disease, cerebrovascular accident, transient ischemic attack, hypertension, anxiety, depression and psychosis. The facility had developed a care plan for the resident but had no initiation dates or review dates on the care plan.</p> <p>In an interview on 7/19/12 at 10:10AM, the facility's MDS coordinator who develops the resident care plans revealed she failed to put an initial date and review date on Resident #31's care plan. In an interview on 7/19/12 at 10:10AM, the facility's Director of Nursing stated that her expectation was that the resident care plans would have the date they were initiated and a review date 90 days later, or whatever the facility assessed the date of review needed to be.</p> <p>4. Resident #4 was admitted to the facility on 12/7/07 with a cumulative diagnosis of Hypertension, Cerebrovascular disease, left side weakness, diabetes mellitus type II, history of reactive airway disease/asthma, degenerative</p>	F 279			

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F 279	<p>Continued From page 5</p> <p>joint disease, delusional ideations. Residents Care Area Assessment (CAA) dated 5/31/12 reveals the resident requires total assistance to complete Activities of Daily Living.</p> <p>Review of Resident #4 Care Plan revealed the resident had a Plan of Care for: Pressure Ulcers, Nutrition, falls, incontinence, and cognitive loss/dementia. The Care plan did not identify a date of onset for resident problem/need or a date in which the goals would be reviewed.</p> <p>During an Interview on 7-19-12 at 10:52am, the MDS Coordinator indicated resident # 4's care plan did not have an onset date or a date in which the Care Plan would be revised. MDS coordinator further indicated the facility utilizes Careplan.com to formulate goals for the residents. The MDS coordinator stated in the instance she changes a date or changes a goal the dates are removed.</p> <p>During an interview on 7-19-12 at 11:19am the director of nursing revealed it is the expectation that care plans are up to date and measurable.</p> <p>5. Resident #8 was admitted to the facility to the facility on 3-13-12 with a cumulative diagnosis of: right hip fracture after a fall, hypertension, history of congestive heart failure, leukocytosis, and history of back surgery. Resident Care Area Assessment (CAA) dated 5/1/12 identified the resident as requiring extensive assistance to complete Activities of Daily Living.</p> <p>Review of residents #8 care plan revealed resident had a Plan of Care for: assistance with ADL ' s, potential for pain, skin integrity and</p>	F 279			

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F 279	<p>Continued From page 6</p> <p>immobility, nutrition, socialization and discharge needs. The Care Plan did not identify a date of onset date for the resident problem/need or a date in which the goals would be reviewed.</p> <p>During an Interview on 7-19-12 at 10:52am, the MDS Coordinator indicated resident #8's care plan did not have an onset date or a date in which the Care Plan would be revised. MDS coordinator further indicated the facility utilizes Careplan.com to formulate goals for the residents. The MDS coordinator stated in the instance she changes a date or changes a goal the dates are removed.</p> <p>During an interview on 7-19-12 at 11:19am the director of nursing revealed it is the expectation that care plans are up to date and measurable.</p> <p>6. Resident #21 was admitted to the facility on 12/21/09 with a cumulative diagnosis of hypertension, hypothyroidism, atypical psychosis, right below the knee amputation, secondary to pulmonary vascular disease, peripheral artery disease, Deviated left foot, and left foot decubitis. Residents Care Area Assessment (CAA) dated 4/11/12 reveals the resident requires total assistance with Activities of daily living and does not appear to aware of her surroundings.</p> <p>Review of resident #21 care plan revealed the resident had a Plan of Care for: risk for developing pressure ulcers, Potential for complications/discomfort related to diagnosis of Pulmonary Vascular disease, assistance with Activities of Daily Living (ADL 's), and potential for falls. Care Plan did not identify a date of onset for resident problem/need or a date in</p>	F 279			

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F 279	Continued From page 7 which the goals will be reviewed. During an interview on 7-19-12 at 10:52am, the MDS Coordinator indicated resident #21's care plan did not have an onset date or a date in which the Care Plan would be revised. MDS coordinator further indicated the facility utilizes Careplan.com to formulate goals for the residents. The MDS coordinator stated in the instance she changes a date or changes a goal the dates are removed. During an interview on 7-19-12 at 11:19am the director of nursing revealed it is the expectation that care plans are up to date and measurable.	F 279			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	Based on the state survey ending on 7/19/2012 the surveyor noted that The facility failed to update comprehensive care plans according to the facility policy. As a plan of correction to this issue, the Director of Nursing (former MDSC) updated care plans for all residents to reflect the date of onset as well as the next evaluation date. All care plans at that time were evaluated and revised according to nursing notes, charts, and assessments. The Director of Nursing reviewed the care plan policy with the MDSC. 10 charts per month will be audited to identify issues with non-compliant careplans. The kardex will be updated as needed by the nursing staff. The process for careplanning will be to put A note to reflect the previous careplan revision. The monitoring results will be		

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F 280	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review the facility failed to update comprehensive care plans according to facility policy for 1 of 5 sampled residents (resident #8). Findings include: Resident #8 was admitted to the facility to the facility on 3-13-12 with a cumulative diagnosis of: right hip fracture after a fall, hypertension, history of congestive heart failure, leukocytosis, and history of back surgery. The Minimum Data Set (MDS) dated 5/1/12 identifies the resident as being coded as dependent for Activities of Daily living (ADL) with a BIM's score of 11. Review of resident #8 care plan dated 3-20-12 revealed the resident had a Care Plan for high risk of falls related to weakness and fall history. The resident 's goal is to remain free of falls and/or fall related injury throughout next review date. Care plan reveals a review dated of 5-16-12. The facility records did not have an updated or revised Care Plan for resident #8. During an Interview on 7-19-12 at 10:52am, the MDS Coordinator indicated revisions to resident care plans are to be completed by the MDS coordinator. The MDS coordinator further revealed there is no current system in place to alert the need for revisions to care plans. The MDS coordinator indicated that Care Plan revision dates are placed on a calendar as reminders to review resident Care Plans. The	F 280	reported to ECU's QA committee every other month as well as Clinical Care and Quality committee. This monitoring tool will be used for six months. The MDSC will complete the audits.	8/16/12	

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F 280	Continued From page 9 MDS coordinator stated resident #8 care plan expired and should have been revised or updated on 5-16-12.	F 280		
F 312 SS=D	During an interview on 7-19-12 at 11:19am the Director of Nursing revealed it is the expectation that care plans are up to date and measurable. 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 observation, staff interview, and record review the facility failed to provide incontinent care and skin care for 1 of 2 sampled residents (Resident #3) who were dependent on staff for activities of daily living (ADL) and toenail care for 2 of 3 sampled Residents. (Resident #14 and Resident # 8) Finding included: 1. Resident #3 was admitted on 06/22/09 with the diagnoses of traumatic brain injury, dementia, dysphasia, and chronic obstructive pulmonary disease. Review of the minimum data set (MDS) dated 6/13/12, revealed Resident #3 was severely impaired of cognition and judgment. She required total assistance with activities of daily living (ADL), bathing, and bed mobility and	F 312	Based on the survey ending on 7/19/2012 the surveyor noted that the facility failed to provide incontinent and skin care for 1of 2 sampled resident who were dependent on staff for ADL's and toenail care for 2 of 3 sampled residents. inservice training was provided to all staff regarding survey deficiencies and the plan of correction for each. The staff was instructed on how to provide incontinent care as well as skin care. Any staff that provides direct patient care was required to be check off on giving a complete bed bath with emphasis on peri-care and catheter care. All residents were assessed for the need for toenail care. Referrals were made for 2 to have toenails cut by a physician and the others trimmed and filed by nursing. The weekly skin assessment form will be changed to reflect the interventions regarding long and thick toenails. The Director of Nursing will be notified by phone or email of any resident that has toenails that may need further treatment. If the Director of Nursing feels the	

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F 312	<p>Continued From page 10</p> <p>transferring Care Area Assessment dated 6/13/12, indicted Resident #3 has contractures to the upper and the lower body. She was total care at all times. She was not resistant or decline care at any time. She gets a shower 2xs a week and a partial bath on other days. She was totally incontinent of bowel and bladder and has to be check frequently.</p> <p>During an observation of bathing on 7/18/12 at 10:30 am, aide #1 rolled Resident #3 on to her left side and her legs were not positioned to facilitate cleansing of the perineum. The soapy cloth was used and she was wiped from between the legs up through the buttock area. The area was not rinsed. It was dried. When asked about the cleaning of the perineum area aide #1 indicated the perineum had been cleaned she then took the cloth was turned it and with second wipe completed the washing of the genital area. Aide #1 indicated the wiping motion from the front of the vagina to the buttocks was enough to clean the folds of the vagina. Resident #3's back was then wiped using the same cloth. The water was not changed during the demonstration. Aide #1 indicted this was suitable cleaning for this resident. A family member used to wash her this way. Aide #1 was asked if the contracted hands were cleaned, upon opening the hands a foul odor was noted. She had no comment regarding the lack of cleaning the hands. Resident # 3 legs and feet were not bathed. Hair was not combed. No deodorants were used.</p> <p>During an interview on 7/19/12 at 8:51am, aide # 3 indicted when giving bed bath the resident was to be kept covered except for the area cleaned. After washing the arms torso and using deodorant the shirt would be put on. The peri</p>	F 312	<p>toenails cannot be trimmed by the staff the physician will be notified. This issue will be monitored monthly by auditing 8 to 10 skin assessments to ensure interventions takes place. Results will be reported to ECU's QA committee every other month as well as the Clinical Care and Quality committee. Monitoring will be ongoing. The Director of Nursing or designee will monitor for six months.</p>	8/16/12

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F 312	<p>Continued From page 11</p> <p>area would be clean by separating the labia and wiping front to back making sure to get the folds area. The partial bed bath was done on days that are not shower days. On shower days if a shower was not given then a total bed bath was done. Total bed bath would include the legs and feet.</p> <p>During an interview on 7/19/12 at 11:19 am, the director of nursing indicated her expectation was the aide to give complete ADL care and the vaginal area should be separated and cleaned front to back using a cloth with soap and water, careful not to introduce contaminates into the urethral area.</p> <p>2. Resident # 14 was admitted to the facility on 12/16/08 with diagnoses in part , dementia , urinary tract infection and peripheral vascular disease. Review of the minimum data set (MDS) dated 6/21/12, revealed she was severely impaired with cognition and judgment and was totally dependent for bathing, and hygiene.</p> <p>Record review of the aide care card revealed it had no date and she required complete assistance with bathing. The nail care section was left unmarked.</p> <p>During an observation of bathing on 7/18/12 at 11:00 am, Resident #14 toenails were observed to be long, thick and yellowed. The nail curled around the end of the right and left first toes, no nails were noted on the left foot 2nd toe and 5th toe right foot the remaining toe nails were observed to be long. Aide #1 indicated Resident # 14 like didn ' t like anyone to mess with her feet</p>	F 312			

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F 312	<p>Continued From page 12</p> <p>During an interview on 7/18/12 at 11:18 am, nurse #1 observed Resident #14 nails were long and curled and indicated the house doctor may need to come in and cut them.</p> <p>During an interview on 7/19/12 at 8:48 am, Resident # 14 indicated she wanted her toe nails s cut and that they were very painful.</p> <p>During an observation on 7/19/12 at 9:25 am , nurse # 2 observed the toe nails of Resident #14 and indicted the nails were very long and curled. She indicated the aid would be able to trim Resident #14 nails, she was not diabetic. She conclude by saying the toenail clippers were kept in the med room and the nails should be trimmed on shower days which were Monday and Wednesday for Resident #14.</p> <p>During an interview on 7/19/12 at 10:47 am, the hospice aid indicated she bathed Resident # 14 on Tuesday and Thursday. She indicted she filed and painted the finger nails she had not provide toe nail care. She indicated she had reported to the nurse in charge the nails were long and that Resident #14 had complained they were painful and she wanted them cut.</p> <p>3. Resident #8 was admitted to the facility to the facility on 3-13-12 with a cumulative diagnosis of: right hip fracture after a fall, hypertension, history of congestive heart failure, leukocytosis, and history of back surgery. The minimum Data Set dated 5-1-12 identifies the resident as being coded as total assistance for Activities of Dally Living (ADL) and further indicates the resident as having a BIM ' s core of 11.</p> <p>A review of residents care plan dated 3-20-12</p>	F 312			

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F 312	<p>Continued From page 13</p> <p>revealed the resident is care planned for Activities of Daily Living (ADL). Care Plan indicates the resident requires assistance with ADL's: requires staff intervention or assistance to remain clean, neat and free of body odors. Approaches identified with ADL care are to provide/assist with bath or shower 2-3 times weekly, more often as desired by resident, oral care two times daily (BID) and as needed (PRN); Grooming and personal hygiene daily and as needed (PRN).</p> <p>A review of resident #8 medical records reveal no documentation regarding nail care being provided by the facility nor consultation from a specialist (podiatry) since date of admission on 3-20-12.</p> <p>Observation on 7-18-12 at 4:15pm revealed the resident in bed, heels floating with feet exposed. Resident toe nails were observed to be long and thick. Resident stated she did want her toenails cut. The resident revealed prior to admission she received nail care from a doctor. Resident communicated she would like to have her nails cut if someone would cut them.</p> <p>Interview with Nursing Assistant (NA) #7 on 7-18-12 at 4:30pm indicated that resident nails are supposed to be checked during bath days. The NA further indicated NA's communicate resident toe nail care needs to the Licensed Practical Nurse (LPN); or the Registered Nurse (RN) who would make the determination if the nails will be cut in house or to contact a podiatrist.</p> <p>On 7/18/12 at 4:35pm the Director of Nursing (DON) observed resident #8 toenails and indicated the resident's toenails were long and in need of trimming. The DON revealed the</p>	F 312			

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F 312	Continued From page 14 residents toe nails would need to be cut by a specialist due to the thickness of the residents toenails. Interview with Registered Nurse (RN) #2 on 7/19/12 at 9:21am revealed the NA make the RN aware of nail care needs following observation of nails during the resident 's bath. RN #2 indicated weekly skin assessments are completed by the RN who document the condition of toenails. The RN stated some residents require a specialist to safely cut residents toenail. In the instance a resident requires a specialist to provide nail care, the nurse would notify the physician to gain approval to schedule an appointment with a specialist. Review of facilities "shower schedule for CNA ' s" from 7-16-12 through 7-19-12 reveal shower days for resident #8 as occurring weekly on Tuesdays and Fridays. Review of the facilities "weekly Skin Assessments" revealed toe nails long and thick on 7/7/12; Toe nails long and thick (not dated); and Toenails thick and yellowish on 6-29-12. Further reviews of the facility record reveal Weekly skin assessment are signed by a Licensed Practical Nurse.	F 312		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315	Based on the state survey ending 7/19/2012 the surveyor observed that the facility failed to secure 2 of 2 sampled urinary catheters and provide thorough incontinent care of a urinary catheter. On 7/25/2012 inservice training was provided to all staff regarding the Urinary Catheter care policy. Policy states Secure catheter utilizing a leg band.	

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F 315	<p>Continued From page 15</p> <p>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: Based on observation, record review and staff interview the facility failed to secure 2 of 2 sampled urinary catheters. (Resident #14 and Resident # 62) and provide thorough incontinent care of a urinary catheter. The Findings include (Resident # 14)</p> <p>1. Resident # 14 was admitted to the facility on 12/16/08 with diagnoses in part, dementia, urinary tract infection and peripheral vascular disease. Review of the minimum data set (MDS) dated 6/21/12, revealed she was severely impaired with cognition and judgment and was totally dependent for bathing, and hygiene.</p> <p>Review of the Catheter care, Urinary policy from the Nursing Services Policy And Procedure Manual dated 10 / 2010, revealed The purpose of this procedure is to prevent catheter-associated urinary tract infections. This stated in part, " Assess the urethral meatus. For the female: Use a washcloth with warm water and soap to cleanse the labia. Use on area of the washcloth for each down ward, cleansing stroke. Change the position of the washcloth and cleanse around the urethral meatus. Do not allow the washcloth to drag on the resident skin or bed linen. With clean wash cloth, rinse with warm water using the above technique. Use the clean washcloth with warm water and soap to cleanse</p>	F 315	<p>leg bands were place on all residents with an indwelling catheter. All new admissions with a diagnosis that supports the use of an indwelling catheter will have a leg band to secure the catheter. The RN completing the admission will be responsible for placing the leg band on the resident The Director of Nursing or the MDSC will ensure compliance within 24 hours of admission by direct observation. The DON or designee will monitor all residents with catheters monthly for six months to ensure compliance. All new employees were provided inservice training on using leg bands for securing indwelling catheters. This will be part of the annual training for ECU employees.</p>	8/16/12	

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F 315	<p>Continued From page 16</p> <p>and rinse the catheter from the insertion site to approximately four inches outward. Secure catheter utilizing a leg band. "</p> <p>Review of the policy, dated October 2010, named " Perineal Care " revealed For a female resident: Wet washcloth and apply soap or skin cleansing agent. Wash Perineal area, wiping from front to back. (1) Separate labia and wash area downward from front to back (Note: If the resident has an indwelling catheter, gently wash the juncture of the tubing from the urethra down the catheter about 3 inches. Gently rinse and dry the area.)</p> <p>(2) Continue to wash the perineum moving from inside outward to and including thighs, Alternating from side to side, and using downward strokes. Do not reuse the same washcloth or water to clean the urethra or labia. (3) Rinse perineum thoroughly in same direction, using fresh water and a clean washcloth (Note : If the resident has an indwelling catheter, hold the tubing to one side and support the tubing against the leg to avoid traction or unnecessary movement of the catheter.) Gently dry perineum. Instruct or assist the resident to turn on her side with her top leg slightly bent, if able. Rinse wash cloth and apply soap or skin cleansing agent. Do not reuse the same washcloth or water to clean the labia. Rinse thoroughly using the same technique as described. Dry the area thoroughly</p> <p>During interview on 7/16/12 at 3:39 pm, nurse #3 indicated the medical diagnoses for the indwelling catheter to aide in the healing of the stage 4 pressure ulcer.</p> <p>During an observation of bathing on 7/18/12 at 11:00 am, Resident # 14 was observed to have an indwelling urinary catheter. Aide #1 was</p>	F 315		

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F 315	<p>Continued From page 17</p> <p>gloved, soap was used to a wet wash cloth. The legs were not spread, the labia and meatus were not cleaned. The portion of the catheter tubing that was exposed was wiped with the same cloth that was used to wash abdomen and lower pelvic area. Powder was sprinkled over the area. When Aide #1 asked was the folds of the vagina cleaned. Aide #1 indicated Resident #14 would not open her legs. During the observation aide #1 was asked was a leg strap used to anchor the catheter. She indicated, " No ". During an interview after the bathing observation, Resident #14 was asked if she would open her legs , she indicated " Yes. " Aide #1 made no attempt to clean Resident #14 she continued to put away the basin and toiletries.</p> <p>During an interview on 7/18/12 at 11:52 am , aide #2 indicated leg straps to secure the catheter tubing were used. The director of nursing gave the aides the leg straps. The care book indicated if an anchor was used. Review of the care book revealed in the toileting section Resident #14 used briefs for incontinence. The catheter section was not marked.</p> <p>During an interview on 7/18/12 at 11:54 am, the MDS nurse indicated leg straps were not used to secure indwelling urinary catheters. No reason was given for not using leg straps.</p> <p>During an interview on 7/18/12 at 12:14 pm, nurse #1 indicted leg straps were not used to secure indwelling catheters. Nurse #1 indicated they were not used in this building.</p> <p>During an interview on 7/18/12 at 12:20 pm the director of nursing indicated no leg straps are used for residents with catheters. She had no reason as to why the leg straps were not used.</p>	F 315			

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F 315	Continued From page 18 2. Resident # 62 was admitted on 3/12/12 , with diagnoses in part of urinary tract infection and hypertension and kidney stones and degenerative disk disease. Review of the minimum data set (MDS) dated 4/13/12 , revealed she was moderately impaired with cognition and judgment. Urinary incontinence was managed with an indwelling catheter and she had a current urinary tract infection. During interview on 7/16/12 at 3:00 pm, nurse #3 indicated the catheter medical diagnoses for the indwelling catheter was a neurogenic bladder . Review of the care book revealed the care sheet was missing. The MDS coordinator indicated 7/18/12 at 12:00pm , she would make a new sheet. During an observation on 7/18/12 at 12:14 pm , Resident #62 indicated to nurse #1 that the catheter was, " stuck up inside her and it was hurting. " Nurse #1 checked the catheter. She adjusted the catheter tubing from under the abdominal fold. There was no leg strap to secure the catheter. Nurse #1 indicated leg straps were not used to secure catheter tubing. During an interview on 7/18/12 at 2:37 pm the director of nursing indicated she had the staff put leg straps on all resident ' s who have indwelling catheters she couldn ' t think of a reason why resident had no catheter leg straps. She indicated she misunderstood the question in her prior interview.	F 315			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a	F 318	Based on the state survey ending 7/19/2012 the surveyor observed that the facility failed to ensure that a resident with limited ROM received appropriate treatment and services to increase ROM and/or prevent further decrease. All splint orders will be put on the nursing treatment sheet. Nursing will be responsible for ensuring that the splints are on		

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F 318	<p>Continued From page 19</p> <p>resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility for 1 failed to maintain a program to address contractures of 2 sampled residents. (Resident #3)</p> <p>Finding included:</p> <p>Resident #3 was admitted on 06/22/09 with the diagnoses of traumatic brain injury, dementia, dysphasia, and chronic obstructive pulmonary disease.</p> <p>Review of the minimum data set (MDS) dated 6/13/12 revealed Resident #3 was severely impaired of cognition and judgment. She required total assistance with activities of daily living, bed mobility and transferring. She had impairment to her right and left upper and lower extremities. She was not receiving physical therapy or restorative nursing of passive, active range of motion or a splinting. Care Area Assessment dated 6/14/12 indicted Resident #3 had contractures to the upper and the lower body.</p> <p>Record review revealed no care plan addressing splinting, range of motion. Review of the treatment record for the month of 07/2012, no range of motion or splinting program.</p>	F 318	<p>properly daily. A resident assessment schedule will be given to the rehab department. Residents will be screened for therapy services quarterly when assessments are due. Therapy will be given the schedule by the last day of the month by the MSDC. Any new recommendations will be written up by therapy and education provided from that department. The recommendations will be given to the MDSC. Training on recommendations for residents discharged from therapy will be provided by the therapy department. All care plans were revised to reflect the use of a new or existing program. There will be a monthly review, evaluation, and documentation of the recommended programs by a unit designee. Documentation and reviews will be kept in the chart. Any concerns will be reported to the MD within 24 hours of review. Documentation will be kept in a restorative log at the nurses station.</p>	8/16/12	

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F 318	Continued From page 21 2:37pm, a director of physical therapy indicated palm guards and soft splints were ordered for Resident #3. She indicted a family member had been trained how to apply and remove splints; he passed away this Spring and the facility had not continued the program. The equipment was found in the room. She indicated the occupational therapist would reevaluate tomorrow and train the staff. During an interview on 7/18/12 at 3:12 pm, nurse #1 indicted she had seen hand rolls in Resident #3 hands in the past but she had not seen them in a while. If nursing had a splinting program it would be on the treatment administration record (TAR). She reviewed the TAR dated 7/1/12 and indicated no splinting or range of motion (ROM) program was in place. During an interview on 7/18/12 at 3:30 pm, the director of nursing indicated there were two restorative aides. One was out on medical leave and the other was working as an aide. Residents were not receiving restorative services.	F 318		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	Based on the survey ending on 7/19/2012 the surveyor noted that dietary did not meet the requirements of storing, preparing, distributing, and serving food under sanitary conditions. The DM has removed clear storage containers. Dry products such as pasta, beans and rice are being ordered with dates on them. When dry products such as pasta, rice, and beans are opened all unused portions are stored in Ziploc	

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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 371	<p>Continued From page 22</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record review, the facility failed to 1) label dry container bins with food products and remove ladles from bins; 2) separate dented cans from ready-to-use food items; 3) ensure food items in one of one walk-in refrigerator were labeled when taken out of the original container; and 4) ensure equipment in the food preparation area was clean and in sanitary conditions and keep exhaust hood filters clean and free of dust and grease. Findings include:</p> <p>1. During an observation of the kitchen dry storage area on 7/16/12 at 10:00 a.m., the following dried products were observed unlabeled: 1 clear container with egg noodles, 1 clear container with macaroni, 1 clear container with black-eyed peas, 1 clear container with rice, 1 clear container with navy beans, and 1 clear container with fettucini noodles. Ladle handles were touching the products. Further inspection revealed 1 open, undated, unlabeled bag of stove-top stuffing in a box on a shelf, 1 package of 12-count hamburger buns with green mold around the edges, and 6 packages of 24-count hot dog buns with hard edges and mold. The dietary manager (DM) indicated that the rolls must have been taken from the freezer because it was not the bread product used for the facility.</p> <p>During an interview with the dietary manager (DM) on 7/16/12 at 10:15 a.m., he identified the products and indicated that he was unaware the products should be labeled once they have been removed from the package and put into the</p>	F 371	<p>bags with the date opened. The DM in serviced staff on 7/16/12 and 7/17/12 on storing and labeling food. The exhaust hood filter has been added to the biweekly cleaning list. The exhaust hood system will remain on a quarterly contract cleaning schedule. Cans will be inspected for dents when cases are delivered as well as rechecked during daily walk through's. Cans will also be checked during weekly inventories. Staff has been in serviced on 7/16/12 on washing and storing dishes. The DM or designee will check for any outdated items, labels, dented cans, bread, pans, filters, bowls, lids, meat slicer daily. The DM has also added these items in the walk through check off list. Monitoring will be ongoing and reported to ECU's QA committee every other month as well as Clinical Care and Quality committee.</p>		

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F 371	<p>Continued From page 23</p> <p>container. He added that the scoops should not have been left in the containers.</p> <p>2. During an observation of the kitchen dry storage area on 7/16/12 at 10:00 a.m., the following dented cans were located on the shelf with other undamaged cans: 2 cans of pineapples, 2 cans of pears, and 8 cans of mandarin oranges. The DM indicated that the expectation was that the stock person should check the cans for dents before placing them on the shelves, and the dented cans should be returned to the vender.</p> <p>3. During the kitchen tour on 7/16/12 at 10:20 a.m., the following opened, unlabeled, or undated items were observed in one of one walk-in freezer: 1 package of dinner rolls, 1 box of open turkey patties, 1 bag of open squash and 7 angel food cakes.</p> <p>During an interview with DM he indicated that all opened food products should be dated/labeled when opened.</p> <p>4. During an kitchen observation on 7/16/12 at 10:00 a.m., the following products were observed opened, unlabeled, and/or undated in one of one walk-in cooler: 2 opened loaves of sliced cheese, 1 silver container of a red substance dated 7/10/12, 1 black container of chicken that had red drippings on top of the aluminum foil, an opened bag of coleslaw, 4 cartons of expired milk dated 6/14/12 (2 cartons) and 7/15/12 (2 cartons). The DM identified all the items in the cooler and indicated that the opened items should have been resealed properly, dated,</p>	F 371		

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F 371	<p>Continued From page 24</p> <p>and labeled. The red substance on the aluminum foil that covered the chicken was identified as blood, and the DM indicated that the foil should not have been on the container of chicken with the substance on it. The red substance in the silver container was identified as ketchup and should have been discarded after three days. He further indicated that the stock person should check all milk cartons and expiration dates and discard items past their expiration.</p> <p>5. During the initial tour of the kitchen on 7/16/12 at 10:00 a.m and 7/18/12 at 10:35AM., the exhaust hood filters above the stove were heavily coated with grease and dust. The slicer had several dried food particles throughout, and 4 meal carts had dried food particles throughout the inside.</p> <p>6. Observation of the kitchen on 7/18/12 at 10:35 a.m. found the following: dome lids were wet or had food particles on them, 15 domes located on the drying rack had dried food particles/substances on the inside, dried food particles were found in 41 wet salad bowls that were stacked on top of one another and in the crate where they were stored, and 5 cups were stored with dried substances and particles.</p> <p>During an interview on 7/18/12 10:35AM with the DM, he indicated that all refrigerated/frozen items that have been opened should be labeled and dated. The slicer should be cleaned after every usage. The dishwashing staff was responsible for ensuring that all dishes were clean and free of leftover particles prior to storage on the drying racks, and the meal carts should be cleaned daily. The DM indicated that he was</p>	F 371			

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F 371	Continued From page 25 unaware that dishes stacked in crates could not be stacked on top of one another while they were drying for the next usage. He indicated that the wash cycle was 160 and rinse cycle was 180 and that the dishes should be dried before they were stacked in the crates. The crates should also be run through the dishwasher as well to ensure they are free of food particles. The DM further stated that the facility staff did not clean the hood or the ovens when there was heavy grease built up. The service for cleaning was contracted out. Staff was responsible only for wiping down basic surfaces of the ovens on the outside.	F 371			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to act on the pharmacist consultant's recommendation for 1 of 10 sampled residents	F 428	Based on the state survey ending on 7/19/2012 the surveyor noted that the facility failed to act on the pharmacist consultant's recommendation for 1 of 10 sampled residents. The staff development nurse will develop a log and monitor all lab recommendations. Nursing was inserviced on the importance of forwarding physician responses to the SDC for verification. Any discrepancies in follow-up will be reported to the DON. The staff developer will conduct monthly audits on all lab recommendations. Results will be reported to ECU's QA committee as well as Clinical Care and Quality committee for six months.	8/16/12	

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F 428	<p>Continued From page 26</p> <p>reviewed for lab results (Resident #21). Findings included:</p> <p>Resident #21 was admitted to the facility on 12/21/09 with cumulative diagnoses that included peripheral vascular disease, osteopenia, osteoporosis, Alzheimer's disease and hypothyroidism. Resident #21 was on Furosemide (a potassium depleting diuretic) 20 mg. (milligrams) daily. The resident was not on a potassium supplement. The last lab to check the potassium level for Resident #21 was September 2011.</p> <p>On 3/26/12, the facility's consultant pharmacist made a recommendation to Resident #21's physician to obtain a BMP (basic metabolic panel) for the resident. This lab would check the resident's potassium level. The resident's physician replied, "More comprehensive ordered. Obtain CMP (comprehensive metabolic panel) on 4/19/12." On 5/15/12, the facility's consultant pharmacist informed the facility in her recommendation that the physician ordered the CMP on 4/19/12. In her note to the facility, the consultant indicated, "Unless otherwise indicated, please follow up with the lab and have results forwarded to the facility."</p> <p>In an interview on 7/18/12 at 3:39PM, the facility's consultant pharmacist stated that the facility does not have lab protocols because the physician doesn't want lab protocols. She further stated that "On the 3/26/12 recommendation, the facility had a new person in facility doing the pharmacist recommendations. I asked her if she had done this recommendation for 5/15/12. She said it was already done. The facility can't locate the</p>	F 428			

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F 428	Continued From page 27 response. I have asked the facility to go ahead and get the lab today." In an interview on 7/18/12 at 4:01PM, the facility's staffing coordinator stated that she handles the consultant pharmacist recommendations. She further revealed that when the physician writes on a pharmacist consultant sheet, he faxes it back to the facility. The ward secretary gets the signed recommendation back and distributes it to the nurse that has that resident that day. The nurse writes the order on a telephone sheet as a faxed order. The staffing coordinator stated, "I think this didn't get to the nurse, it just got filed under the pharmacy recommendations before the nurse got the order. The 5/15/12 recommendations went to the DON (Director of Nursing). Once the DON reviews them, she gives them to me and I research them and do the corrections. I received this stack on 6/21/12. I read it, took it back to the DON, and told her I thought they were duplicates. The DON said she would find the original and go from there. From that point, I don't know what she did with the recommendations. The current stack I just got, this resident's BMP wasn't in there. I looked in the computer and the lab hadn't been done. I would typically reorder the lab but I thought that batch of recommendations had been done. I didn't look through the individual recommendations for 5/15/12-5/30/12".	F 428			
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.	F 441	Based on the state survey ending on 7/19/2012 the surveyor noted that the facility must establish and maintain an Infection Control Program. As a plan of correction to this issue, the Director of Nursing provided an in-service to all staff in regards to preventing the spread		

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F 441	Continued From page 28 (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 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 observation, staff interview, and record review the facility follow contract isolation policy and procedures for 1 of 1 sampled resident. (Resident #3)	F 441	of infection. Staff was given the IC and PPE policy for review. Signs and isolation equipment will be placed on the room door for staff as well as visitors. Staff was educated on the importance of gloving, handwashing, and proper disposal of contaminated material. Care plans will be reviewed and revised to reflect isolation. Isolation material to be thrown away or will be placed in a red bag for proper disposal. The Director of Nursing or designee will monitor all isolation residents monthly to ensure compliance. Results of the audits will be reported ECU's QA committee as well as Clinical Care and Quality committee for six months. Infection control will be a part of the annual training for ECU employees.	8/16/12

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F 441	<p>Continued From page 29</p> <p>Finding included:</p> <p>Resident #3 was admitted on 06/22/09 , with the diagnoses of traumatic brain injury, dementia, dysphasia, and chronic obstructive pulmonary disease.</p> <p>Review of the minimum data set (MDS) dated 6/13/12 , revealed Resident #3 was severely impaired of cognition and judgment. She required total assistance with activities of daily living, bed mobility and transferring. She had impairment to her right and left upper and lower extremities. Care Area Assessment dated 6/14/12 ,indicted Resident #3 had contractures to the upper and the lower body.</p> <p>Review of the Nursing Services Policy and Procedure Manual dated December 2007, revealed in part, Policy Statement Standard Precaution shall be used when caring for residents at all times regardless of there suspected or confirmed infection status. Transmission -Based Precautions shall be used when caring for resident who are documented or suspected to have communicable disease or infections that can be transmitted to others.</p> <p>f. Signs - The facility will implement as system to alert staff to the type of precaution resident requires.</p> <p>(2) The facility will also ensure that the resident 's care plan and care specialist communication system indicates the type of precautions implemented for the resident.</p> <p>Contact Precautions</p> <p>1. In addition to wearing gloves as outlined under Standard precautions , wear gloves(clean,</p>	F 441			

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F 441	<p>Continued From page 30</p> <p>non-sterile) when entering the room.</p> <p>2. While caring the a resident, change gloves after having contact with infective material (for example, fecal material and wound drainage).</p> <p>3. Remove gloves before leaving the room and wash hands immediately with antimicrobial agent or a waterless antiseptic agent.</p> <p>4. After removing gloves and washing hands, do not touch potentially contaminated environmental surfaces or items in the resident ' s room.</p> <p>1.Gown In addition to wearing a gown as outlined under standard precautions wear a gown (clean, nonsterile) for all interactions that may involve contact with the resident or potentially contaminated items in the resident environment. Remove the gown and perform hand hygiene before leaving the resident ' s environment.</p> <p>2. After removing the gown, do not allow clothing to contact potentially contaminated environmental surfaces.</p> <p>Review of the care card had no date, there was no documentation of contact isolation precautions. Record review revealed no care plan addressing contact isolation.</p> <p>Review of the physicians order dated 7/3/12, indicated " patient contact precautions. " Review of the physicians order dated 7/17/12, indicated " continue isolation precautions. "</p> <p>Record review of Case Mix ADL Data sheet 7/15-21/2012, indicate in large letters , " CONTACT ISOLATION. "</p> <p>During an observation that began on 7/18/12 at</p>	F 441			

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F 441	<p>Continued From page 31</p> <p>10:30 am, aide #1 was observed ungloved pulling on a cloth under pad from under Resident #3. When asked was Resident #3 on contact isolation the Aide #1 answered, " Yes, but she (the aide) does not have to use gloves unless the patient had a bowel movement ". When directed to the signage on the door :</p> <p>Review of the signage posted on the door revealed :</p> <ul style="list-style-type: none"> · Perform hand hygiene before entering and before leaving room. · Wear gloves when entering room or cubicle, and /or touching patient ' s intct skin, surfaces, or articles in close proximity · Wear gown when entering room or patient cubicle or if clothing will touch patients items · Use patient-dedicated or single-use disposable shared equipment or clean and disinfect shared equipment (BP cuff, thermometers) between patients. <p>Aide #1 gowned and gloved and began to bathe Resident#3. After completing the bath, she removed her gown and gloves and placed them into the garbage.</p> <p>She indicated she knew she was doing it wrong and carried the dirty linens with her ungloved hands in to the hall way. She placed them into a community hamper, located in the hallway. She returned to the room and washed her hands. She then pushed the linen to the soiled utility room.</p> <p>During an interview on 7/18/12 at 4:30 pm, the director of nursing indicted residents who were on contact isolation have all linens bagged in a blue bag before leaving the room and disposed of in a dirty linen room to prevent contamination with</p>	F 441			

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F 441	<p>Continued From page 32 the other lines.</p> <p>During an interview on 7/19/12 at 8:26 am, the environment services director indicated linens and gowns were sent out to a contracted vender. Blue bags were for linens and the red bag was for the contaminated linen. He was not sure how the nursing home handled the contaminated linens.</p> <p>During an interview on 7/19/12 at 8:51 am, aide # 3 indicated residents when working with a resident who was on contact isolation. She was gowned and gloved at any time she was in contact with the resident. All linen was place into a blue bag and tied then taken to the soiled linen room and hands were washed.</p> <p>During an interview on 7/19/12 at 9:10 am, aide #5 indicated if a resident was on contact isolation, the gowns and gloves were in a caddy on the door. The gown and gloves are put on before entering the room. A blue bag was brought in to remove the linen. After she completed the procedure, the contaminated linen in the bag was tied and the bag taken to the soiled linen room. She then removed her gown and gloves and discarded them in to a trash bag. She washed her hands and disposed of the blue bag into the soiled linen room and washed her hands again.</p>	F 441			

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K 000	INITIAL COMMENTS Surveyor: 27871 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 I construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows: NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by:	K 000		
K 018 SS=D		K 018	The door in room 259 was fixed to close properly by tightening up the hinge on the frame and door. This was corrected on August 22, 2012	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
Gannia Rudder 9-7-12 Interim DPO

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

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

PRINTED: 08/25/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345004	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2012
NAME OF PROVIDER OR SUPPLIER PERSON MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 615 RIDGE RD ROXBORO, NC 27573		
(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 018	Continued From page 1 Surveyor: 27871 Based on observations and staff interview at approximately 11:30 am onward, the following items were noncompliant, specific findings include: door to room 259 would not close and latch for smoke tight seal.	K 018			
K 052 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 11:30 am onward, the following items were noncompliant, specific findings include: there was no audible or visual signal at fire alarm control panel with loss power and telephone connection. 42 CFR 483.70(a)	K 052	The fire alarm panel didn't respond when we disabled the power to the system. we checked with the monitoring company and they didn't get any response either. I called the monitoring company and had a tech to come on site and trouble shoot the problem. The problem was corrected on the evening of August 22, 2012. The tech upgraded the firmware for card 24 and warm started the panel to correct the issue. We both went to the panel and did a power lost test and the ER Dept. confirmed the trouble on card 24 for power loss. Attached is a copy of the ticket from Simplex Grinnell on the problem and the correction. The panel are all connected to the main panel by data link and the main panel has the telephone connection when disconnected shows a trouble also to the ER and the monitoring company		

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

RECEIVED
SEP 10 2012
CONSTRUCTION SECTION

PRINTED: 08/25/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345004	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 08/22/2012
NAME OF PROVIDER OR SUPPLIER PERSON MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 815 RIDGE RD ROXBORO, NC 27573		
(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	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Harmonia ...* TITLE *Interim DPO* (X6) DATE *9-7-12*

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345004	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/22/2012
NAME OF PROVIDER OR SUPPLIER PERSON MEMORIAL HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 816 RIDGE RD ROXBORO, NC 27573	
(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
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