STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345166	A. BUILDING _____ B. WING _____	09/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOKES COUNTY NURSING HOME	1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016

(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 161 SS=C	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to designate the residents as the obligee in the surety bond. Findings included. Review of the surety bond revealed the Patient Fund Bond, effective August 1, 2014 was for $5000. The obligee name was North Carolina Department of Health and Human Services and the obligee address was Division of Medical Assistance, 2501 Mail Service Center, Raleigh, NC 27688. The amount of the surety bond was for $5000 and it was greater than the total amount of residents' funds, $4666.90, on September 3, 2014. On 9/3/14 at 12:40 PM, the Chief Executive Officer was informed that the State of North Carolina could not be the obligee because the State could not take any actions on behalf of the residents in the case of loss. Later on 9/3/14, the CEO presented a surety rider dated 9/3/14 that changed the obligee name and address to "The Individual Residents of Stokes County Nursing Home, 1570 NC 8 & 89 Hwy N, Danbury, NC 27016 " .	F 161	Corrective action to be accomplished for the resident found to be affected by the deficient practice: The surety bond was changed on 9/3/14 to meet current guidelines for the residents of the facility to be named as the obligee. Corrective actions to be accomplished for residents having potential to be affected by the same deficient practice: The surety bond was changed on 9/3/14 to meet current guidelines for the residents of the facility to be named as the obligee. The surety bond will be renewed annually to reflect current guidelines. Measures to be put in place or systemic changes made to ensure that the deficient practice will not occur: The Administrator and DON will review communications from CMS, North Carolina DHHS, Myers and Stauffer, and North Carolina Healthcare Facilities Association to keep current with regulatory changes and guidance. The	9/23/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/25/2014

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F 161	Continued From page 1	F 161	regulatory changes identified and implemented will be reported quarterly to the Quality of Life Committee and Housewide Quality Improvement Committee. How we will monitor our performance to make sure that solutions are sustained: The regulatory changes identified and implemented will be reported quarterly to the Quality of Life Committee and Housewide Quality Improvement Committee in February, May, August, and November.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to provide maintenance service necessary to maintain a safe and comfortable interior by not repairing sheet rock on walls, loose base boards, cleaning light screens, repairing wheelchairs and geri chairs and securing air conditioner filter to unit. Findings included: 1. Observation on 9/4/14 at 10:40 AM revealed approximately 30 dead insects in the screen of the light fixture near the window in room 215-B.	F 253	Corrective action to be accomplished for the resident found to be affected by the deficient practice: The Housekeeping Manager had the entire Long Term Care Facility deep cleaned beginning on September 3, 2014 thru September 10, 2014. This included: scrubbing sinks, scrubbing commodes, cleaning vents, dusting and washing of walls, beds and baseboard. Furniture was pulled away from the walls swept, mopped and walls wiped down.	9/24/14

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F 253	Continued From page 2 2. Observation on 9/4/14 at 10:45 AM revealed the filter in the bottom of the (a/c) air conditioner unit hanging out and on the floor and a/c unit making a knocking noise in room 214-A. 3. Observation on 9/4/14 at 10:50 AM revealed that the bumper behind bed-B in room 213 was loose from the wall with sheet rock cracked on the left side and handle to geri chair has missing foam cover. 4. Observation on 9/4/14 at 10:55 AM revealed electrical outlet plate cover hanging loose from the wall exposing a nickel size hole in the wall. 5. Observation on 9/4/14 at 11:00 AM revealed the geri chair for room 205-A had torn arm rest covers on both arm rest and loose floor base board on the left side of the bathroom door and a piece of base board missing on the right side of the bathroom door approximately 2 inches by 1 inches in size. 6. Observation on 9/4/14 at 11:10 AM revealed an area on the wall in front of the nurse ' s station with peeling sheet rock approximately 6 inches in length and 3 inches wide. 7. Observation on 9/4/14 at 11:15 AM revealed the wheelchair in room 210-B and geri chair in room 218-B with both arm rest torn and in disrepair. During an interview with nurse # 1 on 9/4/14 at 11:55 AM revealed that when repairs are needed from maintenance staff works orders are filled out that are kept at the nurses station and when maintenance makes rounds the pick the forms up. If it is in normal business hours staff can also page maintenance and if it is urgent there is always maintenance staff on call. The repairs are addressed timely unless a part has to be ordered. An interview with nurse aide #3 on 9/4/14 at	F 253	Bugs in light fixture of room 215 B were removed and fixture cleaned on 9/17/14 related to Observation #1. The filter in bottom of AC unit was rehung in room 214A and the fan cage that was broken and making a knocking noise was repaired on 9/19/14 related to Observation #2. The Bumper on bed 213B was taken down, the wall repaired and bumper replaced on 9/22/14 related to Observation #3. The Electrical outlet plate has been replaced and the wall repaired on 9/22/14 related to Observation #4. The 2 inches of base board has been replaced and wall repaired in room 205A on 9/17/14 related to Observation #5. The 6 inch area of wall in front of nurse□s station with damaged sheetrock has been repaired on 9/22/14 related to Observation #6. All geri chairs and wheel chairs with torn arm rests are being pulled in groups of three to four to the maintenance department for repair. This will be done weekly until all have been repaired. Supplies were purchased with repairs initiated on 9/22/14. Corrective actions to be accomplished for residents having potential to be affected	

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F 253	Continued From page 3 12:00 PM indicated that request for maintenance repairs are done by work orders located at the desk and staff can report it to the nurse or fill the form out their self and maintenance will pick the form up when they make rounds. During an interview with the maintenance director on 9/4/14 at 3:03 PM revealed that he makes rounds several times a day to pick up work orders. He depends on staff to let him know when repairs are needed and addresses problems and repairs as they arise. The filters on the a/c units are checked monthly.	F 253	by the same deficient practice: The Housekeeping Manager had the entire Long Term Care Facility deep cleaned beginning on September 3, 2014 thru September 10, 2014. This included: scrubbing sinks, scrubbing commodes, cleaning vents, dusting and washing of walls, beds and baseboard. Furniture was pulled away from the walls swept, mopped and walls wiped down. The light fixtures of all rooms were cleaned. The filters in bottom of AC units have been rehung in all rooms with a mechanism implemented to prevent the filters from falling down. The Electrical outlet plates have been inspected and replaced as needed throughout the unit. Baseboards and sheetrock have been inspected and repaired as needed throughout the unit. Measures to be put in place or systemic changes made to ensure that the deficient practice will not occur: A Maintenance and Housekeeping Checklist of all areas has been developed and implemented. Staff will conduct monthly Maintenance / Housekeeping Checklist of all areas. How we will monitor our performance to	

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F 253	Continued From page 4	F 253	make sure that solutions are sustained: A Maintenance and Housekeeping Checklist of all areas has been developed and implemented. This checklist will be completed on a monthly basis for all areas and submitted to the Housewide Quality Improvement Committee by the Maintenance Director and Housekeeping Manager.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and physician review, the facility failed to follow physician orders for 2 of 4 residents (Resident #6, and #8) who required weekly weights. The findings included: 1. Resident #6 was admitted to the facility on 9/14/12 with a diagnoses that included dementia with behavioral disturbance, paralysis agitans, senile depressive disorder, atrial fibrillation, and hyperlipidemia. Review of Resident #6's physician ordered dated 2/27/14 revealed discontinue weights from twice weekly to once weekly. Review of Resident #6's care plan updated 8/13/14 revealed a goal that said she will not have unplanned weight loss for next 90 days.	F 281	Corrective action to be accomplished for the resident found to be affected by the deficient practice: Resident #6 had a weight obtained and documented on 9/1/2014 resulting in a weight loss less than 5% . Any weight loss >5% will be reported to the physician and the weight loss protocol will be initiated. Resident #6 has received weights according to care plan since 9/1/2014 weight. Resident #8 had a weight obtained and documented on 9/5/2014 resulting in a >5% weight loss. After completing a 3 daily weight checks on 9/6/2014, 9/7/2014 and 9/8/2014 revealed consistent weights	9/19/14

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F 281	Continued From page 5 The interventions included weekly weight with monthly weight calculations weight loss protocol PRN (as needed). Review of Resident #6's treatment sheet for August 2014 revealed weight once weekly, follow weight loss protocol for monthly calculated loss for > or -5%. The weight record revealed Resident #6's last recorded weight was on 8/18/14. The weight record indicated the lift was broken on 8/25/14. No further weights could be obtained by the facility. 2. Resident #8 was admitted to the facility on 2/4/14 with a diagnoses that included dementia, bone and cartilage disease, hypothyroidism, atrial fibrillation and psychosis. Review of Resident #8's physician orders dated 2/4/14 indicated weights to be taken weekly on Fridays on 3rd shift. The physician order dated 8/1/14 indicated dietary consult due to steady weight loss in last month. Review of Resident #8's care plan updated 8/6/14 revealed a goal stating, "she will have no unplanned weight loss for the next 90 days; maintain adequate nutrition for the next 90 day. The interventions included, total feed for all meals, snacks, and liquids; monitor and record intake of meals and snacks form all sources, and report amounts to hall nurse; weekly weights and record; monthly weight calculations. Review of Resident #8's treatment record for the month of August 2014 revealed weekly weights with monthly calculation - follow weight loss	F 281	not consistent with the previously documented weight loss. Resident #8 has received weights according to care plan since 9/8/2014. Care Plans and treatment sheets will be monitored by SNF DON and MDS coordinator weekly for quality improvement compliance. Weights will be obtained on all residents in accordance to their individualized careplan. If a scale is found to have a malfunction this will be reported to maintenance immediately. Resident weights will be obtained using scales from the hospital when scales in the Stokes County Nursing Facility are not in working order as to not delay resident care. Scales were repaired and have been in working order since 8/29/14. Corrective actions to be accomplished for residents having potential to be affected by the same deficient practice: Care Plans and treatment sheets will be monitored by SNF DON and MDS coordinator weekly for quality improvement compliance. Weights will be obtained on all residents in accordance to their individualized careplan. If a scale is found to have a malfunction this will be reported to	

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F 281	Continued From page 6 protocol for loss more than 5%. Review of Resident #8's weight record revealed Resident #8's last recorded weight was on 8/23/14. The note for 8/23/14 identified a 3 day re-weight. On 8/24/14 and 8/25/14 the weight record indicated the weight was unable to be obtained (UTO). The weight record further indicated that on 8/29/14 Resident #8's weight was UTO due to he bath stretcher being broken. Review of Service Request Form dated 8/12/14 revealed, "bath stretcher does not work/won't go down, put new battery will not work". Work is signed as completed by maintenance on 8/13/14. Interview with Nursing Assistant (NA) #5 on 9/4/14 at 9:04 am revealed weights are taken on resident bath days. NA #5 indicated the bath stretcher/weight machine was utilized for resident who were not able to utilize the stand up scale. The bath stretcher had not been working properly and was not available for use. NA #5 further indicated that staff had been utilizing the scale located down stairs in the hospital portion of the facility. Occasionally the stretcher would not be working downstairs and weights could not be obtained. NA #5 indicated that when the bath stretcher is not working NAs were told to document UTO (unable to obtain). Interview with NA #2 on 9/4/14 at 9:12 am revealed the bath stretcher scale had not been working. NA #2 stated staff would utilize the scale from the hospital until when it was working. NA #2 indicated she notifies the charge nurse and engineering/maintenance when the scales are not working. NA #2 stated maintenance had been working on the scales, but was unaware if the	F 281	maintenance immediately. Resident weights will be obtained using scales from the hospital when scales in the Stokes County Nursing Facility are not in working order as to not delay resident care. Scales were repaired and have been in working order since 8/29/14. Measures to be put in place or systemic changes made to ensure that the deficient practice will not occur: Care Plans and treatment sheets will be monitored by SNF DON and MDS coordinator weekly for quality improvement compliance. Weights will be obtained on all residents in accordance to their individualized careplan. If a scale is found to have a malfunction this will be reported to maintenance immediately. Resident weights will be obtained using scales from the hospital when scales in the Stokes County Nursing Facility are not in working order as to not delay resident care. Weights will be reviewed weekly by the SNF DON or MDS coordinator to determine if weight loss has occurred. If weight loss occurs, the physician will be notified and the weight loss protocol will be initiated. Scales were repaired and have been in	

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F 281	Continued From page 7 scales were operating for use. Interview with NA #4 on 9/4/14 at 9:18 am revealed the bath stretcher scale had not been working properly lately. NA #4 could not indicate when the bath stretcher scale was not longer working. NA #4 stated weights were not being done due to the stretcher scale located in the hospital portion of the facility being down as well. The NA stated it was communicated by nursing to write unable to obtain the weights due to the scale being broken. Interview with the Dietician on 9/4/14 at 1:14 pm revealed he was aware the facility had issues regarding weight scales working properly. The dietician continued that it was communicated to him by nursing staff that maintenance was fixing the issue. Interview with Nurse #3 on 9/4/14 at 2:14 pm revealed the scale for taking weights for residents who could not stand was working off and on for some time. Maintenance repaired the scale on 8/29/14 and nurse #3 indicated she witnessed it working. Currently the scale is back down. Nurse #3 stated the residents who could stand were always weighed and there was no issue with the stand up scale. Nurse #3 indicated that when the stretcher scale was not functioning, NAs would use the scale from the hospital unit. Nurse #3 continued that occasionally the scale is not working for the hospital unit. Interview with Nurse #2 on 9/4/14 at 2:16 pm indicated the stretcher scale has been working off and on. Nurse #2 stated that the NAs were told to document UTO to indicate that the residents' weight was unable to obtain. Weights would be	F 281	working order since 8/29/14. Maintenance will be notified of any further repairs needed. Additional parts are now on site to make immediate repairs for the wiring harness issue. Extra parts will be maintained. Maintenance will conduct monthly checklist on equipment to ensure operational. How we will monitor our performance to make sure that solutions are sustained: Care Plans and Treatment Sheets will be monitored weekly by the SNF DON or MDS coordinator to ensure weights are being obtained in accordance with the resident care plans. Compliance with completion and documentation of weights will be compiled and reported to the SNF Quality of Life and Housewide Quality Improvement Committee monthly. A maintenance checklist of equipment will be kept with any findings reported to the Housewide Quality Improvement Committee monthly.	

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F 281	Continued From page 8 obtained when the scale was available. Interview with the Maintenance Director on 9/14/14 at 3:10 pm revealed he was made aware of items that were in need of repair as evidenced by work orders submitted by staff. Maintenance indicated the scales were always giving him problems. The wires are pinched when the scale was utilized and was the source of the machines malfunction. In the instance the scales do not work, maintenance indicated he would tell staff to use the scale downstairs in the hospital unit repairs were made. Maintenance stated it takes weeks to get parts delivered for the lift/electronic scale. Interview with the Administrator on 9/4/14 at 3:13pm revealed it was her expectation that the equipment be in working order. She further indicated she was aware of the bath stretcher/weight scale would malfunction. The administrator stated she would expect maintenance to purchase extra parts so that the recurrent issues could be fixed immediately.	F 281		
F 315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315		10/1/14

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F 315	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to provide a medical justification for the use of a urinary catheter for 1 of 3 sampled residents (Resident #5). The findings included: Resident #5 was admitted to the facility on 12/4/13 with a diagnoses that included dementia, Diabetes Mellitus and Chronic Renal Disease. Review of Resident #5's Minimum Data Set (MDS) dated 12/11/13 revealed the resident had a stage two pressure ulcer and an indwelling catheter. Resident's Care Area Assessment (CAA) triggered for urinary incontinence and indwelling urinary catheter. Review of the care plan dated 12/11/13 for Resident #5 revealed that the facility identified incontinence / urinary catheter / pressure ulcer as a problem with a goal that Resident #5 will have no urinary tract infection for the next 90 days, her current pressure ulcers will be resolved in the next 90 days and no new pressure ulcer formation for the next 90 days. It is hand written on the care plan that the current pressure ulcer had been resolved, but there was no date documented as to when it had been resolved. Interventions included changing the urinary catheter and drainage bag monthly and as needed, daily bath assuring catheter, external and internal labia are cleansed well, monitor for any areas of redness, irritation, or worsening of current ulcers or formation of new ulcers and nursing assistants to report promptly to hall nurse. It is hand written on the care plan to	F 315	Corrective action to be accomplished for the resident found to be affected by the deficient practice: Resident #5 Education with physician for Resident #5, nursing leadership, MDS coordinator and staff regarding the appropriate indications for continuing use of an indwelling catheter beyond 14 days. This education reflects appropriate indications as listed in FTag 315. As a result, the indwelling foley catheter for Resident # 5 has been removed. Physician orders and care plan reflect preventative skin care measures for this resident. Corrective actions to be accomplished for residents having potential to be affected by the same deficient practice: Education with all providers, nursing leadership, MDS coordinator and staff regarding the appropriate indications for continuing use of an indwelling catheter beyond 14 days as listed in FTag 315 has been provided through distribution of a memorandum. This memorandum lists the appropriate indications for indwelling catheter use per FTag 315. Residents with indwelling catheters will be monitored weekly by MDS coordinator to determine if catheter use is still appropriate as listed in FTag 315. When resident no longer meets criteria for	

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F 315	Continued From page 10 continue with the same plan of care on 3/5/14, 5/28/14 and 8/21/14. Review of Resident #5's MDS dated 3/5/14 revealed the resident had a stage two pressure ulcer and an indwelling catheter. Physician's order dated 4/23/14 to maintain the urinary catheter for a sacral decubiti wound until healed. Physician's order dated 4/24/14 was to maintain the urinary catheter to straight drainage for chronic urinary incontinence. Review of Resident #5's pressure ulcer healing chart revealed that on 4/29/14 the width x length x depth of the pressure ulcer was 0 x 0 x 0. It was also documented that the pressure ulcer was closed/resurfaced, the wound is completely covered with epithelium (new skin). Physician's order on 4/30/14 was to discontinue the pressure ulcer treatment due to the wound being healed. Review of Resident #5's MDS dated 5/28/14 revealed the resident was assessed as having short and long term memory problems, was severely impaired for cognitive skills and daily decision making. Resident #5 had an indwelling urinary catheter, a urinary tract infection in the last 30 days and had no pressure ulcers. Review of Resident #5's physician's orders revealed an order written on 7/14/14 for a urinary analysis and culture and sensitivity due to foul smelling urine, increased confusion and decreased urinary output. Lab results on 7/14/14	F 315	indwelling foley catheter, the physician will be notified and an order will be obtained to discontinue the foley catheter. The criteria for appropriate use is clearly stated on the criteria sheet as listed in FTag 315. Review of all residents with indwelling foley catheters has been completed by the MDS coordinator and appropriate indications are documented per the newly developed criteria sheet as listed in FTag 315. Measures to be put in place or systemic changes made to ensure that the deficient practice will not occur: Education with all providers, nursing leadership, MDS coordinator and staff regarding the appropriate indications for continuing use of an indwelling catheter beyond 14 days as listed in FTag 315 has been provided through distribution of a memorandum. This memorandum lists the appropriate indications for indwelling catheter use per FTag 315. Residents with indwelling catheters will be monitored weekly by MDS coordinator to determine if catheter use is still appropriate as listed in FTag 315. When resident no longer meets criteria for indwelling foley catheter, the physician will be notified and an order will be obtained to discontinue the foley catheter. The criteria for appropriate use are clearly stated on the criteria sheet as listed in FTag 315.	

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	345166	A. BUILDING _____ B. WING _____	09/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOKES COUNTY NURSING HOME	1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016

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F 315	Continued From page 11 were positive for E-coli and Proteus mirabilis. Physician's order on 7/14/14 was reviewed for the resident to start on Keflex 500 mg twice a day for 7 days for a urinary tract infection. On 7/20/14 the Keflex was discontinued and Resident #5 was started on Bactrim DS twice a day for 5 days. Review of Resident #5's MDS dated 8/20/14 revealed the resident was assessed as having short and long term memory problems, was severely impaired for cognitive skills and daily decision making. Resident #5 had an indwelling urinary catheter, a urinary tract infection in the last 30 days and had no pressure ulcers. Observation on 9/3/14 at 10:00 AM revealed that Resident # 5 had an indwelling urinary catheter draining to a collection bag secured to the right side of the bed in a protective cover. Physician's order dated 9/4/14 was to leave the urinary catheter inserted due to a diagnosis of stage 2 sacral ulcer. Interview on 9/4/14 at 1:21 PM with nurse # 1 revealed that Resident #5's urinary catheter was placed due to a sacral decubiti sometime in April. Nurse # 1 further stated that when the resident's pressure ulcer healed in April 2014, the urinary catheter was continued due to urinary incontinence. Interview on 9/4/14 at 2:00 PM with the Director of Nursing (DON) revealed her expectations would have been for Resident #5's urinary catheter to be removed upon healing of the pressure ulcer unless there was another justification for maintaining the indwelling	F 315	Physicians will be re-educated on appropriate criteria for use of indwelling catheters as listed in FTag 315 and a monitoring process to ensure quality initiatives are being met using the criteria as listed in FTag 315. How we will monitor our performance to make sure that solutions are sustained: Residents with Indwelling foley catheters will be reviewed weekly by the MDS coordinator for appropriateness of use according to criteria listed in FTag 315 and acquired urinary infections. The criteria for appropriate use is clearly stated on the criteria sheet as listed in FTag 315. Indwelling foley catheters will be removed from residents not meeting criteria at the time of recognition . Appropriate indications for use of indwelling foley catheters according to criteria listed in FTag 315 will be collected and reported to the SNF Quality of Life and Housewide QI committee monthly.	

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F 315	Continued From page 12 catheter. The Director of Nursing also reported that the DON would attend the care plan meeting and bring issues to the meeting and carry out any changes that needed to be made.	F 315		
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 record reviews and staff interviews the facility failed to provide a two person assist for bed mobility for 1 of 2 sampled residents (Resident #25) reviewed for accidents. Resident #25 was admitted to the facility on 8/21/12 with the diagnosis of Alzheimer ' s disease, chronic kidney disease and depressive disorder. The annual Minimum Data Set (MDS) with an assessment reference date of 7/16/14 revealed that Resident #25 was severely cognitively impaired, required extensive assistance with activity of daily living (ADL ' s) and was totally dependant of staff for bed mobility requiring two person assistance. The care plan dated 7/17/14 identified a problem of poor trunk control and on 8/12/14 the care plan	F 323	Corrective action to be accomplished for the resident found to be affected by the deficient practice: All staff have been re-educated on Resident #25 requiring two persons for patient handling and transfers. All staff has been instructed to have two persons in place at the time care is being provided for Resident #25. Nursing Assistant #1 has been counseled related to Resident #25 being a two person assist and safe resident handling. Nursing Assistant #1 has completed safe resident handling education for remedial training in addition to the required annual training.	9/24/14

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F 323	Continued From page 13 was updated and identified a problem of falls, resident with poor trunk control and two person assist for incontinence care while in bed due to recent fall and poor trunk control. The Morse Fall Scale dated for 8/7/14 identified Resident #25 as being at medium risk for falls. Review of the fall investigation for Resident #25 dated 8/12/14 at 5:00 PM revealed that Resident #25's bed was in low position and (NA) Nurse Aide #1 was performing hygiene and while repositioning Resident #25, resident rolled out of bed unto his right side obtaining a skin tear to his right elbow and hematoma to right side of forehead. Interview with NA #1 on 9/4/14 at 2:50 PM revealed that she was turning Resident #25 in bed and rolled him towards her and he went to the floor, she further indicated that the bed was in low position and she knew that she should have assistance of two staff but did not ask for any help and did not have anyone with her at the time. During an interview with the administrator on 8/4/14 at 3:15 PM revealed that her expectations were that when residents requires assistance of 2 persons for transfers and mobility then staff are expected to provide that assistance.	F 323	Corrective actions to be accomplished for residents having potential to be affected by the same deficient practice: All staff members have received remedial safe resident handling training in addition to annual resident handling training. The Nursing Assistant Report Form has been updated to include resident assist requirements to ensure clear communication of each resident□s needs. These forms are updated with any changes in resident condition deeming a care plan revision. These forms will be reviewed with each Resident designated care plan review for any needed changes. Staff members are required to gain assistance from co-workers for patient handling for those residents requiring a two person assist. Measures to be put in place or systemic changes made to ensure that the deficient practice will not occur: Nursing Assistant Report Form has been updated to include each resident□s assistance requirements. All staff members will complete remedial resident handling education and sign a roster after completion. Education began on 9/24/14. Resident Fall Awareness program has been initiated to educate staff on the	

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F 323	Continued From page 14	F 323	number of days since the last resident fall. All staff members are challenged to maintain a safe environment for residents to prevent falls and in turn reach set goals. Staff and Residents celebrate their fall prevention accomplishments each time a goal is met. All incident reports will be reviewed by the MDS Coordinator, Charge Nurse, SNF DON and CNO to identify any injuries resulting from falls, appropriate notifications and treatments and opportunities for improvements that would have prevented the fall. How we will monitor our performance to make sure that solutions are sustained: All incident reports will be reviewed by the MDS Coordinator, Charge Nurse, SNF DON and CNO to identify any injuries resulting from falls, appropriate notifications and treatments and opportunities for improvements that would have prevented the fall. Fall Awareness Program will be monitored daily for days since last patient fall. Monitoring will occur daily by all staff members and leadership. When falls occur, the incident will be investigated to determine any preventable actions. Any preventable actions identified will be addressed appropriately. Falls will continue to be recorded and reported to the Housewide Quality Improvement Committee monthly.	

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F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and observation, the facility failed to discontinue the use of Mucinex for chest congestion for 1 of 5 sampled residents reviewed for unnecessary medications (#15). Mucinex is a brand of over-the-counter medicines that help to thin and loosen mucus, relieve congestion, and suppress cough. The medication was initially ordered in January of 2014 when the resident had an upper	F 329	Corrective action to be accomplished for the resident found to be affected by the deficient practice: Resident #15 had Mucinex ER 600mg tablet changed to as needed order on 9/3/14 at 1445 by NP. On 9/12/14 at 1300, Guafenesin liquid 100mg/5ml syrup, 10 ml QID prn chest congestion for 10 days was	9/23/14

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F 329	Continued From page 16 respiratory infection and continued daily until 9/3/14 in the absence of continued congestion or thick secretions. Findings included: On January 16, 2014, nursing notes documented a nonproductive cough and a hoarse voice. According to a physician's order dated January 24, 2014, resident #15 was prescribed Mucinex, Extended Release 600 milligrams 1 tablet by mouth every night for congestion/cough. A 2/19/14 Nurses Notes revealed, "continues on antibiotic for upper respiratory infection." Review of the monthly Medication Administration Records for February, March, April, May, June, July and August revealed this medication was administered. Review of nurses' notes and pharmacist's notes for the months of June, July and August revealed no respiratory symptoms documented. A Nurse Practitioner's Nursing Home Progress Note dated Aug 13, 2014 read, "She can have Mucinex 600 milligrams 1 daily for congestion". There was no mention of continued congestion in the notations. Resident #15 was observed on 9/3/14 at 9:23 AM and did not have congestion. During an interview on 9/3/14 at 2:35 PM the Nurse Practitioner said, "Sometimes folks get put on it for congestion. We can make it PRN (as needed)". She wrote a new telephone order dated 9-3-14 at 2:45 that read, Discontinue scheduled Mucinex ER 600mg and use PRN	F 329	written. This prompt release medication contains the identical medication as Mucinex Extended Release tablets, but must be given more frequently. Resident #15 also receives Zyrtec 10mg po daily for allergy since admission and has a longstanding medical history of congestion and sinus drainage. Discussion between pharmacist and attending physician on 9/23/14 at 0910 reveals the physician is considering adding scheduled Mucinex ER 600mg tablet back to resident #15□s regimen, feeling it is a good chronic med for this individual patient due to the return of congestion symptoms following medication change on 9/3/14 to PRN. Corrective actions to be accomplished for residents having potential to be affected by the same deficient practice: Indication for use of medication will be included in medication order at time of writing. If the indication for use is not included in med order, the nurse will request indication from provider. If the indication for use is not included in med order, the pharmacist will request indication from provider at time of next monthly chart review. Indications for use are printed out on the monthly Medication Administration Record (MAR) following each medication order.	

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	345166	A. BUILDING _____ B. WING _____	09/04/2014

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F 329	Continued From page 17 daily for congestion. On 9/4/14 at 8:51 AM the medical doctor said, "She may have needed it to reduce thick secretions". He did not provide any documentation to support the use of the medication for thick secretions. Interview with the pharmacist on 9/4/14 at 8:59 AM revealed she did not see any notations in the medical record about the need to reduce secretions. She also referenced her monthly notes which indicated no respiratory signs or symptoms.	F 329	Outcomes for each medication will be followed by the physician, pharmacist and nursing staff, and documented in the chart. Measures to be put in place or systemic changes made to ensure that the deficient practice will not occur: Medical staff members were reminded to include efficacy for all modalities of treatment, positive or negative, in the progress notes at their monthly meeting on 9/23/14. If the issue which caused the treatment to be initiated has resolved, treatment may be discontinued, or frequency lowered, at physician discretion with documentation to reflect reason for changes. This communication is recorded in the minutes of the medical staff meeting. Pharmacist will continue to address indications for medication management in monthly reviews. How we will monitor our performance to make sure that solutions are sustained: Pharmacist will continue to address indications for medication management in monthly reviews. If appropriate, the pharmacist will provide written recommendations for medication changes and monitoring to the attending physician. Any recommendations made are copied to the Nursing Home Director of Nursing.	

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F 456	Continued From page 18	F 456		
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure 1 of 1 mechanical weight device was operable for 4 of 4 residents (Resident #6, #8, #24, #36) who were care planned for weekly weights. The findings included: 1. Resident #6 was admitted to the facility on 9/14/12 with a diagnoses that included dementia with behavioral disturbance, paralysis agitans, senile depressive disorder, atrial fibrillation, and hyperlipidemia. Review of Resident #6's physician's order dated 2/27/14 revealed, discontinue weights from twice weekly to once weekly. Review of Resident #6's care plan updated 8/13/14 revealed a goal of, "she will not have unplanned weight loss for next 90 days. The interventions included weekly weight with monthly weight calculations, weight loss protocol PRN (as needed). Review of Resident #6's treatment sheet for August 2014 revealed, weight once weekly, follow weight loss protocol for monthly calculated loss for > or -5%.	F 456	Corrective action to be accomplished for the resident found to be affected by the deficient practice: Resident #24 was weighed on 9/9/14 resulting in weight loss less than 5%. Weights have been obtained on Resident #24 since 9/9/14 according to care plan. Resident #36 was weighed on 9/6/2014 resulting in a reported weight gain. Weights have been obtained according to care plan for Resident #36 since 9/6/2014. Staff members have been educated on appropriate use of hospital scales if bath scales in SNF are not in working order or are malfunctioning. Staff have been instructed to not document unable to obtain due to the ability to use alternate scales from the hospital. Staff members have received remedial education related to the importance of completing work orders for maintenance when equipment is malfunctioning or not	9/24/14

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F 456	Continued From page 19 The weight record revealed Resident #6's last recorded weight was on 8/18/14. The weight record indicated the lift was broken on 8/25/14. No further weights could be obtained by the facility. 2. Resident #8 was admitted to the facility on 2/4/14 with a diagnoses that included dementia, bone and cartilage disease, hypothyroidism, atrial fibrillation and psychosis. Review of Resident #8's physician orders dated 2/4/14 indicated weights to be taken weekly on Fridays on 3rd shift. The physician order dated 8/1/14 indicated dietary consult due to steady weight loss in last month. Review of Resident #8's care plan updated 8/6/14 revealed a goal stating, "she will have no unplanned weight loss for the next 90 days; maintain adequate nutrition for the next 90 days. The interventions included, total feed for all meals, snacks, and liquids; monitor and record intake of meals and snacks from all sources, and report amounts to hall nurse; weekly weights and record; monthly weight calculations. Review of Resident #8's treatment record for the month of August 2014 revealed; weekly weights with monthly calculation - follow weight loss protocol for loss of more than 5%. Review of Resident #8's weight record revealed Resident #8's last recorded weight was on 8/23/14. The note for 8/23/14 identified a 3 day re-weight. On 8/24/14 and 8/25/14 the weight record indicated the weight was unable to be obtained (UTO). The weight record further indicated that on 8/29/14 Resident #8's weight	F 456	in working order. Staff members have been instructed to escalate equipment needs to management in a timely manner to ensure quality resident care. Scales were repaired and have been in working order since 8/29/14. Corrective actions to be accomplished for residents having potential to be affected by the same deficient practice: Any Resident with a 5% weight loss will have the weight loss protocol initiated and physician notified. Treatment sheets are monitored weekly by MDS Coordinator or SNF DON for any missing weights. Prompt follow up will take place for any missed weights noted on the treatment sheets. Staff members have been educated on appropriate use of hospital scales if bath scales in SNF are not in working order or are malfunctioning. Staff have been instructed to not document unable to obtain due to the ability to use alternate scales from the hospital. Staff members have received remedial education related to the importance of completing work orders for maintenance when equipment is malfunctioning or not in working order.	

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STOKES COUNTY NURSING HOME	1570 NC 8 AND 89 HIGHWAY DANBURY, NC 27016

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F 456	Continued From page 20 was UTO due to he bath stretcher being broken. 3. Resident #24 was admitted to the facility on 8/12/14 with a diagnoses that included Diabetes type II, hypertension, Paralysis, Parkinson's disease and restless leg syndrome. Review of Resident #24's care plan updated 8/7/14 revealed a goal of, "she will not have unplanned weight loss for next 90 days. The interventions included; provide pureed diet, monitor blood sugars, encourage fluid intake, weekly weight with monthly weight calculations weight loss protocol PRN. Review of Resident #24's weight record revealed the last recorded weight was taken on 8/4/14. The weight record indicated a date of 8/9/14 that the weight scale not working. No further weights could be obtained by the facility. 4. Resident #36 was admitted to the facility on 8/27/14 with a diagnoses that included dementia, peripheral vascular disease and diabetes mellitus type II. Review of Resident #36's weight record revealed the last recorded with was recorded on 8/9/14. No weights beyond 8/9/14 could be located for Resident #36. Review of Resident #36's care plan dated 8/14/14 revealed a goal of, "he will have no unplanned weight loss for the next 90 days. The approaches included; weekly weights with monthly calculations follow weight loss protocol PRN. Review of Service Request Form dated 8/12/14 revealed, "bath stretcher does not work/won't go	F 456	Staff members have been instructed to escalate equipment needs to management in a timely manner to ensure quality resident care. Scales were repaired and have been in working order since 8/29/14. Measures to be put in place or systemic changes made to ensure that the deficient practice will not occur: Weekly monitoring of the treatment sheets by the MDS Coordinator or SNF DON to ensure weights are being completed on each resident according to their care plan. Nursing Staff have been re-educated on the importance of escalating equipment needs to leadership for prompt attention for repairs/replacement. Scales were repaired and have been in working order since 8/29/14. Maintenance will be notified of any further repairs needed. Additional parts are now on site to make immediate repairs for the wiring harness issue. Extra parts will be maintained. Maintenance will conduct monthly checklist on equipment to ensure operational. How we will monitor our performance to make sure that solutions are sustained:	

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F 456	Continued From page 21 down, put new battery will not work". The work order was signed as completed by maintenance on 8/13/14. Interview with Nursing Assistant (NA) #5 on 9/4/14 at 9:04 am revealed weights are taken on residents' bath days. NA #5 indicated the bath stretcher/weight machine was utilized for residents who were not able to utilize the stand up scale. The bath stretcher had not been working properly and was not available for use. NA #5 further indicated that staff had been utilizing the scale located downstairs in the hospital portion of the facility. Occasionally the stretcher would not be working downstairs and weights could not be obtained. NA #5 indicated that when the bath stretcher is not working NAs were told to document UTO (unable to obtain). Interview with NA #2 on 9/4/14 at 9:12 am revealed the bath stretcher scale had not been working. NA #2 stated staff would utilize the scale from the hospital until when it was working. NA #2 indicated she notifies the charge nurse and engineering/maintenance when the scales are not working. NA #2 stated maintenance had been working on the scales, but was unaware if the scales were operating for use. Interview with NA #4 on 9/4/14 at 9:18 am revealed the bath stretcher scale had not been working properly lately. NA #4 could not indicate when the bath stretcher scale was not longer working. NA #4 stated weights were not being done due to the stretcher scale located in the hospital portion of the facility being down as well. The NA stated it was communicated by nursing to write unable to obtain the weights due to the scale being broken.	F 456	Weekly monitoring of the treatment sheets by the MDS Coordinator or SNF DON to ensure weights are being completed on each patient according to their care plan. Weekly monitoring of the number of patients on the weight loss protocol by the MDS coordinator. Compliance with completion and documentation of weights will be compiled and reported to the Quality of Life and Housewide Quality Improvement Committee monthly. A maintenance checklist of equipment will be kept with any findings reported to the Housewide Quality Improvement Committee monthly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345166	A. BUILDING _____ B. WING _____	09/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 456	Continued From page 22 Interview with Nurse #3 on 9/4/14 at 2:14 pm revealed the scale for taking weights for residents who could not stand was working off and on for some time. Maintenance repaired the scale on 8/29/14 and nurse #3 indicated she witnessed it working. Currently the scale is back down. Nurse #3 stated the residents who could stand were always weighed and there was no issue with the stand up scale. Nurse #3 indicated that when the stretcher scale was not functioning NAs would use the scale from the hospital unit. Nurse #3 added that occasionally the scale is not working for the hospital unit. Interview with Nurse #2 on 9/4/14 at 2:16 pm indicated the stretcher scale has been working off and on. Nurse #2 stated that the NAs were told to document UTO to indicate that the residents' weight was unable to obtain. Weights would be obtained when the scale was available. Interview with the Maintenance Director on 9/14/14 at 3:10 pm revealed he was made aware of items that were in need of repair as evidenced by work orders submitted by staff. Maintenance indicated the scales were always giving him problems. The wires are pinched when the scale was utilized and was the source of the machines malfunction. In the instance the scales do not work, maintenance indicated he would tell staff to use the scale downstairs in the hospital unit repairs were made. Maintenance stated it takes weeks to get parts delivered for the lift/electronic scale. Interview with the Administrator on 9/4/14 at 3:13pm revealed it was her expectation that the equipment be in working order. She further	F 456		

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F 456	Continued From page 23 indicated she was aware of the bath stretcher/weight scale would malfunction. The administrator stated she would expect maintenance to purchase extra parts so that the recurrent issues could be fixed immediately.	F 456		