

AUG 02 2013

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FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345420	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/28/2013
NAME OF PROVIDER OR SUPPLIER ALAMANCE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1987 HILTON STREET BURLINGTON, NC 27217	
(X4) IO 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 170 SS=C	<p>483.10(j)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL</p> <p>The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews the facility failed to ensure the facility's resident mail was delivered to the facility and it's residents in a timely manor including on Saturdays for 173 of 173 facility residents. Findings include:</p> <p>On 06/28/2013 at 1:30 p.m., an interview was conducted with sampled resident #174. Sampled resident #174 indicated the facility has not had U.S.P.S. mail service (delivery/pick-up) on Saturdays for a long time and no resident as far as she knows receives mail on Saturday. Sampled resident #174 indicated there had been no explanation by administration or the activities director, who was responsible for delivering the mail to the residents as to why there was no mail delivery on Saturday.</p> <p>On 06/28/2013 at 1:55 p.m., an interview was conducted with the facility's administrator concerning delivery of the facility's mail to the resident's on Saturdays. The administrator indicated the facility's mail was handled and distributed by an administrative staff member and that the resident mail was delivered Monday through Friday. The administrator could not explain why there was no mail delivery on Saturdays.</p>	F 170	<p>The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.</p> <p>F 170 -</p> <p>1. How the corrective action will be accomplished for the resident(s) affected?</p> <p>Resident # 174 and all other residents will have mail delivery six days a week to include Saturday's.</p> <p>2. How corrective action will be accomplished for those residents with the potential to be affected by the same practice?</p> <p>All residents will have mail delivery six days a week to include Saturday's.</p> <p>3. Measures in place to ensure that practices will not occur -</p> <p>Administrator will monitor delivery of mail on weekends to assure delivery is taking place by auditing weekly on Mondays x four than monthly x one.</p>	7/31/13

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

[Handwritten Signature]

TITLE

Administrator

(X6) DATE

7/22/13

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 170	Continued From page 1 On 06/26/2013 at 2:00 p.m., an interview was conducted with the facility's administrative staff member who was identified as handling the resident's mail. The administrative staff member indicated she received the facility's mail Monday through Friday from the U.S.P.S. carrier and separated the mail (business and resident mail) and would put the resident's mail into the activities director's in box and the activities director would then pick up the mail and deliver it to the facility's residents. The administrative staff member was asked if she worked on Saturdays and/or what the process was for the residents to receive their mail on Saturdays. The administrative staff member indicated she did not work on Saturdays and the U.S.P.S. had not delivered mail to the facility on Saturdays in quite a while. On 06/26/2013 at 3:16 p.m., a second interview was conducted with the facility's administrator concerning why the U.S.P.S. was not delivering mail to the facility on Saturdays. The administrator indicated he was aware the facility was not receiving mail on Saturdays. The Administrator also indicated he had just contacted the Post Office serving the facility and that some time in 2011, before his employment, there was a request by someone at the facility to have the mail stopped being delivered to the facility on Saturdays. The administrator indicated he was not told who had requested the post office to stop delivering the mail on Saturdays.	F 170	4. How the facility plans to monitor and ensure that correction is achieved and sustained? Mail delivery will be monitored weekly x four than monthly x one and presented at the weekly Quality Assurance Risk Mangement meeting and Quarterly Quality Assurance Meeting x one quarter. Any problems identified will be reviewed for further problem resolution.	7/31/13	
F 279 SS=B	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279			

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F 279	<p>Continued From page 2</p> <p>to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on the observations, staff interviews, resident interview, and record reviews the facility failed to include assessment information in care plan for 1 of 29 residents (resident #270) reviewed for care plan.</p> <p>Findings include:</p> <p>Resident # 270 was admitted to the facility on 5/16/13 after hospitalization for a fractured right femur with some renal failure and rhabdomyolysis. Diagnoses included rehabilitation for fractured femur, supraventricular tachycardia, chronic obstructive pulmonary disease, hyperlipidemia, with a history</p>	F 279	<p>F 279 -</p> <p>1. How the corrective action will be accomplished for the resident(s) affected?</p> <p>Resident # 270 Care plan was updated with all skin impairment areas and interventions.</p> <p>2. How corrective action will be accomplished for those residents with the potential to be affected by the same practice?</p> <p>All residents with skin impairment will have the areas identified on their care plans with goal and interventions. All nurses who initiate, update or change the care plans will be inserviced on including all skin impairment areas on the care plan with goals and interventions.</p> <p>3. Measures in place to ensure that practices will not occur -</p> <p>A sample audit of 10% residents care plans on each unit with skin impairment will be completed weekly x four to ensure compliance than bi-weekly x four than monthly x one.</p>	7/31/13	

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F 279	<p>Continued From page 3 of congestive heart failure and dementia.</p> <p>A review of the 30 Minimum Data Set (MDS) dated 5/16/13 found that resident #270 had moderately impaired cognition. The MDS indicated that he needed extensive assistance of 1 person for bed mobility and bathing. For transferring, walking, dressing, toileting, and hygiene, he needed limited assistance from one person. The MDS noted there was a skin tear.</p> <p>The Care Plan (CP) dated 5/16/13 was reviewed. The CP had a problem of Skin Care: Resident will not develop skin breakdown over the next review period of 90 days. Interventions included using pressure relieving devices to bed and chair and using lotion and moisture barrier. Another problem was skin impairment left hip stage 1 pressure sore admitted with The intervention was treatment as ordered by the physician; notify the physician if the treatment was not effective or the area worsened.</p> <p>There was no mention of an abrasion or skin tear to Resident #270's back.</p> <p>Interdisciplinary Progress notes in review noted that on 5/20/13 a late entry documented that on 5/17/13 Resident #270 was found to have an abrasion to the middle of his back covered with a duoderm. The dressing was changed applying triple antibiotic ointment and covering it with coversite each day and PRN (as needed). On 5/20/13 a noted documented treatment was done to the left lateral upper thigh and left midways of back.</p>	F 279	<p>4. How the facility plans to monitor and ensure that correction is achieved and sustained? Audits of residents care plans on each unit with skin impairment will be completed and reviewed weekly x four to ensure compliance than bi-weekly x four than monthly x one at the weekly Quality Assurance Risk Management meeting and Quarterly Quality Assurance Meeting x one quarter. Any problems identified will be reviewed for further problem resolution.</p>	7/31/13	

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F 279	Continued From page 4 Physicians orders reviewed noted that on 5/20/13 there was an order for a coversite dressing 6"x 6" for an abrasion to the middle of the back. Clean with normal saline (NS), pat dry, apply triple antibiotic and cover with coversite daily and PRN. On 5/21/13 the order was changed to clean wound at the middle of back with NS, pat dry, and apply santyl ointment, cover with telfa and secure with coversite wound dressing. On 6/26/13 an observation was made of the dressing change to the back of Resident #270. The resident stated that the place on his back happened in the hospital. On 6/27/13 at 12:17 pm the Director of Nurses stated in an interview that it was the responsibility of the Unit Manager (UM) to update care plans. During an interview on 6/27/13 at 12:41 pm the UM for Resident #270's hall stated that she updated care plans for the resident's on her hall. In an interview on 6/27/13 at 4:53 pm the UM for Resident # 270's hall and the Nurse Consultant indicated that it was the responsibility of the admitting UM to create the CP. Asked why the place on Resident # 270's back with interventions to prevent worsening or reoccurrence was not in the care plan the UM said the night UM must have overlooked it.	F 279	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.		
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	F 314	How corrective action will be accomplished for each resident found to have been affected by the deficient practice -- Resident # 116 care plan was updated indicating need for 2 assist for bed mobility.	7/26/13	

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F 314	<p>Continued From page 5</p> <p>Individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews the facility failed to follow their plan of care for bed mobility for 1 of 2 sampled residents (resident #116) with a pressure sore. Findings Include:</p> <p>1A) OSHA's Guidelines for Nursing Home Ergonomics During Patient Care documents in part in Figure 4 (Repositioning in Bed - Side to side , Up in Bed) Can Patient Assist - No, Use friction reducing device and 2 or more caregivers. This is not a one person Task.</p> <p>Sampled resident # 116 was admitted to the facility on 10/03/2008 and had diagnoses which included Senile Dementia, Alzheimer's disease, Contracture of the hand, Dysphagia, Abnormal posture, Muscle/jigement disorder, Contracture of the lower leg, Diabetes, Aphasia, Stroke, and Asthma. The physician's orders included - Wound care - Clean wound to sacrum with liquid dial soap, rinse/pat dry with Normal Saline, Apply Silvadine cream to wound and place a telfa pad over area, no tape to wound area, change the dressing every day (QD) and as needed (PRN).</p> <p>The resident's quarterly Minimum Data Set (MDS) dated 05/30/2013 indicated the resident as being severely cognitively impaired and was</p>	F 314	<p>How corrective action will be accomplished for those residents having the potential to be affected by the same deficient practice -- All residents ADL status for bed mobility will be reviewed to identify whether they need two person assist or more. Care plans and resident care guides will be updated for any resident identified ADL status for bed mobility as 2 person assist or more. All Nurses and Nursing Assistants will be in-serviced on the resident care guides and their location by 07/22/13. All Nurses and Nursing Assistants were in-serviced on 2 person or more bed mobility, and turning and repositioning based on the Mosby manual instructions to prevent friction on wounds or cause skin damage by 07/22/13.</p>	7/26/13	

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F 314	<p>Continued From page 6</p> <p>totally dependent upon 2 staff members for bed mobility and dressing. The MDS indicated the resident to need total assistance of 1 staff member for eating, personal hygiene, and bathing. The total assistance needed was due to the resident's bilateral range of motion impairment to both the upper and lower extremities. The MDS also included information the resident had a stage 2 pressure ulcer (sacrum) which was being treated by the facility via the application of non-surgical dressings, ointments/medications, nutritional interventions and pressure relieving devices.</p> <p>The Care Plan for sampled resident #116 was initially dated 09/22/2011 and was updated on 03/15/2013 indicated the resident to need assistance with Activities of Daily Living (ADLs) as the resident had contractions bilaterally in the upper and lower extremities and had impaired cognition. The facility's goals were to ensure the resident was well groomed and dressed daily, have no fall related injuries, and would not develop further skin breakdown though the facility's next care plan review. The facility documented interventions in the care plan that staff would feed the resident all meals, perform oral care daily and as needed, provide peri-care, shower/bathe the resident, turn and reposition the resident, and dress the resident in street cloths daily. Included in the care plan the staff were also required to perform Range Of Motion (ROM) exercises daily to the residents extremities while providing care. There was no information in the care plan as to how many staff members it took or what mechanical devices if any were needed to reposition (bed mobility) or transfer the resident.</p>	F 314	<p>Measures to be put in place or systemic changes made to ensure practice will not re-occur -</p> <p>A sample of 10 percent on each unit of residents requiring more than two assist with bed mobility will be completed weekly x four to ensure they are receiving the appropriate assistance, than BI-weekly x four than monthly x one. Resident care guides and care plan will be updated with any new admission or change in residents needs for bed mobility two or more assist. New hire Licensed nurses and Nursing Assistants will receive education at orientation for resident care guide and location, and on 2 person or more assist with bed mobility and turning and repositioning based on the Mosby manual instructions to prevent friction on wounds or cause skin damage.</p>	7/28/13	

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F 314	<p>Continued From page 7</p> <p>On 06/26/2013 at 5:05 p.m. an interview was conducted with a family member of sampled resident # 116. The family member indicated the resident had a decubitus ulcer on her sacrum/coccyx area for a long time and the facility staff was using a draw sheet to move and reposition resident utilizing only 1 staff member. The family member indicated the resident was could not talk, had to be fed, and had to be totally cared for by the facility's staff as the resident could do nothing on her own. The family member indicated family member had observed the resident being moved and repositioned many times using only one staff member by dragging the resident across the bed with the resident's full weight on the open wound. The family member indicated other family members had requested the facility use 2 persons to move the resident when the resident was in bed and lift the resident using the draw sheet instead of dragging the resident by the draw sheet. The family member indicated the family had talked to the nursing staff about the decubitus ulcer and also talked to Teal Hall unit manager, the DON, and administrator about the issue. The family member indicated the family felt nothing had been done about their concerns as they kept observing the staff still moving the resident in the bed only utilizing one staff member.</p> <p>06/27/2013 at 7:45 a.m., an observation was made of NA #1 repositioning sampled resident # 116 in the bed. Sampled resident # 116 was in the sitting position and was observed to have a draw sheet and pad under her midsection/sacral area between her and the bed sheet. During the observation NA #1 was observed to pull sampled resident # 116 higher up in the bed without the</p>	F 314	<p>How facility will monitor corrective action(s) to ensure deficient practice will not re-occur – Audits of all residents requiring two assist or more with bed mobility, care guides and care plans who require two or more assist will be reviewed weekly x four, Bi-weekly x four, then monthly x one at weekly Quality Assurance Risk Management meeting, and Quarterly Quality Assurance Meeting X 1 quarter. Any problems identified will be reviewed for further problem resolution.</p>	7/26/13	

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F 314	<p>Continued From page 8</p> <p>assistance of any other staff member or using the draw sheet/pad.</p> <p>An interview was conducted with NA #1 on 06/27/2013 at 7:50 a.m. NA #1 was asked why she was moving sampled resident # 116. NA # 1 stated, "I was moving her up in the bed so I could feed her breakfast." Na # 1 was asked if she had any knowledge of or if the facility had any written information as to how many staff members were required to move sampled resident # 116 while in the bed as the resident had an unhealed stage 2 pressure ulcer to the sacral area. NA #1 indicated she did not know how many staff are required to move or reposition sampled resident # 116 while in bed and did not know if the facility had any written information indicating how many staff were required to reposition/move sampled resident # 116. NA #1 indicated she had been off for several weeks but had worked with the resident many times in the past.</p> <p>An interview was conducted with the Director of Nursing (DON) on 06/27/2013 at 10:16 a.m. concerning the resident's Care Plan and what the ADL interventions were concerning the resident's bed mobility and transfers. The DON indicated that the resident's daughter had asked the facility to use 2 staff members when repositioning the resident and transferring the resident. The DON could not find any documentation in the Care Plan to indicate how the need was being met. The DON indicated the Teal hall's unit manager might have the information as each nursing assistant was provided a unit resident care card.</p> <p>An interview with the Teal hall's unit manager and the DON was conducted on 06/27/2013 at 10:35</p>	F 314			

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F 314	<p>Continued From page 9</p> <p>a.m. The unit manager was asked if he could provide Care Plan information for sampled resident # 116 as to how the resident was to be assisted with the ADLs (bed mobility and transfers) by staff. The unit manager indicated each NA had a Resident Care Card that indicated what type of care each resident on the hall needed. A review of the Teal Hall's resident care card was conducted with the unit manager and DON. The unit manager indicated sampled resident # 116 was to have 2 staff members provide bed mobility assist and transfers of the resident. The unit manager and the DON both indicated the column labeled Transfers also covered Bed Mobility (2 staff were to be used with turning, repositioning and/or transferring the resident). The unit manager indicated the column that indicated ADL Assist and indicating 1 staff was only for things like assisting with feeding the resident, performing oral care, doing grooming etc. and not for Bed Mobility, moving or transferring the resident. The unit manager indicated all staff NAs have a copy of the Resident Care Card and should know what each resident needs concerning their care.</p> <p>On 06/27/2013 at 10:55 a.m., a second interview was conducted with NA #1 concerning her copy of the Teal hall resident care card. NA # 1 indicated she did not have a copy of the Teal hall resident care card with her and could not recall what information the Teal hall resident care card documented as to the care and/or services she was required to conduct for sampled resident # 116. NA # 1 indicated she had been given a copy of the Teal hall's resident care card but it was either at home or in her car.</p>	F 314			

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NAME OF PROVIDER OR SUPPLIER ALAMANCE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1987 HILTON STREET BURLINGTON, NC 27217
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 314	<p>Continued From page 10</p> <p>1B) OSHA's Guidelines for Nursing Home Ergonomics During Patient Care documents in part in Figure 4 (Repositioning in Bed - Side to side, Up in Bed) Can Patient Assist - No, Use friction reducing device and 2 or more caregivers. This is not a one person Task.</p> <p>Sampled resident # 116 was admitted to the facility on 10/03/2008 and had diagnoses which included Senile Dementia, Alzheimer's disease, Contracture of the hand, Dysphagia, Abnormal posture, Muscle/ligament disorder, Contracture of the lower leg, Diabetes, Aphasia, Stroke, and Asthma. The physician's orders included - Wound care - Clean wound to sacrum with liquid dial soap, rinse/pat dry with Normal Saline, Apply Slivadine cream to wound and place a telfa pad over area, no tape to wound area, change the dressing every day (QD) and as needed (PRN).</p> <p>The resident's quarterly Minimum Data Set (MDS) dated 05/30/2013 indicated the resident as being severely cognitively impaired and was totally dependent upon 2 staff members for bed mobility and dressing. The MDS indicated the resident to need total assistance of 1 staff member for eating, personal hygiene, and bathing. The total assistance needed was due to the resident's bilateral range of motion impairment to both the upper and lower extremities. The MDS also included information the resident had a stage 2 pressure ulcer (sacrum) which was being treated by the facility via the application of non-surgical dressings, ointments/medications, nutritional interventions and pressure relieving devices.</p>	F 314		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2013
FORM APPROVED
OMB NO. 0938-0381

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345420	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/28/2013
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F 314	<p>Continued From page 11</p> <p>The Care Plan for sampled resident #116 was initially dated 09/22/2011 and was updated on 03/15/2013 indicated the resident to need assistance with Activities of Daily Living (ADLs) as the resident had contractions bilaterally in the upper and lower extremities and had impaired cognition. The facility's goals were to ensure the resident was well groomed and dressed daily, have no fall related injuries, and would not develop further skin breakdown through the facility's next care plan review. The facility documented interventions in the care plan that staff would feed the resident all meals, perform oral care daily and as needed, provide peri-care, shower/bathe the resident, turn and reposition the resident, and dress the resident in street clothes daily. Included in the care plan the staff were also required to perform Range Of Motion (ROM) exercises daily to the residents extremities while providing care. There was no information in the care plan as to how many staff members it took or what mechanical devices if any were needed to reposition (bed mobility) or transfer the resident.</p> <p>On 06/26/2013 at 5:05 p.m. an interview was conducted with a family member of sampled resident # 116. The family member indicated the resident had a decubitis ulcer on her sacrum/coccyx area for a long time and the facility staff was using a draw sheet to move and reposition resident utilizing only 1 staff member. The family member indicated the resident was could not talk, had to be fed, and had to be totally cared for by the facility's staff as the resident could do nothing on her own. The family member indicated family member had observed the resident being moved and repositioned many times using only one staff member by dragging</p>	F 314			

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F 314	<p>Continued From page 12</p> <p>the resident across the bed with the resident's full weight on the open wound. The family member indicated other family members had requested the facility use 2 persons to move the resident when the resident was in bed and lift the resident using the draw sheet instead of dragging the resident by the draw sheet. The family member indicated the family had talked to the nursing staff about the decubitis ulcer and also talked to Teal Hill unit manager, the DON, and administrator about the issue. The family member indicated the family felt nothing had been done about their concerns as they kept observing the staff still moving the resident in the bed only utilizing one staff member.</p> <p>On 06/27/13 at 9:05 a.m., an observation of sampled resident # 116's wound care of the sacrum/coccyx area was conducted. Teal hall nurse #1 and NA #1 were observed in the room to complete the wound care. Before conducting the sampled resident # 116's wound care, Teal hall nurse #1 was observed to pull sampled resident # 116 across the bed closer to her using the draw sheet and pad with resident's full weight on bed and wound and with out the assistance of NA # 1 or any other staff member.</p> <p>An interview was conducted with Teal hall nurse # 1 on 06/27/2013 at 9:20 a.m. concerning the observation of repositioning sampled resident # 116 closer to her by pulling sampled resident # 116 across the bed with the draw sheet/pad by herself with the resident's full weight on the sacral pressure ulcer and without any other staff member's assistance. The Teal hall nurse # 1 was asked if she had any knowledge of or if the facility had any written information as to how</p>	F 314			

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F 314	<p>Continued From page 13</p> <p>many staff members were required to move sampled resident # 116 while in the bed as the resident had an unhealed stage 2 pressure ulcer to the sacral area. The Teal hall nurse #1 indicated she did not know if there was any written facility requirement as to how many staff were required to move sampled resident # 116 while in bed. The Teal hall nurse #1 indicated there were two of them in the room, herself and NA # 1. The Teal hall nurse #1 acknowledged she was the only staff member that moved the resident closer to her by pulling the draw sheet and that the full weight of sampled resident # 116 was on the sacral pressure ulcer when she pulled her across the bed. The Teal hall nurse #1 could not state and did not know if there was a requirement of more than 1 staff member to move sampled resident # 116 while the resident was in the bed (bed mobility).</p> <p>An interview was conducted with the Director of Nursing (DON) on 06/27/2013 at 10:15 a.m. concerning the resident's Care Plan and what the ADL interventions were concerning the resident's bed mobility and transfers. The DON indicated that the resident's daughter had asked the facility to use 2 staff members when repositioning the resident and transferring the resident. The DON could not find any documentation in the Care Plan to indicate how the need was being met. The DON indicated the Teal hall's unit manager might have the information as each nursing assistant was provided a unit resident care card.</p> <p>An interview with the Teal hall's unit manager and the DON was conducted on 06/27/2013 at 10:35 a.m. The unit manager was asked if he could provide Care Plan information for sampled</p>	F 314			

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F 314	Continued From page 14 resident # 116 as to how the resident was to be assisted with the ADLs (bed mobility and transfers) by staff. The unit manager indicated each NA had a Resident Care Card that indicated what type of care each resident on the hall needed. A review of the Teal Hall's resident care card was conducted with the unit manager and DON. The unit manager indicated sampled resident # 116 was to have 2 staff members provide bed mobility assist and transfers of the resident. The unit manager and the DON both indicated the column labeled Transfers also covered Bed Mobility (2 staff were to be used with turning, repositioning and/or transferring the resident). The unit manager indicated the column that indicated ADL Assist and indicating 1 staff was only for things like assisting with feeding the resident, performing oral care, doing grooming etc. and not for Bed Mobility, moving or transferring the resident. The unit manager indicated all staff NAs have a copy of the Resident Care Card and should know what each resident needs concerning their care.	F 314			

AUG 02 2013

July 22, 2013 original submission

Please find enclosed the Plan of Correction for Alamance Health Care Center as required following our annual survey dated June 24 to June 28, 2013. This July 31, 2013 copy contains corrections for all items noted in the survey. I can be contacted at (336) 226-0848 if there should be any questions or concerns regarding this Plan of Correction.

Thank you in advance for your consideration.

Respectfully,



Thomas P. Fitzgibbons
Administrator



North Carolina Department of Health and Human Services
Division of Health Service Regulation

Pat McCrory
Governor

Aldona Z. Wos, M.D.
Ambassador (Ret.)
Secretary DHHS
Drexdal Pratt
Division Director

IMPORTANT NOTICE - PLEASE READ CAREFULLY

July 12, 2013

Mr. Thomas Fitzgibbons, Administrator
Alamance Health Care Center
1987 Hilton Street
Burlington, NC 27217

Thomas.P.Fitzgibbons@MFA.net

Dear Mr. Fitzgibbons:

On June 24, 2013 to June 28, 2013, a recertification and complaint investigation survey was conducted at your facility by the Nursing Home Licensure and Certification Section of the Division of Health Service Regulation to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare/Medicaid programs. This survey found the most serious deficiency to be an isolated deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy, as documented on the enclosed CMS-2567, whereby significant corrections are required. (D)

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Based on survey findings, the alleged complaint violations were not substantiated.

Plan of Correction (PoC)

The facility must submit a PoC for the deficiencies within 10 calendar days from the date it receives its Form CMS-2567. Failure to submit an acceptable PoC by July 22, 2013 may result in imposition of additional remedies by August 11, 2013.

Your PoC for the deficiencies must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how corrective action will be accomplished for those residents having potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not occur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. The plan must be implemented and the

Nursing Home Licensure and Certification Section

<http://www.ncdhhs.gov/dhsr/>

Tel 919-855-4520 • Fax 919-733-8274

Location: 1205 Umstead Drive • Raleigh, NC 27603

Mailing Address: 2711 Mail Service Center • Raleigh, NC 27699-2711

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Mr. Fitzgibbons, Administrator
July 12, 2013
Page Two

- corrective action evaluated for its effectiveness. The PoC is integrated into the quality assurance system of the facility.
- Include dates when corrective action will be completed. The corrective action dates must be acceptable to the State.

The Division of Health Service Regulation is allowing you an opportunity to correct your deficiencies prior to recommending imposition of remedies for failure to substantially comply with program requirements. Remedies will be recommended for imposition by the Centers for Medicare & Medicaid Services (CMS) Regional Office, if your facility fails to achieve substantial compliance by the date specified in your Plan of Correction. It should be noted that the latest date in your Plan of Correction should be no later than July 26, 2013. Failure to specify this date can result in your Plan of Correction not being accepted by the State. Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended. A change in the seriousness of the deficiencies may result in a change in the remedy(ies) selected. When this occurs, you will be advised of any change.

The remedies which will be recommended if substantial compliance has not been achieved by July 26, 2013 may include the following:

- Directed Inservice Training
- Directed Plan of Correction
- Civil Money Penalty
- Discretionary Denial of Payment for New Admission

If you do not achieve substantial compliance within 3 months after the last day of the survey identifying noncompliance (September 28, 2013), the CMS Regional Office must deny payments for new admissions.

We are also recommending to the CMS Regional Office that your provider agreement be terminated on December 28, 2013 if substantial compliance is not achieved by that time.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, we will provide you with a separate formal notification of that determination.

Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution (IDR) process. You may also contest scope and severity assessments for deficiencies that resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, you are required to send your written request identifying the specific deficiencies being disputed postmarked by July 22, 2013 to Becky Wertz, Nursing Home Licensure and Certification Section at the above listed address. An explanation of why you are disputing those deficiencies (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy) along with any supporting documentation must be sent and postmarked by August 1, 2013. You must submit 5 copies of material and highlight or use some other means to identify written information pertinent to the disputed deficiency(ies). Additional written material that does not meet these requirements will not be reviewed. This information should be sent to Becky Wertz, Nursing Home Licensure and Certification Section, at the above listed address. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action. IDR Procedures can be accessed at: <http://www.nedhhs.gov/dhsr/nhlc/idr.html>.

Mr. Fitzgibbons, Administrator
July 12, 2013
Page Three

Customer Service Feedback

In order to better serve our customers, and as part of our efforts to provide excellent services, you are being asked to complete a customer service survey. Your opinion is important to us, and will assist us in developing new and better ways to do our job. We have designed the survey to address key expectations of our surveyors and our division regarding the survey process.

Please note: Because the survey is confidential, your identity will not be known to the Division of Health Service Regulation or the North Carolina Department of Health and Human Services.

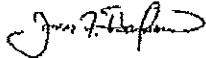
Thank you very much for your participation as we strive to improve the services we provide to licensed health care providers across the state of North Carolina

The Customer Service Survey web site: <http://www.ncsurveymax.com/TakeSurvey.aspx?SurveyID=12K0372>
(Survey Max does not work well with all browsers, please access survey with Internet Explorer)

Thank you for participating in this confidential survey. Should you wish to have a confidential discussion regarding this survey or your interaction with the Division of Health Service Regulation, please feel free to contact Drexdal Pratt, Director at 919-855-3750 or email at drexdal.pratt@dhhs.nc.gov.

If you have any questions concerning the instructions contained in this letter, please contact me.

Sincerely,



James Hartman
Facility Survey Consultant

JH: mc

Enclosures
Statement of Deficiencies

Fax copies of plans of correction will no longer be accepted

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

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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, one story, with a complete automatic sprinkler system.	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 7/18/13 at approximately noon the hazardous area was non-compliant, specific findings include A. The door to kitchen storage did not close and latch tightly in it's frame. B. There was not positive latching provided on the corridor doors leading to the laundry/service hall.	K 029	K 029 The door and frame located at the kitchen storage has been corrected to latch tightly on August 1, 2013. This door, along with all others, will be will be checked as a part of the monthly maintenance program The doors leading to the laundry/service areas will have positive latching. These new installments will occur prior to August 30, 2013. There appear to be no further doors needing positive latching where they do not already exist.	8/30/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Shan P. Fitzgerald* TITLE *Administrator* (X8) DATE *8/1/13*

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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K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 7/18/13 at approximately noon the sprinkler system was non-compliant, specific findings include</p> <p>A. There was not a sprinkler head in the overhand near the fire alarm control panel, courtyard exit. The overhand was greater than four foot.</p> <p>B. The sprinkler/fire alarm certification conducted 7/16/13 had the following items outstanding: two smoke detectors in the kitchen not operating properly, three fire extinguishers in need of 12 year hydro test, the air compressor was in need of replacement, the FDC sign was in need of replacement, sprinkler pip clogged in room 911/riser, sprinkler box missing parts.</p>	K 062	<p>K062</p> <p>Bids are now being taken on installing necessary sprinkler heads as required in select overhangs meeting the four foot minimum. Work on these sprinklers is anticipated to occur prior to August 30, 2013. A maintenance audit of overhangs will be used to assure that all overhangs meeting the requirement are met.</p> <p>The two smoke detectors not operating properly, the three fire extinguishers in need of twelve year hydro tests, the air compressor in need of replacement, the FDC sign needing replacing, the sprinkler pip switch, and the sprinkler box missing parts have been addressed through a contracted service. Each of these issues are scheduled to be corrected prior to August 30, 2013. The inspection of fire related equipment including alarms and extinguishers will be checked as a part of the monthly maintenance program.</p>	8/30/13
K 067 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2</p> <p>This STANDARD is not met as evidenced by:</p>	K 067		

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K 067	Continued From page 2 42 CFR 483.70(a) By observation on 2/16/12 at approximately noon the following Heating, Ventilating, and Air Conditioning system (HVAC) was non-compliant; specific findings include A. The HVAC system switch did not shut down the system near the service hall B. The HVAC system (one of two systems) located in the laundry was not functioning properly.	K 067	K067 The HVAC system switch for the HVAC near the service hall is scheduled to be fixed to shut down properly prior to August 30, 2013. This system, as well as each of the others, will be checked as a part of the monthly maintenance program. The HVAC system in the laundry area is being replaced and scheduled to be completed prior to August 30, 2013. This system as well as all others is maintained through monthly maintenance audits performed at our center.	8/30/13