JAN 2 5 2013

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

PRINTED: 01/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345356	A. BUILDING _____ B. WING _____	C 12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE HEALTH CARE CENTER	320 NORTH MAIN STREET RICH SQUARE, NC 27869

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F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete background checks for 3 (N #6, DA #1, Housekeeper #1) of 5 employees, failed to verify nurse aide registry for 2 (NA #5, #6) of 5 employees and failed to obtain references for 5 (Nurse #6, NA #5, NA #6, DA #1, Housekeeper #1) of 5 employees whose employee files were reviewed. Findings include: Review of an undated facility form titled "Abuse Prevention Program" read in part: "Our abuse prevention program provides procedures that govern, as a minimum: conducting employment background checks." Review of facility form, revised 07/23/07, titled "Employment Application Policy and Procedure" under the section titled "Procedure" two of the areas listed are: · Before an applicant receives a conditional offer of employment appropriate verification of credentials must be performed. Every applicant considered for employment (including nurses) must be checked against the Health Care Personnel Registry (HCPR). All nurses must have their licenses checked against the NC (North Carolina) Board of Nursing	F 226	Preparation and/or execution of the plan of corrections does not constitute admission or agreement by the provider of the truth of the items alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provision of the Federal and State laws. F 226 483.13 © DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES Castlebranch statewide background checks were run by the Administrator on 3 (N #6, DA #1, Housekeeper #1) and found to be in compliance on 1/4/2013. Nurse Aide registry verification was accomplished and found to be in compliance on 2 (NA #5, #6) by the DON on 1/4/2013. 2 references were obtained on 5 employees (Nurse #6, NA #5, NA #6, DA #1, Housekeeper #1) by the DON, DM and Housekeeping Manager on 1/5/2013. The department heads were inserviced on the requirements for prospective employee pre employment on 1/11/2013 by the Administrator.	

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

James Ray Lovegrove | Administrator | 1-11-13

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 226	Continued From page 1 Before an applicant receives a conditional offer of employment, two reference checks must be completed. Reference checks will be completed by the Staff Development Coordinator (SDC). Review of the facility employee handbook revealed the following statement: "Complete background inquiry or fingerprint clearance. Each new employee will be considered conditionally employed pending the result of a criminal or additional background investigation." 1. Review of Nurse #6 employee file revealed the Nurse was hired on 09/26/12, and one personal reference had been obtained. No other information was found in the employee file to indicate any other reference had been attempted. Further review indicated that a background check was initiated on 11/05/12 after the employee had been working at the facility. An interview, on 12/20/12 at 1:00 PM, was conducted with the Director of Nurses (DON). She indicated at the time the employee was hired the SDC had left, and she was the person who have completed these areas for a new employee. The DON relayed that a person had not been in place in the SDC position until recently. She confirmed the reference checks had not been completed and the background check was completed after Nurse #6 began working at the facility. An interview, on 12/20/12 at 1:30 PM, was conducted with the Administrator. The Administrator indicated he expected for the all of the required information to be completed upon	F 226	F 226 continued from page 1 To insure that employee screening has been accomplished prior to employment a 20 item list of forms, copies and tests has been implemented and must be completed prior to employment. Included in this list are forms for checking licensed professionals with the NC Board of Nursing. Non licensed applicants must be checked with the North Carolina Department of Health and Human Services, Division of Health Services Regulations, Health Care Personnel Registry Section. All applicants must have a statewide Criminal Background check provided by 'Castlebranch'. Applicants must have two (2) references contacted and documented, as per corporate policy. The BOM will check the prospective employee pre employment file for completeness prior to employee hire date.	

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F 226	Continued From page 2 hire. 2. Review of Nurse Aide (NA) #5 employee file revealed the NA was hired on 10/24/12 and one personal reference check had been completed. No other information was found in the employee file to indicate any other reference had been attempted. Further review indicated the check of HCPR for NA #5's status on the registry was completed on 12/10/12. An interview, on 12/20/12 at 1:00 PM, was conducted with the Director of Nurses (DON). She indicated at the time the employee was hired the SDC had left and she was the person who would have completed these areas for a new employee. The DON stated that a person had not been in place in the SDC position until recently. She confirmed an additional reference had not been attempted and the status on the HCPR site for NA #5 had been completed on 12/10/12 An interview, on 12/20/12 at 1:30 PM, was conducted with the Administrator. The Administrator indicated he expected for the all of the required information to be completed upon hire. 3. Review of NA #6 employee file revealed the NA was hired on 11/14/12 and one personal reference had been completed. No other information was found in the employee file to indicate any further reference had been attempted. Further review indicated the check of HCPR for NA #6 ' s status on the registry was completed on 12/10/12..	F 226	F 226 continued from page 2 01/2 & 3/2013 a complete audit of current personnel and was conducted by the BOM and Administrator . Personnel that had Criminal background checks that required Castlebranch were verified by Castlebranch and found in compliance and confirmation placed in the employees file. Actual results of the Criminal Background check are kept in the Administrator's office. Licensed Professionals Licenses were verified and non-licensed employees were verified with the NC HCPR. The Administrator will audit the next 20 new employee files or for the next 4 months for compliance and will report the outcome at the monthly QA meeting. Correction Date: 1/11/2013	1/17/2013

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F 226	Continued From page 3 An interview, on 12/20/12 at 1:00 PM, was conducted with the Director of Nurses (DON). She indicated at the time the employee was hired the SDC had left and she was the person who would have completed these areas for a new employee. The DON stated that a person had not been in place in the SDC position until recently. She confirmed an additional reference had not been attempted and the status on the HCPR site for NA #6 had been completed on 12/10/12. An interview, on 12/20/12 at 1:30 PM, was conducted with the Administrator. The Administrator indicated he expected for the all of the required information to be completed upon hire. 4. Review of Dietary Aide (DA) #1 employee file revealed the DA was hired on 11/23/12 and no reference checks had been attempted. Further review indicated that a background check completed on 11/14/12 was only for the county in which the DA lived and read in part: "This is not a statewide search." An interview, on 12/20/12 at 1:30 PM was conducted with the Administrator. The Administrator stated he had expected the employee references to have been done. He relayed that he had seen the background check, noted they had been done in North Carolina, but did not notice that the background check was not a statewide search. He continued that the facility usually used the services of a NC vendor to complete the required background checks, but had not done so for this employee. The Administrator stated he expected for all the	F 226		

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F 226	Continued From page 4 necessary information needed to be completed upon hire. 5. Review of Housekeeper #1 employee file revealed the Housekeeper had been hired on 10/24/12 and no reference checks had been attempted. Further review indicated that a background check was completed on 10/10/12 only for the county in which the housekeeper lived and read in part: "This is not a statewide search." An interview, on 12/20/12 at 1:30 PM was conducted with the Administrator. The Administrator stated he had expected the employee references to have been done. He relayed that he had seen the background check, noted they had been done in North Carolina, but did not notice that the background check was not a statewide search. He continued that the faculty usually used the services of a NC vendor to complete required background checks, but had not been done so for this employee. The Administrator stated he expected for all the necessary information needed to be completed upon hire.	F 226		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by	F 274	F 274 483.20 (b)(2)(ii) COMPREHENSIVE ACCESS AFTER SIGNIFICANT CHANGE Plan of Care for resident #60 has been updated to include resident assessment completed for significant change in status related decline in cognition and a decline in activities of daily living on 12/21/2012.	

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F 274	Continued From page 5 implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a significant change assessment for 1 (Resident #60) of 1 sampled resident, who had a significant weight loss, a decline in cognition and a decline in activities of daily living. Resident #60 was admitted to the facility on 08/27/12. Cumulative diagnoses included fracture right femoral condyle (an area of the femur) and osteoarthritis. Review of the admission Minimum Data Set (MDS) assessment, dated 09/03/12, revealed Resident #60 had no short or long term memory loss, and was able to make daily decisions. The assessment indicated the resident ' s admission weight was 116 pounds, required limited assistance of one staff member for toileting and personal hygiene. Review of the quarterly MDS assessment, dated 12/0312, revealed Resident #60, had severely impaired cognition. The assessment indicated the resident ' s weight was 89 pounds, and Resident #60 was totally dependent on one staff member for toileting and personal hygiene. An interview, on 12/20/12 11:10 AM, was	F 274	F 274 continued from page 5 MDS coordinator was in-serviced on criteria for change in status related to significant change assessment according to MDS 3.0 guidelines by the corporate consultant on 1/17/13 An audit was performed by the MDS coordinator of facility residents assessments completed in last 90 days to identify residents at risk for potential significant change in status related to significant weight loss, decline in cognition and decline in activities of daily living. DON will assure that residents triggering for significant change MDS are completed in a timely manner. By reviewing the weekly risk management meeting with the MDS coordinator and IDT to capture any future significant changes in a timely manner.	

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F 274	Continued From page 6 conducted with Nurse #2, who was the MDS nurse. Nurse #2 relayed that she had noted Resident #60 ' s decrease in cognition, the weight loss and the decline with activities of daily living. She indicated she was aware that a significant change had occurred. Nurse #2 stated at the weekly meeting prior to the quarterly MDS, the staff was discussing the resident and therapy indicated Resident #60 had just resumed therapy and perhaps in a week or so there would be some improvement. She relayed Resident #60 had remained in decline and a significant change should have been completed. An interview, on 12/20/12 at 2:45 PM, was conducted with the Director of Nurses (DON). The DON stated she would have expected when a significant change has been identified in the MDS process that a significant change MDS would be completed.	F 274	F 274 continued from page 6 MDS coordinator and RN Supervisor will audit MDS assessments and documentation for significant change in status related to significant weight loss, decline in cognition and decline in activities of daily living weekly x 4 weeks, then monthly x 4 months. The DON will discuss results at the monthly QA meeting. Completion Date: 1/15/2013	1/17/2013
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 staff interviews and record reviews, the facility failed to monitor the condition of a resident post-fall for 2 (Resident #27 and #72) of 3 residents who experienced falls.	F 309	F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Medical records for #27 and #72 were reviewed by the interdisciplinary team for accuracy, timeliness and documentation for post fall documentation on 12/21/2012	

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F 309	Continued From page 7 Findings include: Review of a facility " Fall Protocol " , undated, revealed a category entitled " Falls Without Injury " . Instructions under the category included: Vital Signs every shift for 24 hours. For documentation purposes the following were listed to include in a nurse note: time of occurrence, time family and MD notified, Range of Motion evaluation of extremities, pain, and examination of skin for discoloration or bruising. Document every shift for 24 hours. Day shift to document for 3 days after the initial 24 hour period. 1) Resident #27 was re-admitted to the facility on 11/16/07 with diagnoses to include dementia, lack of coordination, paralysis agitans (similar to Parkinson ' s disease), and anxiety state. Review of the resident ' s most recent Minimum Data Set (MDS), a quarterly assessment of 12/5/12, indicated the resident required total care of 2 or more staff for bed mobility, and extensive assistance of one staff member for transfer and locomotion on and off the unit. The assessment revealed the resident did not walk. Resident #27 was assessed as having had functional limitations of both upper extremities and both lower extremities. Review of the resident ' s medical record revealed a nurse note of 6/29/12 at 2:30 AM revealed the resident was found on a floor mat beside the bed. A nurse note was written on 6/29/12 at 3 PM that documented the resident had no falls at that time. A nurse note written on 7/1/12 at 10 PM documented the resident	F 309	F 309 continued from page 7 Interdisciplinary team reviewed residents with fall reports prior 90 days for and accuracy of post fall documentation, timeliness of interventions. Any intervention needing added or removed were discussed at this time. Licensed nurses were in-serviced by the DON and educated on post fall monitoring and documentation on 12/21/2012. Newly hired nurses will be given education on required post fall documentation during licensed nurse orientation. This in-service covered required documentation regarding falls. DON will review each medical record of residents with a fall for proper documentation. This audit will be conducted daily x 3 weeks, each fall x 4 weeks, any fall thereafter x 2 weeks, then monthly. The DON will discuss her findings at the monthly QA meeting. Correction Date: 01/15/2013	1/17/2013

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F 309	Continued From page 8 received no injuries from his fall. The next documented nurse note was written on 7/4/12 for a Quality Assurance review regarding weight loss and was followed by a nurse note of 7/13/12. A nurse note, of 9/19/12 at 2:45 PM, documented the resident was reaching for a call light and toppled out of a wheelchair. A nurse note was written on 9/19/12 at 10:50 PM that indicated the resident had shown no signs or symptoms of injury related to the fall. The next nurse note was documented on 9/20/12 at 3:05 AM and revealed the resident had no ill effects as a result of the fall. A nurse note was written 9/20/12 at 2:38 PM to include no signs of injury. The next documented nurse note was 10/3/12. A nurse note of 11/28/12 at 10:50 AM revealed the resident slid off of the side of bed trying to fix his pants (per resident) and slid onto the floor mat. The next nurse note was documented on 11/29/12 at 2 AM and revealed the resident received no injury. A nurse note was documented on 11/29/12 at 1 PM and indicated the resident experienced " no apparent injury " from sliding off the side of the bed on 11/28/12. The next nurse note was documented on 12/3/12 at 7 PM and was unrelated to the fall of 11/29/12. An interview was conducted with Nurse #1 on 12/19/12 at 10:43 AM. The nurse reported when a resident fell, the following shift was to document vital signs and the resident was assessed for any new changes, like bruises. Nurse #1 stated nurses were expected to assess and document on the resident every shift for 3 days after a fall. An interview was conducted with MDS Nurse #1	F 309		

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F 309	Continued From page 9 on 12/19/12 at 11:01 AM. The MDS nurse reported nurses were expected to document the fall in the nurse notes and document every shift for 72 hours after a resident fell. An interview was conducted with the Director of Nursing (DON) on 12/19/12 at 11:15 AM. The DON indicated she expected the nurses to follow the falls protocol and document on the resident for 3 days, every shift. In this case, the DON expected the nurses to document every shift for the 3 days and felt it was observed, but not documented as it should have been. The DON stated she expected the nurses to follow the facility's guidelines for falls documentation 2) Resident #72 was admitted to the facility 12/3/10. The resident ' s diagnoses included joint contracture of multiple sites, cerebral artery occlusion with infarct (stroke), and generalized muscle weakness. An MDS Assessment of 11/5/12, a quarterly assessment, revealed the resident ' s function status as totally dependent on 2 or more staff for bed mobility and transfer. ' The activity of walking in the room or corridor did not occur; and required total assistance for locomotion on and off the unit, dressing, and toilet use. The assessment indicated the resident had 2 or more falls since admission but none since the prior assessment A facility report revealed Resident #27 experienced a fall on 9/4/12 at 7 AM. Review of the resident ' s medical record revealed a nurse note documented on 9/4/12 at 2 PM. The note	F 309		

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F 309	Continued From page 10	F 309		

indicated the resident was very talkative and appropriate and indicated the resident tried to go the bathroom and walk unassisted. The resident was taken to the bathroom and an alarm was placed on his wheelchair. The next nurse note was documented 7/7/12 for a " Monthly Summary "

Review of a nurse note of 11/5/12 at 11:45 AM revealed the resident was found sitting on the bathroom floor. The resident was assessed and sent to the emergency room for evaluation. The resident returned to the facility on 11/512 at 9 PM and documented hospital recommendations received. Documentation also included the resident had no complaints of pain or discomfort. Post fall documentation continued and was documented 11/6/12 at 2:20 AM., 11/6/12 at 1:50 PM, 11/6/12 at 6:15 PM, and the last documentation was written 11/7/12 at 12:30 AM on the resident ' s post-fall status.

An interview was conducted with Nurse #1 on 12/19/12 at 10:43 AM, the nurse reported when a resident fell, the following shift was to document vital signs and the resident was assessed for any new changes, like bruises. Nurse #1 stated nurses were expected to assess and document on the resident every shift for 3 days after a fall.

An interview was conducted with MDS Nurse #1 on 12/19/12 at 11:01 AM. The MDS nurse reported nurses were expected to document the fall in the nurse notes and document every shift for 72 hours after a resident fell..

An interview was conducted with the Director of Nursing (DON) on 12/19/12 at 11:15 AM. The

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F 309	Continued From page 11 DON indicated she expected the nurses to follow the falls protocol and document on the resident for 3 days, every shift. The DON stated she expected the nurses to follow the facility's guidelines for falls documentation.	F 309		
F 323 SS=D	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 staff interviews and record review, the facility failed to implement new interventions after a fall for 1 (Resident #27) of 3 sampled residents who had multiple falls. Findings include: Resident #27 was re-admitted to the facility on 11/16/07 with diagnoses to include dementia, lack of coordination, paralysis agitans (similar to Parkinson's disease), and anxiety state. Review of the resident's most recent Minimum Data Set (MDS), a quarterly assessment of 12/5/12, indicated the resident had severe cognitive impairment and required total care of 2 or more staff for bed mobility, and extensive assistance of one staff member for transfer and locomotion on and off the unit. The assessment	F 323	F 323 483.25 (h) FREE OF ACCIDENT HAZARDS/SUPERVISION/ DEVICES The medical record for resident #27 has been reviewed on 12/28/2012 by the interdisciplinary team and new interventions discussed and updated. Interdisciplinary team met on 12/28/2013 and reviewed fall reports in last 90 days for accuracy. Current interventions in place and new interventions for that fall. Residents that are high risk for falls were discussed by interdisciplinary team for appropriate interventions. Care plans reviewed and up dated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345356	A. BUILDING _____ B. WING _____	C 12/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICH SQUARE HEALTH CARE CENTER	320 NORTH MAIN STREET RICH SQUARE, NC 27869

(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 12 revealed the resident did not walk. Resident #27 was assessed as having had functional limitations of both upper extremities and both lower extremities. Review of the resident's care plan of 12/11/12 revealed a problem identified as "At Risk of Further Falls". The goal was written as: Resident will not have any injuries from falls (for) 90 days. Interventions were listed in part as: Remind resident to ask for assistance by pushing call bell, encourage resident to call for assistance, keep personal items within reach, and replace all resident's personal items back within reach. A facility report regarding Resident #27 ' s falls revealed staff found the resident on the floor on 5/17/12 at 3:05 PM. The resident was on top of the mat lying on his left side. Vomit was noted under his face, and was orange and clear in color. The resident stated he was fine and that he slid out of his bed. No injuries were noted. Bed alarm was active and sounding. Call bell was within reach. Review of the fall's investigation and follow-up indicated in part: " what additional interventions are recommended? The written answer was documented as: " frequent check when walking past door ". An interview was conducted with the Director of Nursing (DON) on 12/20/12 at 1:58 PM. The DON indicated frequent checks when walking past the door were part of staffs' regular routine and was not a new intervention. A facility report regarding Resident #27's falls revealed the resident was found on the mat beside the bed on 6/29/12 at 6:30 AM. The	F 323	F 323 continued from page 12 Licensed nurses were in-serviced by the DON and educated on falls interventions, timeliness and follow up on 12/21/2013. Newly hired licensed nurses will be educated on post fall prevention and documentation during orientation. DON will audit falls report and post fall documentation for appropriateness and timeliness weekly x 4 weeks, then every 2 weeks x 4 weeks, then every month x 4 months for new interventions and post fall documentation. The DON will bring results to the monthly QA meeting. Correction Date: 01/15/2013	1/17/2013

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F 323	Continued From page 13 resident stated he was fine and that he slid out of his bed. The resident reported he climbed out of the bed onto floor because he " spilled some water ". Review of the fall ' s investigation and follow-up indicated in part: " what additional interventions are recommended? " The space for new interventions was left blank. An interview was conducted with the Director of Nursing (DON) on 12/20/12 at 1:58 PM regarding the resident's fall on 6/29/12. The DON stated she didn't see any new interventions to prevent falls from re-occurring. A facility report regarding Resident #27's falls revealed on 9/19/12 at 2:50 AM revealed the resident was reaching for a call light and toppled out of a wheelchair onto a mat. The alarm was in place and sounded. Review of the fall's investigation and follow-up indicated in part: What additional interventions are recommended? The written answer was documented as: " Resident has dementia but severally impaired, has ability to understand he should call for assistance with picking up items. " An interview was conducted with the DON on 12/20/12 at 1:58 PM. The DON stated there were no new interventions for the fall and expected new intervention were implemented for every fall. A facility report regarding Resident #27's falls revealed on 11/28/12 at 10:50 AM, the resident slid off the side of the bed onto the floor mat while trying to fix his pants. Review of the fall's investigation and follow-up indicated in part: What additional interventions are recommended? The written answer was documented as: "	F 323		

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F 323	Continued From page 14 Remind resident to use call light for assistance. Educate staff to check resident frequently and offer assistance as needed ". An interview was conducted with the DON on 12/20/12 at 1:58 PM. The DON stated the intervention to remind the resident to use call light was not appropriate due to dementia and the resident was not going to remember. The DON indicated new interventions are expected with each fall and there were no new interventions for the falls. An interview was conducted with Nurse #2 on 12/20/12 at 12:58 PM. The nurse stated she completed the investigation and follow-up on the accident/incident reports. The nurse stated that most of the time, the resident couldn't remember the fall. The nurse stated frequent checks when walking past the door was a general standard for all staff. At the time she wrote the intervention for the fall of 5/17/12, she thought it was appropriate to check on him more often to assist him with things he may have dropped. Regarding the fall of 6/29/12, Nurse #2 reported the nurse who reviewed the fall report no longer worked at the facility. The fall of 8/21/12, the nurse stated, when looking at the care plan, her real goal was to prevent injury and each time the resident fell. The MDS nurse stated she didn't know what to do at this point except protect him from injury.	F 323		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371	F 371 483.35 (I) FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY	

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F 371	Continued From page 15 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews, the facility failed to store cheese in a safe manner to prevent mold, the facility failed to maintain a convection oven, range, and can opener in clean condition. Findings include: An initial tour of the facility ' s walk in refrigerator with the Dietary Manager (DM) on 12/17/12 at 10:12 AM revealed a bag of yellow and white mixed grated cheese. The cheese contained a small clump of greenish-blue matter. The zippered plastic storage bag for the cheese was dated as opened 12/6/12 and was partially opened across the top half of the bag. Review of the most recent " Position ' A ' Daily Cleaning Duties " of 12/12/12 revealed #7 as " Clean refrigerator for dessert and tea storage, organize and discard out of date food " . The task was not signed as having been completed. The DM stated the bag was expected to be closed and the cheese needed to be discarded because of the greenish-blue matter. An observation of the hand operated can opener on 12/17/12 at 10:20 AM revealed a buildup of blackened matter on the face of the cutting blade. Blackened/brownish matter was observed around the base of the can opener where it was attached	F 371	F371 continued from page 15 No resident was named in citation. Any resident in facility can be affected by this practice. The DM discarded the moldy cheese on 12/17/2013. The can opener, convection oven, and oven knobs were cleaned on 12/17/2013 by the Maintenance Manager. The kitchen staff was in-serviced on job descriptions defining areas of the kitchen each position was responsible for cleaning on 1/8/2013 by the DM. The DM in-serviced the kitchen staff regarding food requiring dating and checking at each shift for spoilage. Discard any out-of-date or spoiled food. Food preparation equipment is to be effectively sanitized, stored and cleaned to prevent potential sanitation issues on 1/8/2013. Newly hired dietary staff will be instructed regarding food dating and discarding of food and sanitizing of preparation during their orientation with the DM.	

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F 371	Continued From page 16 to a stainless steel table. The DM stated the area was expected to be cleaned daily by kitchen staff and the area needed a little "elbow grease" when being cleaned. An observation of the convection oven on 12/17/12 at 10:22 AM revealed a buildup of light brown/tan matter on the inside of the doors that also collected around the glass insert in the doors. There was a buildup of blackened matter in the corners under the door hinges and a buildup of brownish tan matter around the door stop in the center. An observation of the front of the oven on 12/17/12 at 10:26 AM revealed a buildup of blackened/brown matter on 6 of the knobs. Behind the knobs also had a buildup of blackened/brown matter. Two black knobs with silver colored centers had blackened/brown buildup matter on the face of the knobs. There was darkened matter buildup around the base of the knobs and the outer edges of the silver covered face of the knobs. The right side of the oven had a seam between the splash guard for the top of the oven and the base of the oven. The seam across the bottom of the splash guard and at the back of the guard was filled with greasy blackened matter. The DM stated kitchen staff cleaned the oven three times weekly. An interview was conducted with the Cook on 12/17/12 at 10:32 AM. The Cook revealed she usually cleaned the oven once a week but did not document when she cleaned it and probably cleaned it last on Wednesday of last week. Review of the kitchen ' s " Position ' A Daily	F 371	F371 continued from page 16 Cleaning assignments for areas and equipment located in and used by the kitchen staff have been assigned to each kitchen employee position (cook, Position A & position B). Descriptive check sheets for each position have been implemented and each position on every shift must complete their assigned cleaning tasks prior to shift end. The DM conducted an in-service for position responsibilities regarding cleaning and the new forms on 1/8/2013. Newly hired employees will be instructed on their cleaning assignments related to their position of hire by the DM during orientation. A triple check system for cleanliness has been implemented which includes the Dietary Manager, Maintenance Supervisor and Administrator. The Dietary consultant will also conduct inspections when on premises.	

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F 371	Continued From page 17 Cleaning Duties " dated 12/12/12, and the " B " Position Duties dated 12/14/12 revealed no specific schedule for cleaning the range, convection oven, or can opener. During an interview with the DM on 12/20/12 at 2:30 PM, the DM indicated there was no deep cleaning schedule for the kitchen. An interview was conducted with the Administrator on 12/20/12 at 3:45 PM. The Administrator indicated the refrigerator was expected to be free of colored matter in the stored cheese and expected the kitchen equipment to be clean.	F 371	F371 continued from page 17 The DM and MS will provide the Administrator with the work sheets 5 x /week for 12 weeks, then weekly for 3 months. The results of these audits will be discussed at the monthly QA meeting by the DM. Date completed: 01/11/2013.	01/17/2013

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345356	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 12/20/2012

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RICH SQUARE HEALTH CARE CENTER	320 NORTH MAIN STREET RICH SQUARE, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 284	483.20(l)(3) ANTICIPATE DISCHARGE: POST-DISCHARGE PLAN

When the facility anticipates discharge a resident must have a discharge summary that includes a post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment.

This REQUIREMENT is not met as evidenced by:
Bases on record review and staff interviews, the facility failed to develop a care plan for discharge for 1 (Resident #89) of 2 sampled residents who were reviewed for community discharge. Findings include:

Resident #89 was admitted to the facility on10/05/12. Cumulative diagnoses included diabetes mellitus, muscle weakness, difficulty walking, depressive disorder and insomnia.

Review of the admission Minimum Data Set (MDS) assessment, dated 10/12/12, indicated Resident #89 had no short or long term memory problems and was able to make daily decision. The assessment revealed the resident rejected care 1-3 days a week, was totally dependent on staff for bed mobility, transfers, and bathing; required extensive assistance for personal hygiene; and, was able to walk in the room and to toilet with limited assistance. Review of section Q of the MDS regarding goal setting, the assessment indicated both the resident and the family participated in the interview, that an active discharge plan was in place for the resident ' s return to the community, and that referrals had been made to the local contact agency.

Review of Resident #89 ' s medical record and admission care plan revealed no plan for discharge.

Review of the Social Worker ' s admission note, dated 10/05/12, revealed the resident had been admitted for rehabilitation to return home.

Review of the Social Worker ' s progress note, dated 12/06/12, indicated the resident was alert, oriented, made needs known and was able to do something ' s for himself. The note continued that the resident had scored well on a brief interview for mental status, and had some mood indicators like feeling down related to missing home. Further the note indicated the resident came to the facility for therapy, had plans to return home which had not happened, and discharge at the time was uncertain.

An interview, on 12/19/12 at 5:35 PM, was conducted with the Social Worker (SW). The SW relayed that when Resident #89 was admitted to the facility, he and the family wanted him to stay at the facility for 20 days to get stronger. She indicated he did not progress as expected and the decision was made to keep him at the facility a little longer. The SW stated at this time the family goes back and forth about Resident #89 going home. She relayed that she does stay in contact with the family regarding their choices, but had not documented any of the information in the medical record related to the progression of the discharge plans. When asked about the information on the MDS related to discharge plans in place and the referrals being made, the SW stated that was the intent at the time of the assessment that he would be returning home. The SW relayed she knew what would be needed with regards to discharge of the resident and the agency that

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM OR SNFs AND NFs	PROVIDER # 345356	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 12/20/2012

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 284	Continued From Page 1 would be contacted when it was needed so she does not document any plan.

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

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	345356	A. BUILDING 03 - NEW BUILDING /NEW LO B. WING _____ MAR 04 2013	02/13/2013

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K 000	INITIAL COMMENTS A. Based on observation on -2/13/2013 the facility is type V 111 and is completely covered by a sprinkler system.	K 000	K-18 Preparation and/or execution of the plan of corrections does not constitute admission or agreement by the provider of the truth of the items alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provision of the Federal and State laws. Door closures in the: • Clean Linen Room • Chart Room Have been repaired by Maintenance Supervisor and are operating correctly as of 3/8/2013.. Door Latch at the Kitchenette Dutch Door has been added to insure the top will latch automatically when closed to the lower pert of the Dutch Door as of 3/8/2013. A monitoring tool has been created to insure that doors and closures in the facility are monitored on a weekly basis for proper functioning by the Maintenance Supervisor.	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings are constructed to resist the passage of smoke. Doors are provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches are prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: A. Based on observation on 02/14/2013 the Charting room and the clean linen room at the nurses station failed to latch when closed. 42 CFR 483.70 (a)	K 018		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 02/14/2013 the interior release device for the freezer and the cooler were blocked by food racks. 42 CFR 483.70 (a)	K 038		

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

Virginia S Lambert DON | RN-DON | 2.28.13 CD

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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			Monitoring tool will be submitted to the administrator for 12 weeks. Then monthly for 3 months any changes or repairs necessary will be accomplished within 48 hours of notification to Administrator. Administrator shall report any corrective measures accomplished for door closures at monthly QA meeting. K-38 Emergency escape cranks in the Kitchen: • Walk-In Freezer • Refrigerator Have had the shelving legs obstructing proper operations shimmed away by Maintenance Supervisor from escape cranks, and are operating correctly as of 3/8/2013.	3/8/2013

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

CD

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			A monitoring tool has been created to insure that these escape cranks are checked on a weekly basis for proper functioning by the Maintenance Supervisor and will be submitted to the administrator for 12 weeks. Then monthly for 3 months. Administrator will report any changes in status and repairs required at monthly QA meeting.	3/8//2013

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