STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	05/31/2013

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STANLY MANOR	625 BETHANY CHURCH RD BOX 38 ALBEMARLE, NC 28001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The 2567 was amended 6/18/2013. F456 was deleted.	F 000	Resident #70 had catheter bag cover placed on catheter bag to ensure privacy and dignity.	5-29-13
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to cover the urinary catheter bag for 1 (Resident # 70) of 2 sampled residents with an indwelling catheter, and failed to sufficiently cover 1 (Resident #19) of 3 residents reviewed for dignity by allowing the resident to remain exposed in an incontinent brief. The findings included: 1. Resident #70 was admitted to the facility on 5/1/13 with multiple diagnoses including neurogenic bladder. The admission MDS assessment dated 5/14/13 indicated that Resident #70 had moderate cognitive impairment and had a catheter. On 5/28/13 at 11:05 AM and on 5/29/13 at 10:30 AM and 2:25 PM, Resident #70 was observed in bed with an indwelling catheter in place. The catheter bag was not covered and was visible to the hallway. On 5/29/13 at 2:30 PM, NA #1 (nurse's aide) was interviewed. She stated that the catheter bag	F 241	All current residents with catheters had catheter bag covers placed on catheter bags to ensure privacy and dignity. DON revised catheter policy to include "catheter bag to be covered at all times." All nursing dept staff and therapy Dept staff on all shifts/on all days of the week all part time/ full time/ and relief staff will be in-serviced on use of catheter bag covers on all residents with catheters at all times by the SDC RN. All nursing staff on all shifts/on all days of the week/ all part time/ full time/and relief will be in-serviced on revisions to the catheter policy to include "catheter bags to be covered at all times" This in-service was completed by the SDC RN. Resident #19 was covered by nursing staff to ensure privacy and dignity. Rounds were completed by facility staff to ensure no further exposure issues were noted.	5-29-13 6-21-13 6-27-13 6-27-13 5-29-13 5-29-13

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

Stephanie Ich-Honeycutt | Administrator | 6-27-2013

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 241	Continued From page 1 was only covered when the resident was up in wheelchair. On 5/29/13 at 3:45 PM - MDS Nurse #1 was interviewed. She stated that catheter bag should be covered at all times. On 5/30/13 at 4:05 PM, administrative staff #1 was interviewed. She stated that catheter bag should be covered at all times. 2. Resident #19 was admitted to the facility on 6/5/12. Diagnoses included Alzheimer's disease and dementia. The quarterly Minimum Data Set (MDS) dated 4/24/13 revealed the resident had severe cognitive impairment. On 5/29/13 at 10:35 AM, Resident #19 was observed lying on his bed with no covers on and wearing a T shirt and incontinent brief. The door to his room was wide open. Housekeeping Staff (HS) #1 was observed to enter the room and mop the floor. The door was left open and the resident remained uncovered. During an interview on 5/29/13 at 10:37 AM, HS#1 said she should have either covered the resident or called for the nursing assistant. HS#1 added that she was concentrating on finishing her assigned cleaning tasks before the housekeeping carts had to be off the hall. During the interview, a nursing assistant was observed to enter the room and close the door. During an interview on 5/31/13 at 9:22 AM, the	F 241	All current facility staff will receive in-service on privacy, dignity and respect of each residents individuality. Ongoing education regarding dignity and privacy will be provided annually and at new employees orientation. Resident liaison or Activity Director will conduct a walk through audit to monitor dignity, privacy, and respect of each residents individuality and to monitor catheter bags coverage useage. The audit will take place weekly and will include all residents care areas and common areas. The audit information will be discussed in QA monthly until three months of compliance is sustained.	6-27-13 6-27-13 6-21-13

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F 241	Continued From page 2 Housekeeping Director (HD) stated she expected staff to intervene in some manner if a resident was exposed inadequately clothed, such as by letting the nurse or nursing assistant know, pulling the curtain, or just covering the resident if possible. During an interview on 5/31/3 at 10:09 AM, the Staff Development Coordinator (SDC) indicated that she taught new housekeeping employees during their orientation that they cannot do direct care but can do minimal things for the residents. The SDC said if a resident was exposed, she would expect the housekeeper, at a minimum, to use the call light for the nurse and pull the privacy curtain.	F 241	diately updated resident #4 use	5-29-13
			Dietary Manger immediately updated care plan to reflect resident #60's weight loss	5-29-13
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment	F 279	All resident care plans were reviewed by the MDS nurse to ensure that a care plan had been developed on all residents with urinary catheters The facility's systematic approach to updating care plans in regards to catheter care will be managed by reviewing all new admission orders, 24hr reports and telephone orders completed by SDC RN or MDS RN daily Mon-Fri. Care plans will be developed for use of Foley catheter within one week of initiation of order.	5-31-13 6-21-13

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F 279	Continued From page 3 under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to develop a care plan for the use of the indwelling catheter for 1 (Resident #4) of 2 sampled residents with indwelling catheters and for 1 (Resident #60) of 3 residents with on-going weight loss. The findings included: 1. Resident #4 was admitted to the facility on 8/6/12 with multiple diagnoses including urinary retention and neurogenic bladder. The quarterly Minimum Data Set (MDS) assessment dated 4/10/13 indicated that Resident #4 was cognitively intact and was always incontinent of bladder. On 5/1/13, there was a doctor's order to insert an indwelling catheter and to connect to a drainage bag for diagnosis of neurogenic bladder. The care plans were reviewed. There was no care plan developed after 5/1/13 for the use of the indwelling catheter. On 5/29/13 at 3:45 PM, MDS Nurse #1 was interviewed. She stated that she updated the care plans when there were changes in the resident's plan of care. She added that she had to review the 24 hour reports everyday and had to update the care plan if there were changes in the plan of care. She revealed that she did not develop the care plan for the indwelling catheter because she was not informed when the indwelling catheter was inserted for Resident #4.	F 279	The facility systematic approach to updating care plans for significant weight loss reports will be managed by the Dietary Manger or the MDS nurse through the interdisciplinary weight committee held weekly. An update to the care plan will take place if a significant wt loss is noted by the Dietary manager or MDS RN. All residents triggering for significant weight loss will be reviewed by the Dietary Manager and a care plan will be developed within one week by the Dietary Manager or the MDS RN All current care plans will be audited every two weeks by DON or ADON to ensure all residents with Foley catheters or significant weight loss have a care plan documented to address weight loss and/or catheter issues The audits of catheter and wt loss will be reviewed at the Monthly QA committee until three months of compliance is met.	6-21-13 6-27-13 6-21-13 6-21-13

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F 279	Continued From page 4 2. Resident #60 was admitted to the facility on 12/17/12. Diagnoses included progressive dementia, diabetes, congestive heart failure and history of multiple cerebrovascular accidents. Admission orders included a no added salt, no concentrated sweets diet. The admission Minimum Data Set (MDS) dated 12/29/12 indicated Resident #60 had memory problems, severe cognitive impairment, required extensive assistance with eating and received a therapeutic diet. The Care Area Assessment (CAA) for nutrition, dated 12/29/12, revealed the resident's intake ranged from 0 - 100% of meals. The care plan dated 1/6/13 included a problem of needing therapeutic diet due to diabetes, congestive heart failure and hypertension. The goal was, "Resident will consume 75-100% of diet daily over the next 90 days." Interventions included diet as ordered, monitor weights and report continued loss to MD. Weights were as follows: 12/19/13 - 208 pounds 1/18/13 - 202 pounds 2/21/13 - 186 pounds A Nutritional Progress Note dated 2/2813 included 5.1% weight loss in 30 days. The physician and responsible party aware made aware of the weight loss. Physician orders dated 3/1/13 included sugar free ice cream with lunch and dinner daily.	F 279		

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F 279	Continued From page 5 On 3/19/13, Resident #60's weight was 182. The quarterly MDS dated 3/20/13 revealed no changes in cognition, amount of assistance needed with eating or therapeutic diet. A Nutritional Progress Note by the Dietary Manager (DM) dated 3/22/13 acknowledged the continued weight loss. The DM recommended whole milk with all meals; this was approved by the physician. The care plan was reviewed on 3/22/13 with a written notation, initialed by the DM, to continue an additional 90 days. The care plan did not address weight loss. On 4/16/13, Resident #60's weight was 177 pounds. The DM note dated 4/19/13 acknowledged continued weight loss and recommended to stop the sugar free ice cream and start sugar free Magic Cups with lunch and supper to increase caloric intake. On 4/22/13 the physician approved the Magic Cups as recommended. On 5/16/13 the resident's weight was 172 pounds. During an interview on 5/29/13 at 4:26 PM, the DM stated that she would care plan weight loss if meal consumption was 25% or less or if the resident had a significant weight loss. During an interview on 5/29/13 at 5:27 PM, Administrative Staff #1 stated weight loss was discussed by the weight committee, either weekly or monthly depending on how frequently the resident was weighed. Administrative Staff #1	F 279		

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F 279	Continued From page 6 indicated that she expected Resident #60 to have been care planned for weight loss since weight loss had been identified before the quarterly assessment in March.	F 279	The order for sugar free magic cup with lunch and supper was immediately added to the MAR for resident #60. The order for sugar free ice cream was removed. Dietary communication slip was completed by nursing and given to Dietary. Assistant Dietary Manager updated residents meal card with the changes. All current resident charts were audited by the medical records assistant to ensure that all residents with order supplements were receiving them as ordered.	5-31-13 6-12-13
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to follow physician orders to prevent further weight loss for 1 of 3 residents (Resident #60). The findings included: Resident #60 was admitted to the facility on 12/17/12. Diagnoses included progressive dementia, diabetes, congestive heart failure and history of multiple cerebrovascular accidents. Admission orders included a no added salt, no concentrated sweets diet. The admission Minimum Data Set (MDS) dated 12/29/12 indicated Resident #60 had memory problems, severe cognitive impairment, required extensive assistance with eating and received a	F 325	Systematic changes will include By monthly audits by the DON, ADON, Dietary Manager or Assistant Dietary Manager to ensure that all residents with supplement orders are receiving them as ordered The audits will be reviewed monthly at the QA meeting and will continue to be reviewed until three months of compliance is sustained.	6-21-13 6-21-13

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F 325	Continued From page 7 therapeutic diet. The Care Area Assessment (CAA) for nutrition, dated 12/29/12, revealed the resident's intake ranged from 0 - 100% of meals. The care plan dated 1/6/13 and reviewed 3/22/13 included a problem of needing therapeutic diet due to diabetes, congestive heart failure and hypertension. The goal was, "Resident will consume 75-100% of diet daily over the next 90 days." Interventions included diet as ordered, monitor weights and report continued loss to MD. Weights were as follows: 12/19/13 - 208 pounds 1/18/13 - 202 pounds 2/21/13 - 186 pounds A Nutritional Progress Note dated 2/2813 included 5.1% weight loss in 30 days. Physician and responsible party aware of weight loss. Physician orders dated 3/1/13 included sugar free ice cream with lunch and dinner daily. On 3/19/13, Resident #60's weight was 182. A Nutritional Progress Note by the Dietary Manager (DM) dated 3/22/13 acknowledged the continued weight loss. The DM recommended whole milk with all meals; this was approved by the physician. On 4/16/13, Resident #60's weight was 177 pounds. The DM note dated 4/19/13 acknowledged continued weight loss and recommended to stop the sugar free ice cream and start sugar free Magic Cups with lunch and supper to increase caloric intake. On 4/22/13 the physician approved the Magic Cups as	F 325		

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F 325	Continued From page 8 recommended. Review of the April Medication Administration Record (MAR) revealed Sugar Free Magic Cup at 1200 (12:00 PM) and 1700 (5:00 PM) beginning 4/22/13, and Sugar Free Ice Cream with lunch and supper was crossed out as discontinued on 4/22/13. Review of the May MAR revealed "Sugar Free Magic Cup" BID (twice a day) with a line drawn through "Magic Cup" and "Ice Cream" was written in. There was no physician order in the chart to stop the Magic Cup and resume the ice cream. Observation on 5/29/13 at 5:31 PM revealed Resident #60 being fed supper. The tray slip read for Sugar Free Ice Cream with supper, and the ice cream was on the tray. Magic Cup was not included on the tray or tray slip. Observation on 5/30/13 at 12:45 PM revealed Resident #60 being fed lunch. The tray slip read for Sugar Free Ice Cream with lunch, and the ice cream was on the tray. Magic Cup was not included on the tray or tray slip. During an interview on 5/31/13 at 7:58 AM, Administrative Staff #1 indicated that the Magic Cup should not have been crossed off the MAR. If an order on the MAR is changed, the expectation is that the old order is completely crossed off and dated, and the new order is entered on a blank section of the MAR.	F 325		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of	F 332		

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F 332	Continued From page 9 medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to ensure that medication error rate was 5% or below by not following the manufacturer's specifications. Three errors (Resident #22) of 26 opportunities were observed resulting in 11.5% error rate. The findings included: 1a. Resident #22 was originally admitted to the facility on 7/27/12 and was re-admitted on 5/29/13 with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD). The facility's policy (undated) for " Administration of oral inhalers " was reviewed. The policy read in part " 6. Administer medications as follows: g. repeat doses, as prescribed, allowing at least 1 minute between puffs. " The records revealed that Resident #22 was re-admitted to the facility on 5/29/13. The telephone order dated 5/29/13 revealed " cancel orders from (name of hospital). Resume all prior orders with changes oxygen ordered. " The physician's orders for May, 2013 revealed that Resident #22 had an order dated 7/28/12 for Symbicort (combination of corticosteroid and beta 2-adrenergic agonist) - inhale 2 puffs by mouth daily for COPD (shake well, wait 1 minute between puffs, rinse mouth after use).	F 332	Resident #22 was monitored for any reactions occurring due to administration of eye drops, and inhaler not being administered as directed. Resident #22 had additional instructions added to inhalers and eye drop order to include waiting one minute between puffs of inhaler and rinsing mouth after every inhaler administration of steroid. Additional instructions were added to eye drop order to wait 3-5 mins between each drop of same or different eye drop." Nurse #2 was immediately counseled on proper administration of inhaler and eye drops by the SDC RN. All current resident orders were reviewed by staff nurse to ensure proper instruction is present on orders for inhalers or eye medications to include "wait 3-5 mins between drops of same or different eye meds" "Wait one minute between puffs on inhalers and rinse mouth after use."	5-29-13 5-30-13 5-29-13 6-21-13

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F 332	Continued From page 10 On 5/30/13 at 8:05 AM, Nurse #2 was observed during the medication pass. Nurse #2 was observed to prepare and to administer 2 puffs of Symbicort to Resident #22 without waiting at least a minute between puffs. At 8:25 AM, Nurse #2 was interviewed. She stated that she did not know how long she had to wait between puffs. She acknowledged that she did not wait at least one minute between puffs. 1b. Resident #22 was originally admitted to the facility on 7/27/12 and was re-admitted on 5/29/13 with multiple diagnoses including Chronic Obstructive Pulmonary Disease (COPD). The facility's policy (undated) for " Administration of oral inhalers " was reviewed. The policy read in part " the resident's mouth should be rinsed after administering steroid inhalers. " The records revealed that Resident #22 was re-admitted to the facility on 5/29/13. The telephone order dated 5/29/13 revealed " cancel orders from (name of hospital). Resume all prior orders with changes oxygen ordered. " The physician's orders for May, 2013 revealed that Resident #22 had an order dated 7/28/12 for Symbicort - inhale 2 puffs by mouth daily for COPD (shake well, wait 1 minute between puffs, rinse mouth after use). On 5/30/13 at 8:05 AM, Nurse #2 was observed during the medication pass. Nurse #2 was observed to prepare and to administer 2 puffs of Symbicort to Resident #22. Nurse #2 was not	F 332	All licensed nursing staff, and med aides on all shifts/on all days of the week and weekend/ all part time/ full time/and relief will be in-serviced on proper administration of eye medications and inhalers to include "wait times between eye medications, wait time between inhaler puffs and rinsing mouth after use." Also in-serviced on medication pass observation. Education completed by pharmacy consultant or SDC RN. All inhaler and eye drop orders will be reviewed monthly to ensure instructions are present during monthly review of MAR's by SDC RN and or ADON. Systematic approach will be implemented to perform one medication pass audit per week on licensed nursing staff and/ or medication aides (this will include full time part time and relief staff). Observation will include all shifts/on all days randomly. Audit will observe 25 medication opportunities. Audits will be performed by DON, ADON, SDC or pharmacy services	6-27-13 6-27-13 6-27-13

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F 332	Continued From page 11 observed to instruct Resident #22 to rinse her mouth after. At 8:53 AM, Nurse #2 was interviewed. She stated that she was aware that she had to rinse the mouth after administration of steroid inhaler. She acknowledged that she did not instruct the resident to rinse her mouth after and stated " I would do it now. " 1c. Resident #22 was originally admitted to the facility on 7/27/12 and was re-admitted on 5/29/13 with multiple diagnoses including dry eyes. The facility's policy (undated) for " Administration of eye drops " was reviewed. The policy read in part " 13. If (2) or more different eye drop preparations are to be used in the same eye or more than one drop of the same medication in the same eye, wait at least three (3) to five (5) minutes before instilling each additional medication to the eye. " The records revealed that Resident #22 was re-admitted to the facility on 5/29/13. The telephone order dated 5/29/13 revealed " cancel orders from (name of hospital). Resume all prior orders with changes oxygen ordered. " The physician's orders for May, 2013 revealed that Resident #22 had an order dated 11/6/12 for " Artificial Tears - instill 2 drops in both eyes twice a day for dry eyes - wait 3-5 minutes between eye drops. " On 5/30/13 at 8:05 AM, Nurse #2 was observed during the medication pass. Nurse #2 was observed to prepare and to instill 2 drops of Artificial Tears to both eyes of Resident #22.	F 332	Audits of medication passes will be reviewed monthly at the QA meeting until three months of compliance is met.	6-27-13

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	345281	A. BUILDING _____ B. WING _____	05/31/2013

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

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F 332	Continued From page 12 Nurse #2 was not observed to wait at least 3 minutes between drops. At 8:25 AM, Nurse #2 was interviewed. She stated that she was aware that she had to wait for 5 minutes between drops. She acknowledged that she did not wait 5 minutes between drops but did not provide any explanation.	F 332		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on policy review, observations and staff interviews, the facility failed to ensure that opened food containers were labeled and dated, discard expired food items, date frozen health shakes, once placed in the refrigerator for thawing and use a sanitation solution at the correct concentrated strength, when wiping down surfaces. The findings included: The facility's Dietary Services Daily Operation policy, dated November, 2012 stated that "All items are to be labeled and dated by cooks or Assistant Dietary Manager."	F 371	The four cheese Danishes and expired protein supplements were immediately removed and discarded by the Assistant Dietary Manager The unlabeled bins were immediately emptied, cleaned and labeled appropriately by the Assistant dietary Manager The undated healthy shakes were immediately removed and discarded by the assistant Dietary manager All food storage areas were checked to ensure proper labeling and dating was present by the assistant Dietary Manager. In-service was held for all Dietary staff, full time, part time, relief, all shifts and all days to educate on proper labeling, dating, and discarding of food items by the Dietary Manager.	5-28-13 5-30-13 5-30-13 5-30-13 6-4-13

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F 371	Continued From page 13 1. On 5/28/13 at 10:35 am, during the initial tour of the kitchen, 4 cheese danishes were found opened, and undated in the freezer. At 10:38 am, the Dietary Manager was interviewed. She stated that food that was found undated, should have been dated. 2. On 5/28/13 at 10:37 am, the dry storage room was toured. A case of high protein supplements (24 cans) were present with an expiration date of January 1, 2013. A second case of supplements was found with an expiration date of July 1, 2012. The Dietary Manager was interviewed on 5/28/13 at 10:40 am. She stated that staff accidentally forgot to remove the supplements from the dry storage area, when the facility stopped using the product a long time ago. 3. On 5/30/13 at 11:20 am, during a tour of the kitchen, 3 plastic bins were observed under the kitchen prep table, with three out of six of the bins lacking labels. At 11:21 am, the Dietary Manager was interviewed and asked what the contents in the unmarked containers were. She opened each one and identified, thickeners, egg noodles and bread crumbs. She stated that a dietary aide had wiped down the container earlier and forgotten to re-label the containers. 4. On 5/30/13 at 11:29 am, one of the two reach in coolers, had 9 undated healthy shakes placed in the unit to thaw. On the container was a guideline from the manufacturer that read, "Use	F 371	The liquid sanitizer solution noted at 150ppm strength was immediately discarded by the Assistant Dietary Manager. The sanitation liquid solution policy of Stanly Manor states ranges should be between 150ppm-200ppm. Dietary Staff full time/ part time/ relief All days and all shifts were educated on the policy of liquid sanitizer by the Dietary Manager. Dietary Manager or Assistant Dietary Manager will conduct weekly audits of storage areas to ensure proper labeling of dates and expiration reviews of products. This audit will also include weekly review of sanitizer solution to ensure proper range of solution. The audit for storage area to ensure Proper labeling and expiration of food Products along sanitizer solution log will be submitted at monthly QA to ensure compliance until three months of compliance is sustained.	5-30-13 6-4-13 6-11-13 6-21-13

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F 371	Continued From page 14 within 14 days after thawing." At 11:30 am, the Dietary Manager was asked how staff could tell when the shake was placed in the cooler to thaw. She stated that the original box gets dated once opened, while still in the freezer. She commented that the shakes were placed in the cooler earlier today and that she didn't realize that a date needed to indicate when the shake would expire. 5. On 5/30/13 at 11:40 am, the cook was observed, retrieving a rag from a small pail with liquid solution and wiping down surfaces. The Assistant Dietary Manager was asked to test the solution for its strength. She retrieved a special tape for the solution, which had color codes to indicate the strength. She stated that the goal was to have the solution at 200 strength. When she tested the solution, it read at 150. She then asked the cook how long she had been using the solution and the cook responded since 11:00 am. The Assistant Dietary Manager tossed out the solution, created a new batch and tested it. It read 200. At 11:41 am, the Dietary Manager was interviewed. She commented that apparently the chemical strength breaks down the more the solution gets used. The Assistant Dietary Manager stated that their staff checks the solution daily, but does not record the strength once tested.	F 371		
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly.	F 372		

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 372	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to properly dispose of empty food containers and maintain the cleanliness of the loading dock. The findings included: On 5/30/13 at 3:20 pm, three large plastic bags were observed stacked on top of each other, on the loading dock. In front of the bags, was a dark burgundy syrup substance, dried into the cement. There were two large trash barrels with lids, next to the stacked bags, that had two additional large plastic bags, covered in thick cob webs, lying on top of the containers. The maintenance assistant was present and stated that the dietary department placed their empty cans in bags and placed them on the dock for someone to pick up to recycle. He then opened the bag, which had many large empty institutional size food cans that had not been rinsed clean. He lifted the lid of the trash barrel, which was partially full and had more empty cans inside. He stated that his department did not maintain this area, that the dietary department was responsible for the loading dock. On 5/31/13 at 8:30 am, the Dietary Assistant Manager was interviewed. She stated that her staff placed the bags on the loading dock, but the cans were intended to be placed inside of the	F 372	Recyclable cans were immediately discarded off back dock by the Maintenance Director Walk through of back dock was conducted to ensure no other disposal issues were noted by the Maintenance Director. The systematic plan in place will be to discard of empty food containers in the main disposals bins. Stanly Manor has terminated the contract with the recycle company. The facility will perform bi-weekly walk throughs by the Maintenance Director or Housekeeper Director to ensure all back dock areas are In proper order. The walk throughs will be reviewed monthly at the QA meeting until three months of compliance is sustained.	5-30-13 5-30-13 5-31 -13 6-27-13 6-21-13

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 372	Continued From page 16 trash barrels. She was not certain how long the bags of cans had been sitting on the loading dock. On 5/31/13 at 11:15 am, Administrative Staff #2 was interviewed. She commented that the facility had made informal arrangements with a person in the community to retrieve the empty cans of food for recycling, but evidently he hadn't been visiting them too often, so she would need to explore other options.	F 372		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431	The vial of Aplisol not dated was discarded immediately. The medication refrigerator was inspected to ensure proper labeling of open medication by the DON. Education on proper labeling of multi-dose vial medication was given to licensed nursing staff and medication aides by the SDC RN and pharmacy consultant for all shifts all days, relief, full time, and part time. Systematic approach will include weekly audits of all medication refrigerator to ensure proper labeling of open medication by the DON or ADON. Audits will be reviewed monthly to in QA until three months of compliance is sustained.	5-30-13 5-31-13 5-31-13 6-21-13 6-21-13

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 431	Continued From page 17 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on facility policy, observation and staff interviews, the facility failed to date one opened multi-dose vial of Aplisol (tuberlin purified protein derivative vaccine used to test for tuberculosis) in one of one medication refrigerators. The findings included: An undated facility policy titled " Expiration of Opened Multi-dose vials " stated, in part, " Policy: All multi-dose vials of injectable medications and vaccines shall be dated by the designated staff person at the time that the seal is broken and the first dose drawn. " During a check of the medication refrigerator on 5/30/13 at 11:00 AM., a vial of Aplisol was noted to be opened and undated. On 5/30/13 at 11:00 AM., Nurse #1 stated the vial should have been dated when opened. On 5/30/13 at 11:15 AM., Administrative staff #1 stated the nurse should have put the date on the vial of Aplisol when it was opened.	F 431		

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	345281	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/27/2013

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type II (211) construction, two story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	The storage room near loading Dock that requires two motion to open was corrected. The tumbler device was taken out so only one motion is required to open the door. All facility exit doors were reviewed to ensure only one motion is required for opening.	July 1, 2013 July 1, 2013
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. 19.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 10:30 am onward, the following items were noncompliant, specific findings include: door to storage room near loading dock; requires two motion of hand to open door. 42 CFR 483.70(a)	K 038	A monthly walk through will be completed by the Maintenance Director or Staff Development Coordinator to ensure exit access doors are readily accessible at all times. The walk through will be documented on a monthly QA tracking form. The walk through QA tracking form will be discussed monthly at the QA meeting until three months of compliance is sustained.	July 30, 2013 July 30, 2013
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits.	K 072		

RECEIVED
JUL 15 2013
CONSTRUCTION SECTION

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

Stephanie Hunt-Honeycutt — Administrato — 7-10-13 GW

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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K 072	Continued From page 1 7.1.10 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 10:30 am onward, the following items were noncompliant, specific findings include: all drop down key pad's for wall mounted klosh system projects more than 7 inches from wall into corridor reducing width of corridor. 42 CFR 483.70(a)	K 072	The facility has purchased retractable springs that will be placed on the key board trays. These devices will ensure that the key boards automatically self close to an upright position when the keyboard is not in use. A walk through will be conducted to ensure all mounted key board trays receive the spring activated device.	August 11, 2013 August 11, 2013
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 10:30 am onward, the following items were noncompliant, specific findings include: generator did not crank and transfer within 10 seconds when tested. 42 CFR 483.70(a)	K 144	A monthly walk through will be completed by the Maintenance Director or Staff Development Coordinator to ensure key board mounts are working correctly and closing flush with wall. The walk through will be documented on a monthly QA tracking form. The walk through QA tracking form will be discussed monthly at the QA meeting until three months of compliance is sustained.	July 30, 2013 July 30, 2013

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			The generator was repaired by having a by- pass installed near the fuel block causing the time for the generator to crank within the regulated time of 10 seconds.	July 25, ,2013
			The maintenance director will continue to test weekly the generators cranking time to ensure the 10 second timing rate is maintained. The information will be recorded on the generator log.	July 30 2013
			The generator log will be reviewed at the QA meeting until 3 months of compliance is sustained.	July 30, , 2013