DEC 10 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	11/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBASSADOR HEALTH & REHAB OF WADESBORO, LLC	2051 COUNTY CLUB ROAD WADESBORO, NC 28170

(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 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes:	F 156	Preparation and submission of this plan of correction by **Ambassador Health & Rehab of Wadesboro, LLC** does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gary L Lookabell — TITLE: Administrator — (X6) DATE: Revised: 12/04/12

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 156	Continued From page 1 A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's	F 156		

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F 156	Continued From page 2 policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to provide the reason for change in Medicare coverage, provide the contact information in the event an appeal was desired as well as provide the date the Liability Notice was sent for 3 of 3 sampled residents (Residents # 39, 4 and 22). The findings include: 1. A record review was conducted on 11/1/12 in the business office. It revealed that Resident #39 was admitted to the facility on 3/16/12. A letter titled, Notice of Medicare Non-Coverage was given to him stating that his current Medicare coverage would end on 5/1/12, with the last day of coverage being listed as 4/30/12. The reason for coverage ended was not posted, nor was there a contact number shared in the event he wanted to request an immediate appeal:	F 156	F 156 1. Resident #39 Non-coverage Medicare benefits letter was updated by Business Office Manager on 11/20/12 to include reason for non-coverage, appeal phone contact number and sent certified mail to responsible party.	

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F 156	Continued From page 3 On 4/28/12, Resident #39 signed the form, to acknowledge receipt of the information. The Administrative Staff #3 was interviewed on 11/1/12 at 2:30 pm. She stated that the MDS (Minimum Data Set) nurses conveyed to her when a resident was scheduled to lose Medicare coverage, then she would meet with the resident or RP (responsible party) to get a signature to document that the notice was given. She stated that she does not date the form, include a phone number to request an appeal (until she was informed to do so in August, 2012) or provide a reason for service ending, because she didn't know it was required. She stated that whenever someone called her to ask why the Medicare service had ended; she referred them to MDS department, who could provide them with that information. 2. A record review was conducted on 11/1/12 in the business office. It revealed that Resident # 4 was admitted to the facility on 1/28/12. A letter titled, Notice of Medicare Non-Coverage was presented to her RP on 7/27/12, when the document was signed. It stated that her Medicare service would end on 7/30/12; the reason for cessation was unknown. The form also did not contain contact information in the event the RP wanted to request an immediate appeal. The Administrative Staff #3 was interviewed on 11/1/12 at 2:30 pm. She stated that the MDS (Minimum Data Set) nurses conveyed to her when a resident was scheduled to lose Medicare coverage, then she would meet with the resident	F 156	Resident #4 Non-coverage Medicare benefits letter was updated by Business Of Manager on 11/20/12 to include reason for non-coverage, appeal phone contact number and sent certified mail to responsible party. Resident #22 Non-coverage Medicare benefits letter was updated by Business Office Manager on 11/20/12 to include reason for non-coverage, appeal phone contact number and sent certified mail to responsible party. 2. An audit was completed by Business Office Manager on 11/19/12 related to resident's Non-coverage Medicare benefits letters that was issued in the past 30 days to ensure reason of non-coverage and appeal phone contact information was included as required. Follow up contact provided to the responsible party was completed as needed.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 156	Continued From page 4 or RP (responsible party) to get a signature to document that the notice was given. She stated that she does not date the form, include a phone number to request an appeal (until she was informed to do so in August, 2012) or provide a reason for service ending, because she didn't know it was required. She stated that whenever someone called her to ask why the Medicare service had ended; she referred them to MDS department, who could provide them with that information. 3. A record review was conducted on 11/1/12 in the business office. It revealed that Resident # 22 was admitted to the facility on 6/8/12. A letter titled, Notice of Medicare Non-Coverage was discussed with her RP over the phone, on 8/10/12. The RP was informed at that time, that Medicare coverage would end on 8/12/12, reason unknown. There was no phone contact information provided to the RP in the event she wanted to request an immediate appeal. The Administrative Staff #3 was interviewed on 11/1/12 at 2:30 pm. She stated that the MDS (Minimum Data Set) nurses conveyed to her when a resident was scheduled to lose Medicare coverage, then she would meet with the resident or RP (responsible party) to get a signature to document that the notice was given. She stated that she does not date the form, include a phone number to request an appeal (until she was informed to do so in August, 2012) or provide a reason for service ending, because she didn't know it was required. She stated that whenever someone called her to	F 156	3. Business Office Manager was re-educated by the Administrator on 11/2/12 related to the requirements of including reason for non-coverage and appeal phone contact information for letters of Notice of Non-Coverage. 4. The Administrator or Director of Nursing will complete an audit weekly for 4 weeks and monthly for 2 months to ensure Letters of Notice of Non-Coverage continue to include the reason for non-coverage and the appeal phone contact information as required. A report will be submitted to the Quality Assurance Committee monthly for 3 months. The Administrator is responsible for monitoring and follow-up. Date of Compliance: 11/28/12	11/28/12

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F 156	Continued From page 5 ask why the Medicare service had ended; she referred them to MDS department, who could provide them with that information.	F 156		
F 247 SS=B	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to give notice to the resident or the legal representative before getting a new room mate for 2 (Residents # 26 & # 66) of 3 sampled residents. The findings include: 1. Resident # 26 was admitted to the facility on 7/28/11. The latest quarterly MDS (Minimum Data Set) assessment dated 9/28/12 indicated that Resident #26's cognitive status was intact. On 10/29/12 at 3:40 PM, Resident #26 was interviewed. He stated that he did not receive a notice that he was getting a new room mate. He indicated that his current room mate was admitted in March, 2012 and he was not informed that he was coming. Review of the social services notes and nurse's notes revealed no documentation that the resident had received a notice of the new room mate. On 11/1/12 at 11:15 AM, the social service staff member was interviewed. She stated that she	F 247	F 247 1. Resident # 66's Responsible Party was notified on 11/16/12 by the Social Services Director related to the roommate change. Resident # 26 met with the Social Services Director on 11/16/12 related to the new roommate and any current concerns.	

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F 247	Continued From page 6 was aware that the resident or the legal representative had to be informed when there was a change in room but she was not aware that the resident or the legal representative had to receive a notice when there was a change in room mate. She further stated that she was new to this position but she could not find documentation that the resident had received a notice when he had a new room mate. On 11/1/12 at 2:38 PM, Nurse #2 was interviewed. She stated that the nursing staff or the social service staff informed the resident or the legal representative when there was a room change but not when there was a new room mate. 2. Resident #66 was admitted to the facility on 3/22/12. The significant change in status MDS assessment dated 9/7/12 indicated that Resident #66 had memory and decision making problems. Review of the records revealed that on 10/26/12, Resident #66 had a new room mate. There was no documentation in the nurse's notes or social services notes that the legal representative was informed of the new room mate. On 11/1/12 at 11:15 AM, the social service staff member was interviewed. She stated that she was aware that the resident or the legal representative had to be informed when there was a change in room but she was not aware that the resident or the legal representative had to receive a notice when there was a change in room mate. She acknowledged that she did not	F 247	2. Social Services Director will complete an audit by 11/28/12 of active residents for the past 3 months for roommate changes to assure notification was given and documentation completed as required. The audit and supporting documentation was submitted to the Administrator for review. 3. The Administrator re-educated the Social Services Director and Director of Admissions on 11/2/12 related to the requirements of notification of roommate changes. The Director of Admissions or Administrator will be responsible for room changes in the absence of the Social Service Director.	

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F 247	Continued From page 7 inform the legal representative of Resident #66 when the room mate was placed in his room. On 11/1/12 at 2:38 PM, Nurse #2 was interviewed. She stated that the nursing staff or the social service staff informed the resident or the legal representative when there was a room change but not when there was a new room mate.	F 247	4. The Administrator or Director of Nursing will complete an audit weekly for 4 weeks; then monthly for 2 months to ensure room change notifications continue to be completed and documented as required. A report of these findings will be submitted to the Quality Assurance Committee by monthly for 3 months. The Social Services Director will be responsible for monitoring and follow-up. Date of compliance: 11/28/12	11/28/12
F 257 SS=B	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observations, resident and staff interviews, the facility failed to maintain comfortable hot water temperatures in 1 of 3 resident rooms, 2 of 2 common bathrooms and for 3 of 3 alert and oriented residents (Residents # 57, #6 and # 26). The findings include: 1. Resident #57 was admitted to the facility on 9/30/09. His last quarterly Minimum Data Set (MDS) assessment, dated 8/10/12 listed him as being cognitively intact. During an interview with Resident #57 on 10/30/12 at 9:48am, he was asked if he was comfortable living in the facility. He responded that when it came to the water in the building, "	F 257		

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F 257	Continued From page 8 hot is not hot or the pressure is not good " . He continued that " all the water temps (temperatures) are the same hot is not hot and cold is not cold. " The water temps in Resident #57's room were not checked after his concerns were expressed, because he had a change in his medical condition and had several visitors in his room daily. On 11/1/12 at 3:00 pm, the Administrative Staff #5 conducted an audit of water temps in the common bathrooms and a sample of rooms in the facility. He shared that he had not heard any complaints about water pressure, but ideally, he liked to maintain the hot water range between 100-116 degrees. Nurse Aide # 4 was interviewed on 11/1/12 at 4:18 pm, stated that when she gave baths to residents, the water started off cold and eventually warmed up. Nurse Aide # 5 was interviewed on 11/1/12 at 4:20 pm stated that when she gave baths to residents, the water took about 3 minutes to warm. Nurse Aide # 6 was interviewed on 11/1/12 at 4:22 pm. Stated that when she gets a resident ready for a bath, she turned on the water first in the shower, gathered her supplies, then gets the resident and brings to the bathroom. The water was warm by then. 2. On 11/1/12 at 3:00 pm, the Administrative Staff	F 257	F 257 1. Maintenance Director adjusted the temperature controls on the Hot Water heater 11/1/12. Maintenance Director then checked water temperatures on 11/2/12 in resident rooms # 57, #6, and #26. The Maintenance Director also checked the water temps in both shower rooms on 11/1/12 with temperatures ranging from 102-110 degrees. Resident # 57 was unable to be re-interviewed due to his medical decline. Resident # 6 was interviewed by Administrator on 11/16/12 related to the comfort of the current water temperatures. Resident # 26 was interviewed by Administrator on 11/16/12 related to the comfort of the current water temperatures. 2. Maintenance Director checked water temperatures throughout the facility on 11/2/12. Temperatures ranged from 104- 108 degrees.	

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F 257	Continued From page 9 #5 conducted an audit of water temps in the common bathrooms and a sample of rooms in the facility. He shared that he had not heard any complaints about water pressure, but ideally, he liked to maintain the hot water range between 100-116 degrees. When he tested the West Hall Bath, he mentioned that it took awhile for the water to heat up. The water from the shower head temperature started out at 74.8 degrees at 3:09 pm and increased to 96.0 degrees at 3:12 pm. Nurse Aide # 4 was interviewed on 11/1/12 at 4:18 pm, stated that when she gave baths to residents, the water started off cold and eventually warmed up. Nurse Aide # 5 was interviewed on 11/1/12 at 4:20 pm stated that when she gave baths to residents, the water took about 3 minutes to warm. Nurse Aide # 6 was interviewed on 11/1/12 at 4:22 pm. Stated that when she gets a resident ready for a bath, she turned on the water first in the shower, gathered her supplies, then gets the resident and brings to the bathroom. The water was warm by then. 3. On 11/1/12, Room 3 was tested by the Administrative Staff #5 and started out with a hot water temperature at the sink at 89.9 degrees. The Administrative Staff #5 stated that when the water temperature is low, he will turn on a faucet at a sink, across the hall, drawing the water from the heater. He walked across the hall and turned	F 257	3. The staff was re-educated by the Staff Development Coordinator on 11/16/12 related to reporting abnormal water temperature to the Maintenance Director or Administrator. The Maintenance Director was re-educated by the Administrator on 11/20/12 related to the requirements of maintaining safe, comfortable water temperatures. 4. Maintenance Director will check water temperatures in 3 rooms and 1 shower room per hall 4 times weekly for 2 weeks; then weekly for 2 weeks; then monthly for 2 months to ensure safe, comfortable water temperatures continue to be maintained. Findings will be reported to the Quality Assurance Committee monthly for 3 months The Maintenance Director and Administrator will be responsible for monitoring and follow-up. Date of compliance: 11/28/12	11/28/12

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F 257	Continued From page 10 on the faucet in that room and allowed the faucet in Room 3, to continue running. After 4 minutes, Room 3's hot water increased to 112.2 degrees. Nurse Aide # 4 was interviewed on 11/1/12 at 4:18 pm, stated that when she gave baths to residents, the water started off cold and eventually warmed up. Nurse Aide # 5 was interviewed on 11/1/12 at 4:20 pm stated that when she gave baths to residents, the water took about 3 minutes to warm. Nurse Aide # 6 was interviewed on 11/1/12 at 4:22 pm. Stated that when she gets a resident ready for a bath, she turned on the water first in the shower, gathered her supplies, then gets the resident and brings to the bathroom. The water was warm by then. 4. On 11/1/12 at 3:22 pm, the East Hall Bath's water temperature was tested at the shower. The water pressure was low and the Administrative Staff #5 stated that the shower did not have good water pressure, even though he commented that the facility had just installed new shower heads. The water from the shower was touched and felt cool to slightly warm. It was tested at 82 degrees. The water continued to run and at 3:28 pm, the temperature increased to 102.5 degrees. On 11/1/12 at 3:00 pm, the Administrative Staff #5 conducted an audit of water temps in the common bathrooms and a sample of rooms in the facility. He shared that he had not heard any complaints about water pressure, but ideally, he liked to maintain the hot water range between	F 257		

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F 257	Continued From page 11 100-116 degrees. Nurse Aide # 4 was interviewed on 11/1/12 at 4:18 pm, stated that when she gave baths to residents, the water started off cold and eventually warmed up. Nurse Aide # 5 was interviewed on 11/1/12 at 4:20 pm stated that when she gave baths to residents, the water took about 3 minutes to warm. Nurse Aide # 6 was interviewed on 11/1/12 at 4:22 pm. Stated that when she gets a resident ready for a bath, she turned on the water first in the shower, gathered her supplies, then gets the resident and brings to the bathroom. The water was warm by then. 5. On 11/1/12 at 3:45 pm, Resident #5 was interviewed. A review of his medical chart demonstrated that on his quarterly MDS assessment, 9/21/12, he was assessed with a moderate cognitive impairment but could make his needs known. He stated when asked if the water temperatures in the facility were comfortable, that " The water was not always hot enough. " On 11/1/12 at 3:00 pm, the Administrative Staff #5 conducted an audit of water temps in the common bathrooms and a sample of rooms in the facility. He shared that he had not heard any complaints about water pressure, but ideally, he liked to maintain the hot water range between 100-116 degrees.	F 257		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	11/01/2012

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F 257	Continued From page 12 Nurse Aide # 4 was interviewed on 11/1/12 at 4:18 pm, stated that when she gave baths to residents, the water started off cold and eventually warmed up. Nurse Aide # 5 was interviewed on 11/1/12 at 4:20 pm stated that when she gave baths to residents, the water took about 3 minutes to warm. Nurse Aide # 6 was interviewed on 11/1/12 at 4:22 pm. Stated that when she gets a resident ready for a bath, she turned on the water first in the shower, gathered her supplies, then gets the resident and brings to the bathroom. The water was warm by then. 6. Resident #26 was admitted to the facility on 7/28/11. On his quarterly MDS, dated 9/28/12, he was assessed as being cognitively intact. On 11/1/12 at 3:46 pm, Resident #26 was interviewed. When asked if the hot water in the building was comfortable, he commented that the water was not as hot as he would prefer. On 11/1/12 at 3:00 pm, the Administrative Staff #5 conducted an audit of water temps in the common bathrooms and a sample of rooms in the facility. He shared that he had not heard any complaints about water pressure, but ideally, he liked to maintain the hot water range between 100-116 degrees. Nurse Aide # 4 was interviewed on 11/1/12 at 4:18 pm, stated that when she gave baths to residents, the water started off cold and eventually warmed up.	F 257		

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F 257	Continued From page 13 Nurse Aide # 5 was interviewed on 11/1/12 at 4:20 pm stated that when she gave baths to residents, the water took about 3 minutes to warm. Nurse Aide # 6 was interviewed on 11/1/12 at 4:22 pm. Stated that when she gets a resident ready for a bath, she turned on the water first in the shower, gathered her supplies, then gets the resident and brings to the bathroom. The water was warm by then.	F 257		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, family and staff interview and document review, the facility failed to assess and treat an open area for 1 of 3 sampled residents (Resident # 81). The findings included: Resident #81 was admitted on 9/6/12 with diagnoses including acute kidney failure and congestive heart failure. The Admission Minimum Data Set (MDS) dated	F 309		

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F 309	Continued From page 14 9/13/12 revealed Resident #81 had short and long term memory problems and was moderately impaired in decision making. Review of the incident log from 9/6/12 - 10/29/12 revealed the resident's most recent reported skin tear was 10/12/12 Review of the incident report dated 10/12/12 revealed that at 9:50 AM that day an unwitnessed skin tear was discovered on the resident's left arm. The report indicated the wound was cleansed and steri-strips were applied. Review of the Treatment Administration Record 10/27/12 - 10/29/12 revealed no skin tear treatments ordered or documented. On 10/29/12 at 4:38 PM Resident #81 was observed lying in bed. On the resident's left arm was a band aid with died dark red matter that had oozed along the top and bottom edges of the band aid. Review of the weekly skin check dated 10/30/12 revealed no current or previous open areas or skin tears noted. Resident #81's skin was described as intact. On 11/1/12 at 8:50 AM during medication pass the Responsible Party (RP) was observed removing a band aid from Resident #81's left forearm. The band aid had died dark red matter that had oozed along the top and bottom edges of the band aid and it appeared dirty with a blackened haze over the surface of the band aid. When the band aid was removed dried dark red matter remained on the resident's arm. The skin that had been under the band aid was reddened	F 309	F 309 1. Resident #81 had a complete body audit completed by Licensed Nurse on 11/1/12. Resident #81's physician was notified by the Licensed Nurse on 11/1/12 related to the abrasion with new orders noted. 2. Licensed nurse completed body audit on 11/06/12 for each resident to assure open areas had orders for treatment 3. Licensed Nurses were re-educated by Assistant Director of Nursing on 11/3/12 -11/5/12 related to the requirements of new open areas to include notification of the responsible party and physician for treatment orders. Certified Nursing Assistants were re-educated by Assistant Director of Nursing on 11/3/12 -11/5/12 related to the requirements of notifying nurse immediately when skin issues are discovered	

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F 309	Continued From page 15 and slightly swollen and a small previously open area was noted. Interview with the RP at this time revealed she thought the resident had hit his left arm on the weekend when staff was doing something with him, which she thought might have been a weight. She did not know who put the band aid on and stated she did not witness the incident. When asked, she said that she did not think the open area was from the skin tear on 10/12/12 unless it had reopened when Resident #81 hit his arm on the weekend. Interview with Nurse #5 revealed she had not been aware of any current open areas for Resident #81 and had not been providing treatments to his left forearm. She added that when open areas were treated by the treatment nurse a dressing was used, not a band aid. Interview with Administrative Nurse #1 revealed that the skin check on 10/30/12 should have identified the band aid and any open area it was being used for. She also added that all open areas were to be reported on the weekly skin check, and to the nurse, and that treatment was to be ordered and initiated as indicated. Administrative Nurse #1 acknowledged observing that Resident #81's skin was reddened and slightly swollen under where the band aid had been.	F 309	4. The Director of Nursing or Assistant Director of Nursing or Staff Development Coordinator will complete 4 random skin checks weekly for 4 weeks and monthly for 2 months to assure open areas continue to be identified, to include responsible party, physician notification and treatment orders as required. A report of these findings will be submitted to Quality Assurance Committee monthly for 3 months. The Director of Nursing is responsible for monitoring and follow-up Date of Compliance: 11/28/12	11/28/12
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	F 314		

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F 314	Continued From page 16 they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and document review, the facility failed to maintain the appropriate air mattress setting for 1 of 3 sampled residents with a pressure ulcer (Resident #55) The findings included: The Medline SupraCXC low pressure loss alternating pressure mattress " control box has a dial adjustment from soft to firm to set system for individual patient. Capacity of the Supra CXC is 300 pounds turn dial to patients weight " . (Medline, In-service Information for Medline Supra Low Pressure Loss and Alternating Pressure Mattress, undated). Resident #55 was last admitted on 7/13/12 with diagnoses including hypertension and diabetes. The Significant Change Minimum Data Set (MDS) revealed Resident #55 was cognitively intact and required limited assistance of one person for bed mobility and transfers. The MDS also indicated Resident #55 had two stage 3 pressure ulcers and had pressure reducing devices for his wheelchair and bed. Review of the Pressure Ulcer Weekly Assessment from 9/1/12 - 10/29/12 revealed the	F 314	F314 1) Resident #55's air mattress setting was re-assessed and adjusted by the Licensed Nurse on 11/1/12. The Licensed Nurse explained to Resident #55 the importance of maintaining mattress settings per resident's weight on 11/1/12 2. Licensed Nurse and Director of Nursing completed an audit on 11/1/12 related to residents on air mattresses to ensure settings follow recommended guidelines. 3. Nursing staff was re- educated by Staff Development Coordinator and Director of Nursing on 11/03/12 related to maintaining air settings per recommended guidelines and per plan of care.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 17 resident's right buttock pressure ulcer had been unstageable then progressed to a stage 4 but was showing improvement overall. Review of the Weight Record revealed that on 10/3/12 Resident #55 weighed 211 pounds. On 10/29/12 at 4:30 PM Resident #55 was observed lying in bed. The mattress on the bed was observed to be a pressure relieving air mattress. The air mattress setting was not observed at this time. On 10/31/12 at 2:45 PM, the dressing change to the gluteal fold pressure ulcer on Resident # 55's right buttock was observed, the wound measured 3 cm (centimeters) in length x 1.5 cm (width) x 0.2 cm (depth) and was 100 percent granulation tissue. Interview with Nurse #5 at this time revealed the highest stage of the ulcer was stage 4. The resident had no other pressure ulcers at this time. On 10/31/12 at 5:12 PM, Resident #55 was observed lying in bed. The air mattress on the bed was observed to be a " Medline Supra CXC " low air loss and alternating pressure mattress. The dial for setting the softness versus firmness of the air mattress had numbers ranging from 50 (soft) to 350 (firm) and had hash marks at intervals of 10 between each number. Underneath the dial the following was inscribed: lbs (pounds). The dial was turned up past the highest/firmest setting of 350. On 10/31/12 at 5:20 PM, interview with Nurse #5 revealed that she was responsible for setting the firmness of the mattress. She stated that the	F 314	4. Director of Nursing or Assistant Director of Nursing or Staff Development Coordinator will complete an audit weekly for 4 weeks and then monthly for 2 months to ensure air mattresses settings continue to be maintained per recommended guidelines and per plan of care. The results of these findings will be submitted to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow-up. Date of compliance 11/28/12	11/28/12

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F 314	Continued From page 18 mattress was intended to be set according to the resident's comfort. After, observing the " lbs " (pounds) inscription on the dial, she acknowledged the mattress was intended to be set by resident weight and turned the dial to 210 as the resident weighed 211 pounds. Nurse #5 indicated she had not previously noticed the " lbs " (pounds) inscription.	F 314		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to prevent injury (blister) from the baseboard heater to 1 (Resident #85) of 3 sampled residents. The findings include: The instruction/installation reference form of baseboard heater was reviewed. The form under cautions and warning statements revealed " high temperatures are present at outlet air openings. Keep electrical cords, drapes and other furnishings or objects clear of these openings. High temperatures, keep electrical cords, drapes and other furnishings away from the heater. " Resident #85 was admitted to the facility on	F 323		

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F 323	Continued From page 19 11/30/11 with multiple diagnoses including Schizophrenia, Anxiety State, Depressive Disorder and Hypertension. The significant change in status MDS (Minimum Data Set) assessment dated 8/16/12 indicated that Resident #85 had memory and decision making problems. The care plan was reviewed. There was a care plan initiated on 10/16/12. The problem was " blister to right hand. " The goal was " blister will heal without signs of infection through next review date 11/20/12. " The approaches were " assess and record measurements as needed, observe for signs/symptoms of pain and intervene appropriately, treatment as ordered, observe for signs/symptoms of pain and observe standard precaution. " The nurse's notes were reviewed. The notes dated 10/10/12 at 3:30 PM revealed that while the nursing assistants were making rounds, Resident #85 was found to have her hand down beside the bed. When her hand was pulled up, a large fluid filled blister was noted on top of her right hand. The notes further indicated that the attending physician was informed and Silvadene cream was ordered. The notes at 3:45 PM indicated that Resident #85 was moved to the door side of the room. The weekly non pressure progress reports were reviewed. The report dated 10/11/12 indicated an intact fluid filled blister to right hand 3 x 2 cm (centimeter) in size and oozing serous fluid. The blister was treated with Silvadene and dry dressing daily.	F 323	F323 1. Resident #85 was moved away from the baseboard heat on 10/10/12 by Director of Nursing, Administrator and Certified Nursing Assistants. The physician was notified by the licensed nurse on 10/10/12 with treatment orders noted. An audit was completed 10/10/12 by the Director of Nursing and Administrator to assure there were no residents or objects close to any baseboard heaters. 2. An audit was completed on 11/1/2012 by Administrative staff related to resident's beds to ensure beds are positioned away from baseboard heaters. 3. Staff were re-educated on 11/3/2012 by the Assistant Director of Nursing and Staff Development Coordinator and Director of Nursing related to ensuring residents' beds and linens are positioned away from baseboard heaters.	

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F 323	Continued From page 20 The telephone orders were reviewed. On 10/24/12, the attending physician had ordered to discontinue Silvadene cream to right hand. The new order was to clean the right hand blister with wound cleanser and apply Calcium Alginate and dry dressing daily. On 10/25/12, the Calcium Alginate was discontinued and was changed to Hydrogel. On 10/30/12 at 9:46 AM, Nurse #2 was interviewed. She stated that Resident #85 had a blister on her right hand from a baseboard heater. On 10/30/12 at 10:42 AM, Resident #85 was observed in low bed by the door. She had a dressing to her right hand. On 10/30/12 at 11:45 AM, the treatment nurse was interviewed. She stated that the blister on the resident's right hand was from the baseboard heater. On 10/31/12 at 10:45 AM, the administrative staff #5 was interviewed. He stated that he had heard of a resident, who was on low bed by the window, was found to have a blister from the baseboard heater. He further indicated that this resident was the only resident in the building on low bed. On 10/31/12 at 11:30 AM, the beds in rooms 2 W, 21 W, 25 W and 26 W were observed with the residents in bed. The beds were about 2-3 inches from the baseboard heaters. The heaters were turned on and the metal frames were hot when touched. On 10/31/12 at 11:35 AM, administrative staff members #1 and #2 were interviewed.	F 323	4. The Administrative team or designee will conduct rounds 4 times weekly for 4 weeks, then monthly for 2 months to ensure residents' continue to be positioned away from base board heaters. The findings of these audits will be submitted to the Quality Assurance Committee monthly for 3 months. The Administrator will be responsible for the monitoring and follow-up. Date of Compliance: 11/28/12	11/28/12

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F 323	Continued From page 20 The telephone orders were reviewed. On 10/24/12, the attending physician had ordered to discontinue Silvadene cream to right hand. The new order was to clean the right hand blister with wound cleanser and apply Calcium Alginate and dry dressing daily. On 10/25/12, the Calcium Alginate was discontinued and was changed to Hydrogel. On 10/30/12 at 9:46 AM, Nurse #2 was interviewed. She stated that Resident #85 had a blister on her right hand from a baseboard heater. On 10/30/12 at 10:42 AM, Resident #85 was observed in low bed by the door. She had a dressing to her right hand. On 10/30/12 at 11:45 AM, the treatment nurse was interviewed. She stated that the blister on the resident's right hand was from the baseboard heater. On 10/31/12 at 10:45 AM, the administrative staff #5 was interviewed. He stated that he had heard of a resident, who was on low bed by the window, was found to have a blister from the baseboard heater. He further indicated that this resident was the only resident in the building on low bed. On 10/31/12 at 11:30 AM, the beds in rooms 2 W, 21 W, 25 W and 26 W were observed with the residents in bed. The beds were about 2-3 inches from the baseboard heaters. The heaters were turned on and the metal frames were hot when touched. On 10/31/12 at 11:35 AM, administrative staff members #1 and #2 were interviewed.	F 323		

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F 323	Continued From page 21 Administrative staff member #2 stated that Resident #85 was found to have a blister on her hand. She added that the resident was on low bed by the window and her bed was moved immediately by the door. She also stated that department heads had to check bed placement during daily angel rounds. Administrative staff member #1 stated that all staff members were in-serviced to make sure beds were away from the wall/baseboard heaters at least 6-12 inches. She added that Resident #85 was found with her hand hanging off the bed between the bed and the heater. The in-service records dated 10/11/12 were reviewed. The in-service topics included making sure all items were clear of the baseboard/wall heat. All items (bed, linens, cords, furniture) were removed from baseboard areas if found. Patient's safety and fire hazards were discussed. Staff members were reminded to check rooms during rounds for resident's safety and fire hazards. The facility's plan of action dated 10/10/12 was reviewed. The problem was " resident's right hand found having fluid filled blister (top of hand). Hand was hanging off bed between bed and heater. Hand was not on heater or against wall. Bed was in lowest position r/t (related to) fall risk and anxiety. " The goal was " to have no injuries related to any environmental hazards (walls, beds, side rails, etc). " The approaches were " order for first aide to blister, resident's bed immediately moved to opposite side of room, 100% body audit done on all residents that are placed beside wall/near heaters, in-serviced all staff on importance of keeping beds 6-12 inches away from the walls, department heads to check placement of beds during daily angel rounds and nursing administration to do spot checks	F 323		

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F 323	Continued From page 22	F 323		

throughout day on positioning of beds. " There was no documentation that bed placement was checked during the daily angel rounds or the nursing administration had conducted spot checks of bed positioning.

On 10/31/12 at 1:57 PM, Nurse #3 was interviewed. She stated that she was assigned to Resident #85 when the blister was found on the resident's hand. She indicated that the resident's bed was a low bed by the window where the baseboard heater was located. She revealed that the resident had behaviors of swinging her arms and legs off the bed. She reported that on 10/10/12, the nursing assisted had reported to her that Resident #85 had a blister on her right hand. She revealed that the heater was turned on at that time. She believed that the blister was from the heater because she was found with her hand between the bed and the heater. The resident's bed was moved by the door right after the incident.

On 10/31/12 at 2:43 PM, nursing assistants (NAs) #1 and #2 were interviewed. NAs #1 and #2 reported that they were making rounds when Resident #85 was found with her legs and right hand lying off the bed. They went in the room to reposition her. She was on low bed by the window. Her right hand was off the bed between the bed and the heater. When they pulled her right hand up, a blister was noted on top of her hand. They informed Nurse #3 immediately. NA #2 reported that the base board heater was turned on when they found her.

On 11/1/12 at 10:15 AM, the treatment nurse was observed during the dressing change. The blister

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	11/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBASSADOR HEALTH & REHAB OF WADESBORO, LLC	2051 COUNTY CLUB ROAD WADESBORO, NC 28170

(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 323	Continued From page 23 was observed on top on her hand just above the ring finger. The treatment nurse was observed to clean the blister with wound cleanser and Hydrogel was applied and covered with a dry dressing. On 11/1/12 at 10:24 AM, the treatment nurse was interviewed. She indicated that she had worked at the facility for 11 years and she had no knowledge that Resident #85 had blister in the past. The only blisters she had known were on her heel which already had healed up and the blister on her right hand (10/10/12). On 11/1/12 at 11:35 AM, OT (occupational therapist) #1 was interviewed. She stated that therapy was working on Resident #85 due to the edema on her right hand. She reported that OT was working on the resident for ROM (range of motion) exercises and splinting starting 9/17/12. She further stated that diathermy therapy was started on 10/11/12, right after the blister was found.	F 323		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		

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F 441	Continued From page 24 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 record review, observation, staff interview and review of facility policy, the facility failed to ensure staff wore gloves when administering insulin for 1 (Nurse #1)of 1 nurse observed and did not post a contact precaution sign on 3 (Resident #85, #74 & # 36)of 3 sampled residents on contact precautions. The facility also failed to follow their policy on contact precaution by not wearing gloves and washing hands when entering/exiting a contact precaution room (Residents #74 & #36). The findings	F 441	F441 1. Nurse #1 had 1:1counseling conducted on 10/31/12 by Director of Nursing related to the requirements of maintaining infection control practices while administering insulin and other injectable medications Residents #85's "See Nurse Signs" was removed and the required Isolation sign was placed by the Director of Nursing on 11/1/12 Resident #74's "See Nurse Signs" was removed and the required Isolation sign was placed by the Director of Nursing on 11/1/12 Resident #36's "See Nurse Signs" was removed and the required Isolation sign was placed by the Director of Nursing on 11/1/12. Administrative staff #5 received 1:1 counseling by the Director of Nursing on 11/15/12 related to the requirements of completing hand	

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F 441	Continued From page 25 included: A facility policy dated 9/10 entitled, "Medication Administration Subcutaneous Insulin" read in part, "9. Prepare injection." "10. Return insulin container to medication cart for storage. 11. Put on gloves. 12. Check last site of injection and select a new appropriate site for injection. 13. Cleanse injection site with antimicrobial agent. Allow to dry. 14. Expel air from syringe. 15. Grasp and pinch the skin around the injection site if using a syringe. 16. Insert needle quickly. Release skin. 17. Inject insulin slowly. Leave needle in the skin for several seconds after injection with finger on the plunger or per manufacturer recommendation. 18. Remove needle and apply firm pressure over site to prevent seepage of insulin. Do not rub area. 19. Engage safety device, and discard syringe and needle in appropriate syringe disposal container. Do not recap needle. 20. Remove gloves." 1. On 10/31/12 at 9:06 AM, Nurse #1 was observed to prepare and administer Lantus insulin to Resident #9. The nurse did not wear gloves. At 9:16 AM, Nurse #1 was observed to prepare and administer Novolog insulin to Resident #9. The nurse did not wear gloves. During an interview on 10/31/12 at 10 AM, Nurse #1 indicated that she was nervous and forgot to wear gloves. She added that she knew to wear gloves when giving insulin. During an interview on 11/1/12 at 2:12 PM, Administrative staff #1 stated she expected staff to wear gloves when administering insulin.	F 441	washing when entering/leaving isolation rooms. 2. An audit was completed by the Director of Nursing on 11/16/12 related to residents receiving insulin and other injectable medications for signs and symptoms of infection related injectable administration. The Staff Development Coordinator completed medication administration observations on 11/5/12 to ensure Licensed Nurses are wearing gloves and washing hands as required. An audit was completed by Director of Nursing on 11/1/12 related to residents requiring specialized precautions to ensure the required posted signs were in place. An audit was completed by the Director of Nursing on 11/2/12 related to staff entering and exiting residents' rooms for required infection control practices to include hand washing.	

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F 441	Continued From page 26 2. Resident #85 was admitted to the facility on 11/30/11 with multiple diagnoses including Pressure ulcer. The significant change in status MDS (Minimum Data Set) assessment dated 8/16/12 indicated that Resident #85 had memory and decision making problems and had a stage III pressure ulcer. Review of the weekly pressure ulcer progress report revealed that on 8/24/12, the stage III pressure ulcer on the sacrum had changed to a stage IV pressure ulcer. On 10/2/12, there was a doctor's order to culture the sacral wound due to foul odor. The culture report dated 10/2/12 revealed MRSA (Methicillin Resistant Staphylococcus Aureus). On 10/11/12, there was a telephone order which read " contact precaution initiated due to MRSA in sacral wound. " On 10/29/12 at 2:30 PM, 10/30/12 at 9:10 AM and 10/31/12 at 2:25 PM, the sign on Resident #85's door was observed. The sign on the door read " see nurse before entering. " On 11/1/12 at 10:50 AM, Nurse #4 was interviewed. She stated that the facility had a contact precaution sign but it was kept inside the drawer of the isolation cart. The sign was not hang due to privacy reasons. The facility's policy on Infection Control, dated July, 2007 focusing on the contact precaution category was reviewed. It read that " Contact precautions will be implemented for specified	F 441	3. Licensed Nurses were re-educated on 11/3/12 by the Director of Nursing and the Staff Development Coordinator related to maintaining infection control while administering insulin and other injectable medications. Staff was re-educated by the Director of Nursing and the Staff Development Coordinator on 11/3/12 related to infection control requirements for residents on precautions to include posting the required signage on the resident's door and hand washing requirements when entering and exiting resident rooms.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING _____ B. WING _____	11/01/2012

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F 441	Continued From page 27 residents known or suspected to be infected or colonized with micro organisms that occurs when performing resident care activities that requires touching the resident's dry skin, or indirect contact (touching) with environmental surfaces or resident care items in the resident's environment. Guidelines: Gloves: worn by all persons entering room. Strict hand washing procedures will be observed and monitored. Hand washing will occur upon entering resident room, immediately upon removal of gloves when leaving resident room, and as indicated during resident care. " 3. Resident #74 was admitted to the facility on 1/9/12 with a re-entry date of 8/24/12. He had the following cumulative diagnoses: peripheral vascular disease, dementia and a seizure disorder. On the quarterly Minimum Data Set (MDS) assessment, 9/28/12 he was determined to have cognitive impairments and be totally dependent on staff for toilet use, dressing, personal hygiene and bed mobility. On 10/29/12 at 11:18 am, Resident #74's room was observed with a clear plastic drawer cart, containing personal protective equipment outside of his room. Above the cart, was a sign that read, " Please see nurse before entering room. " In the closed top drawer of the cart, was a colored sign with instructions that were unavailable for review. Nurse #6 was passing medication and was asked if Resident #74 had an infectious condition. She replied that he had MRSA (methicillin-resistant staphylococcus aureus) in his right foot ulcer. Resident #74's record was reviewed. It revealed on 10/8/12 he was placed on an anti-biotic for MRSA in a foot wound. That same day, a	F 441		

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 28 telephone order was received to initiate contact precautions due to MRSA. On 11/1/12 at 10:35 am, Nurse #4 was observed exiting Resident #74's room, after passing his medication. The contact precaution sign was not hung on his door. At 10:50 am, she was asked why Resident #74 had a sign on his hallway wall to see the nurse. She commented that he had something growing in his wound. It was their expectation that anyone visiting with Resident #74 should see the nurse before entering his room for further direction. She stated that they have a contact sign in his drawer but do not hang it for privacy reasons. On 11/1/12 at 11:30 am, Administrative Staff #5 walked into the room of Resident #74, who remained on contact isolation, without wearing gloves or washing his hands. He went to his sink and turned on the faucet, to test the water temperature. After he completed his task, he turned off the faucet and walked into the hallway, without washing his hands first. When questioned about their infection control policy, he stated that he should have washed his hands and returned to the room to wash them. The Administrative Staff # 1 was interviewed on 11/1/12 at 11:40 am. She shared that they do not hang contact precaution signs because of the corporate policy which restricts hanging them on the outside of the door, due to their HIPPA (Health Insurance Portability and Accountability Act of 1996) policy.	F 441	4. Infection control nurse or designee will complete a review weekly for 4 weeks and then monthly for 2 months to ensure nurses continue to follow infection control guidelines for medication administration including injectable medications, required isolation signs are in place when applicable, and maintaining infection control practices including hand washing. The results of these reviews will be submitted to the Quality Assurance Committee monthly for 3 months. The Director of Nursing will be responsible for monitoring and follow-up. Date of Compliance: 11/28/12	11/28/12

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
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F 441	Continued From page 29 4. Resident #36 was admitted to the facility on 9/23/11 with the following cumulative diagnoses: Dementia and hypertension. On 9/26/12 her significant change MDS was completed and assessed her as having cognitive impairments, and requiring extensive assistance with bed mobility, transfers, dressing and personal hygiene. On 10/31/12 at 1:45 pm, Resident #36 was observed to be sitting in her room, with a clear plastic cart outside of her door, with personal protective equipment contained. Above the cart, was a sign that read, " Please see nurse before entering room. " In the closed top drawer of the cart, was a colored sign with instructions that were unavailable for review. A record review was conducted of Resident #36's chart. It revealed that new orders to treat shingles were called in on 10/31/12. It stated that contact precautions should be initiated. On 11/1/12 at 10:50 am, Nurse #4 was interviewed. She stated that Resident #36 was being treated for shingles and that anyone entering her room, should stop and speak with the nurse before entering. She shared that they do not hang a contact precaution sign, due to privacy reasons. Administrative Staff #5 was observed in the room of Resident #36 on 11/1/12 at 11:37 am. There was no contact precaution sign hung on the door. She was visiting with her roommate and was viewed handling the faucet, door knobs, bed equipment, without wearing gloves. Upon exiting the room, she was asked to relay their infection	F 441		

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
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F 441	Continued From page 30 control policy. She stated that although she knew Resident #36 had begun treatment for an infectious condition, she didn't think that she needed to wear gloves since she was only handling items for the roommate. The Administrative Staff # 1 was interviewed on 11/1/12 at 11:40 am. She shared that they do not hang contact precaution signs because of the corporate policy which restricts hanging them on the outside of the door, due to their HIPPA policy.	F 441		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345392	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 11/1/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBASSADOR HEALTH & REHAB OF WADESBORO, LLC	2051 COUNTY CLUB ROAD WADESBORO, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 160	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to convey expired resident funds to the Executor of the Estate or Clerk of Courts for 1 (Resident #10) of 3 sampled residents. The findings included: Review of the business office records for Resident #10 revealed that the resident expired on 7/14/12. The facility closed the resident's personal funds account on 7/16/12 and issued a check payable to a funeral home with the funds that had been in the account. During an interview on 11/1/12 at 1:26 PM, the business office manager indicated she was not aware she was required to make the check payable to the Estate or the Clerk of Courts.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING 01 - MAIN BUILDING 01 B. WING	11/29/2012

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K 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 existing Health Care section of the LSC and its referenced publications. This facility is Type III (222) protected construction utilizing North Carolina Special locking arrangements, and is equipped with an automatic sprinkler system. CFR#: 42 CFR 483.70 (a)	K 000	Preparation and submission of this plan of correction by, **Ambassador Health and Rehab of Wadesboro, LLC**, does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely pursuant to the requirements under state and federal laws.	
K 018 SS=D	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 1¾ 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: Based on the observations and staff interviews	K 018	K 018 1. The hasp/latches were removed from the room side of the bathroom doors in room 15 and room 34 by the Maintenance Director 11/30/12. 2. Doors through out the facility were inspected by the Maintenance Director and Administrator on 11/30/12.to insure there were no hasp/latches on bathroom doors 3. The Maintenance Director and the Department Team Leaders were re-educated by the Administrator that roller latches are prohibited by CMS regulations in health care facilities 11/30/12.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Gary D Lookabell | TITLE: Administrator | (X6) DATE: 12/13/12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/29/2012

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K 018	Continued From page 1 on 11/29/2012 the following Life Safety item was observed as noncompliant with the locking of doors in the facility, specific findings include: The bathroom doors in room 15 on the East hallway and room 34 on the West hallway had door hasp/latches on the room side of the bathroom doors. CFR#: 42 CFR 483.70 (a)	K 018	4. The Maintenance Director and Administrator will inspect doors weekly for 4 weeks and monthly for 2 months to insure there continues to be no hasps/latches on bathroom doors. The results of these findings will be submitted to the Quality Assurance Committee monthly for 3 months. The Maintenance Director and	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 11/29/2012 the following Life Safety item was observed as noncompliant with the sprinkler coverage for the facility, specific findings include: The sprinkler rating for the beauty shop was a Green bulb (200°F) sprinkler head utilized in high heat areas. CFR#: 42 CFR 483.70 (a)	K 056	Administrator will be responsible for monitoring and follow-up. Date of Compliance 12/13/12. K 056 1.The 200 degree sprinkler head in the beauty shop was replaced with a 155 degree sprinkler head by an outside sprinkler company 12/3/12.	12/13/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345392	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/29/2012

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			2. Facility sprinkler heads were inspected by the Maintenance Director 11/29/12 to insure sprinkler heads meet Life Safety Code requirement. 3. The Maintenance Director was re-educated by the Administrator on 12/12/12 related to maintaining sprinkler heads per Life Safety Code requirements. 4. The Maintenance Director will audit and inspect facility sprinkler heads monthly for 3 months to ensure sprinkler heads continue to meet Life Safety Code requirements. The results of these findings will be submitted to the Quality Assurance Committee monthly for 3 months. The Maintenance Director and Administrator will be responsible for monitoring and follow-up. Date of compliance: 12/13/12	12/13/12