STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON STREET CHERRYVILLE, NC 28021

(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 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 and staff and physician interviews the facility failed to follow up on a dietary recommendation to increase a nutritional supplement due to weight loss for 1 of 3 residents reviewed for nutrition (Resident #106). The findings included: Resident #106 was admitted on 02/06/14 with diagnoses including Alzheimer's disease and diabetes mellitus. Review of a significant change Minimum Data Set (MDS) dated 01/29/16 revealed Resident #106 had short and long-term memory loss and moderately impaired cognitive skills for daily decision making. The significant change MDS further revealed Resident #106 required limited assistance with eating and was ordered a mechanically altered therapeutic diet. The significant change MDS noted Resident #106 weighed 124 pounds with no weight loss observed. Review of the Care Area Assessment (CAA) Summary for ADL (Activities of Daily Living) Functional dated 02/03/16 revealed Resident #106 was reviewed for significant change due to a decline in ADL. The CAA summary noted Resident #106 began having lower back pain early January 2016 and was also treated for a	F 281	Carolina Care Center provides or arranges services that meet professional standards of quality. Corrective action for follow up on a dietary recommendation to increase a nutritional supplement for resident #106 was achieved during survey by contacting physician about supplement order. Physician referred order to Registered Dietician for review 4-28-16. RD reviewed and recommended no changes to order due to stable weight. Corrective action for other residents having potential to be affected by the alleged deficient practice was corrected by Registered Dietician reviewing residents using the weight variance report for the past 6 months to ensure that all residents with significant weight loss or gain had been reviewed and recommendations had been followed up. There were no other recommendations that needed follow up. Measures put into place to ensure alleged deficit practice does not recur include the following:	5/19/16

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

Electronically Signed | 05/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON STREET CHERRYVILLE, NC 28021

(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 281	Continued From page 1 urinary tract infection. The CAA summary further revealed Resident #106's intake had been poor and she had received IV (intravenous) fluids twice in the last 14 days for dehydration. It was further noted Resident #106 was ordered a sugar free (SF) nutritional supplement four times a day. Review of a care plan dated 02/03/16 revealed Resident #106 was at risk for weight loss due to a history of poor appetite. Interventions included: provide supplement as ordered, monitor and record weight as ordered, and provide encouragement and assistance at meals. Review of Resident #106's recorded weights revealed the following: - 10/08/15- 125 pounds - 01/28/16- 124 pounds - 02/25/16- 111 pounds - 03/24/16- 112 pounds - 04/21/16- 113 pounds Further review of the medical record revealed Resident #106 was assessed by the Registered Dietitian (RD) on 02/26/16 due to significant weight change in the past 28 to 84 days. The RD noted Resident #106 received a pureed diet with no concentrated sweets and 60 milliters (ml) of SF nutritional supplement four times a day. The RD recommended increasing the SF nutritional supplement to 120 ml four times a day and to contact the RD as needed for potential changes to Resident #106's nutrition regimen. Review of Resident #106's Medication Administration Record from 02/26/16 through 04/27/16 revealed a physician's order for 60 ml of SF nutritional supplement four times a day with medication pass. The nutritional supplement was	F 281	- New system put into place with the following measures: Residents reviewed placed on new Dietary Audit Form. Recommendations are placed on new Registered Dietician referral form for each resident and ones with recommendations will be given to physician for review. After review physician then forwards to MDS nurse for follow up on any orders. MDS returns folder to Dietary Manager. RD recommendations are placed in the EHR in resident documents under the Dietician consult tab. Original is placed in the RD Consult notebook in the Dietary Office. - New admissions reviewed within 14 days of admission by Registered Dietician - Significant weight loss/gain skin problems, enteral feedings and/or other concerns as indicated reviewed monthly by Registered Dietician. -In-house residents reviewed monthly by Registered Dietician for the next 90 days initially, then quarterly. -In-Service on new Dietary Recommendations Procedure for Dietary Manager, Assistant Dietary Manager,and MDS. 5/16/16 -New Weight Loss-Gain Recommendation Weekly Audit from implemented by Dietary Manager. 5/12/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON STREET CHERRYVILLE, NC 28021

(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 281	Continued From page 2 initialed as given by a nurse four times a day with just a few refusals noted. An interview with Nurse #3 on 04/28/16 at 9:35 AM revealed Resident #106 took the SF nutritional supplement without difficulty and did not refuse it. During an interview on 04/28/16 at 11:58 AM the Dietary Manager (DM) stated she ran and reviewed the weight variance report at the end of the month when she got her new list of weights. The DM explained the program was set up to alert her when a resident had a 4% weight loss in 30 days so she could be aware of weight loss before it was 5% in 30 days which was considered significant weight loss. The interview further revealed the RD was contracted for 8 hours a month and the DM referred residents with significant weight loss to the RD for recommendations. The DM noted she would bring any recommendations to the physician if he was in the facility or fax the recommendation to his office. The weight variance report was reviewed during the interview and the RD confirmed Resident #106 triggered for a 10.4% weight loss in 28 days on 02/25/16. In addition, the department heads had a tracking meeting every Tuesday and the DM included for discussion any resident with significant weight loss. An interview with the Physician on 04/28/16 at 1:48 PM revealed he recalled Resident #106 had weight loss and thought it was due to dehydration. The Physician stated he did not recall a recommendation from the RD in February 2016 and would expect that to be communicated to him.	F 281	-Significant weight changes reviewed in stand up. -Weight change interventions from previous week reviewed in Weekly Tracking Committee. Monitors put into place to ensure follow up on dietary recommendations include: Registered Dietician Audit completed monthly. Registered Dietician Audit results reported to Weekly Tracking Committee for corrective actions and follow up. Results of weekly tracking reports reviewed in Quality Assurance and Assessment Committee monthly to determine effectiveness or change in procedure of plan. Recommendations of significant weight loss or gain will be reported in Weekly Tracking Committee. Quality Assurance and Assessment committee reviews Tracking Reports for a period of one year. –	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON STREET CHERRYVILLE, NC 28021

(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 281	Continued From page 3 A follow up interview was conducted with the DM on 04/28/16 at 2:01 PM. The DM had located a copy of the fax request the RD wrote on 02/26/16 to increase Resident #106's SF nutritional supplement from 60 ml four times a day to 120 ml four times a day due to significant weight loss in the past month. The DM had initialed the request on 02/29/16 and noted she had sent the fax request to the Physician. The DM stated she did not follow up to confirm the Physician had responded to the fax request and did not currently have a system in place for following up on fax requests. An interview with the Assistant Director of Nursing (ADON) on 04/28/16 at 3:01 PM revealed the DM attended the Tuesday tracking meetings and informed the team of any residents with significant weight loss. The ADON stated the DM usually sent a recommendation to the Physician or referred residents' with weight loss to the RD. The summaries of the weekly meetings were reviewed during the interview and revealed Resident #106 was reported to have significant weight loss during the week of 02/22/16 through 02/28/16. The ADON recalled they had discussed that Resident #106 had been sick and was not eating. The interview further revealed the team did not have a system to follow up with residents' weight loss at subsequent weekly tracking meetings and they assumed the DM had taken care of any referral or recommendation(s). The ADON further stated she expected the DM to follow up with the Physician after sending a fax request.	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		5/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON STREET CHERRYVILLE, NC 28021

(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 312	Continued From page 4 A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review and resident, family and staff interviews the facility failed to provide oral care and nail care for 1 of 3 dependent residents reviewed for activities of daily living (Resident #55). The findings included: 1. Resident #55 was admitted to the facility on 08/31/09 with current diagnoses of muscle weakness, lack of coordination and chronic pain. The quarterly Minimum Data Set (MDS) dated 04/22/16 revealed Resident #7 had moderately impaired cognition and required extensive assistance with personal hygiene. Review of the care plan dated 04/25/16 revealed Resident #55 had a decline in independent mobility and received occupational therapy for diagnoses of muscle weakness and lack of coordination. Interventions included to remove partial at night and brush teeth, break larger tasks into smaller segments, explain expected therapy outcomes and provide frequent rest periods to prevent fatigue. Observations made of Resident #55's teeth throughout the survey revealed the following: - 04/26/16 8:45 AM observed upper and lower	F 312	Carolina Care Center provides necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Corrective action for oral care and nail care Resident #55 was achieved for during survey by teeth brushed and nails clipped.4/28/16 Corrective action for other residents having potential to be affected by the alleged deficient practice was corrected during survey by in-house residents evaluated for problems with oral care/nail care. No other nail/oral care concerns found. 4/28/16 Measures put into place to ensure the alleged deficient practice does not recur include the following: -Procedures for mouth care,teeth brushing, dentures, cleaning and storing, care of fingernails/toenails.4/29/16 - In-Services on personal care and hygiene of the resident and review of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON STREET CHERRYVILLE, NC 28021

(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 312	Continued From page 5 teeth to be covered in a thick white film with a thicker white substance coating the lower gum line. - 04/27/16 9:30 AM observed upper and lower teeth covered with thick white substance. - 04/27/16 1:45 PM observed family member brush Resident #55's teeth. - 04/28/16 8:49 AM observed upper and lower teeth with a white thick film. During an interview conducted on 04/27/16 at 1:47 PM Resident #55's family member stated staff did not brush Resident #55's teeth. The family member stated she had requested over and over to the nurse aides (NAs) and the nurse's for Resident #55 to have her teeth brushed at least once a day but it didn't get done unless she brushed them for her when she visited. During an interview conducted on 04/28/16 at 8:41 AM NA #4 stated Resident #55 was out of bed when she arrived for her shift and she took her to breakfast and brought her back from breakfast. NA #4 stated she did not brush Resident #55's teeth after breakfast. During an interview on 04/28/16 at 8:49 AM Resident #55 stated her teeth had not been brushed that morning. She stated her family brushed her teeth when they visited. During an interview conducted on 04/28/16 at 11:20 AM the Director of Nursing (DON) stated it was her expectation that dependent residents' teeth should be brushed daily by staff. 2. Resident #55 was admitted to the facility on 08/31/09 with current diagnoses of muscle weakness, lack of coordination and chronic pain.	F 312	updated procedures for CNA's and licensed nurses. 5/16/16 - Weekly Audit form for Management Nursing updated with nails clean and trim, contracted joints check for assistive device. Mouth care, will get CNA to correct if needed. 5/12/16 Monitors put into place to ensure oral and nail care are provided include : -Management Nurses will use updated audit form to evaluate personal care and concerns weekly and report concerns in Weekly Tracking Committee. All residents will be audited weekly. Each Management Nurse will review approximately 10 residents according to census with back up nurse scheduled as needed. 5/12/16 The results of the Weekly Tracking reports will be reviewed in the monthly Quality Assurance and Assessment Committee to determine effectiveness or change in procedure or plan. Quality Assurance and Assessment Committee reviews Tracking Reports for a period of one year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON STREET CHERRYVILLE, NC 28021

(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 312	Continued From page 6	F 312		

The quarterly Minimum Data Set (MDS) dated 04/22/16 revealed Resident #7 had moderately impaired cognition and required extensive assistance with personal hygiene.

Review of the care plan dated 04/25/16 revealed Resident #55 had a decline in independent mobility and received occupational therapy for diagnoses of muscle weakness and lack of coordination. Interventions included remove partial at night and brush teeth, break larger tasks into smaller segments, explain expected therapy outcomes and provide frequent rest periods to prevent fatigue.

An observation made on 04/28/16 8:49 AM Resident #55's right hand clinched in a tight fist, when Resident #7 opened her right hand her fingernails were observed to be ¼ to ½ inch long and uneven. Skin on right palm was observed to be very red and had indentations from fingernails. Left hand fingernails were observed to be ¼ to ½ long and uneven.

An interview conducted with the Restorative Nurse on 04/28/16 at 9:05 revealed it was the floor staff, nurse aides and nurses, to provide nail care to Resident #55. The Restorative Nurse was accompanied to Resident #55's room on 04/28/16 at 9:10 AM to observe resident fingernails and she confirmed the right hand had indentions in the palm from the fingernails and the right and left hand fingernails needed to be trimmed.

An interview conducted on 04/28/16 at 11:20 AM with the Director of Nursing revealed it was her expectation for residents' fingernails to be trimmed on shower days and as needed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON STREET CHERRYVILLE, NC 28021

(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 315	Continued From page 7	F 315		
F 315 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to handle the indwelling urinary catheter bags in a manner to prevent urinary tract infections during the transfers of 2 of 2 residents sampled with indwelling urinary catheters (Residents #62 and #87). The findings included: 1. Resident #62 was admitted to the facility originally on 01/19/16 and readmitted on 01/29/16. Her diagnoses included fractures of the clavicle, tibia, and ankle, and having had a previous cerebral vascular accident. Nursing notes dated 02/01/16 at 2:44 PM revealed Resident #62 had pain and discomfort in her abdominal area and her abdomen was distended. The physician was notified and ordered an indwelling urinary catheter to be placed resulting in 1000 cc's (cubic centimeters)	F 315	Carolina Care Center ensures 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. Corrective action for Resident#62 was achieved during survey by correct placement of catheter by staff and for Resident#87 by reeducating staff of correct placement. Corrective actions for those residents having potential to be affected by the alleged deficient practice include:	5/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON STREET CHERRYVILLE, NC 28021

(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 315	Continued From page 8 of urine removed from her bladder. The physician's progress note dated 02/03/16 noted a diagnoses of urinary retention with orders to leave the indwelling urinary catheter in place. A care plan was initiated on 03/01/16 which addressed the potential for complications and infection related to the use of an indwelling catheter and closed drainage system. The goal was for the resident not to develop urinary tract infections. One of the interventions was "Never raise the drainage bag above the bladder to prevent urine flowing back into the bladder." On 03/15/16 laboratory results of a urinalysis revealed evidence of enterococcus species, staphylococcus species coagulase, and veridiidans group streptococci. The physician ordered the antibiotic Cipro 250 milligrams (mg) to be administered twice a day for 5 days. Nursing notes dated 03/16/16 revealed an attempt to discontinue the use of Resident #62's indwelling urinary catheter. Per nursing notes on 03/19/16 the indwelling urinary catheter had to be reinserted and left in for urinary retention. Resident #62 was observed being transferred from her wheelchair to her bed on 04/27/2016 at 2:21 PM. The Occupational Therapy Aide (OTA) assisted Resident #62 transfer from her wheelchair to her bed. When Resident #62 sat on bed the OTA held the catheter at the resident's head level. When the resident laid back in bed the OTA placed the foley catheter bag on the rod at the bottom of the bed that holds the cover off of the legs and feet. The catheter bag stayed there a couple of minutes before the Staff	F 315	- Residents with urinary catheters checked for proper placement of bag. No concerns noted.4/28/16. -CNA's, Licensed Nurses, and contracted therapy employees in-serviced on proper care and positioning of catheter bag.4/29/16 Measures put into place to ensure alleged deficient practice does not recur include: - Update of Catheter Care Procedure 4/29/16 - In-service for CNA's, Licensed Nurses, and contracted therapy employees on proper positioning of catheter care. - Weekly Management Nurses Audit updated with catheter bag placement and proper positioning during transfer. All residents will be audited weekly, each Management nurse has approximately 10 residents according to census and with back up nurse scheduled as needed. Monitors put into place to ensure alleged deficient practice does not recur include: Catheter care and proper position of catheter bag monitored by management nurses during weekly audits. Concerns are reported in Weekly Tracking Committee for corrective actions needed. The results of the Tracking Committee reports are reviewed in monthly Quality Assurance and Assessment Committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON STREET CHERRYVILLE, NC 28021

(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 315	Continued From page 9 Development Coordinator (SDC), who was present for this observation, took the catheter bag and placed it on the side of the bed. After pericare was completed and staff left the room the SDC stated the OTA should not have placed or held the catheter bag above the level of the bladder. An interview with the OTA involved in the transfer was conducted via phone on 04/28/16 at 9:34 AM. OTA stated she was aware the catheter bag was to be maintained below the resident's bladder. She further stated that she hooked it to the foot cradle of the bed, causing it to be above the residents bladder during the transfer, because she did not want to lay it on the bed. She stated she knew staff were going to do catheter care and thought since the bag would not be there too long it was alright to hang it on the bed cradle. Interview with the Director of Nursing on 04/28/16 at 11:22 AM revealed her expectation was that the catheter drainage bag would remain below the resident's bladder level even during a transfer. 2. Resident #87 was admitted to the facility on 01/04/13 and most recently on 02/19/15. Her diagnoses included Parkinson's Disease and neurogenic bladder. Review of laboratory results revealed the following urinary tract infections and treatments: *07/11/16 the report noted greater than 100,000 cfu/ml proteus mirabilis treated with the antibiotic Bactrim for 10 days. *08/07/15 the report noted greater than 100,000 cfu/ml escherichia coli treated with the antibiotic Keflex 500 mg (milligrams) every 6 hours for 10	F 315	meeting for recommendations or changes needed to plan. Quality Assurance and Assessment Committee reviews Tracking Reports for a period of one year. -	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON STREET CHERRYVILLE, NC 28021

(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 315	Continued From page 10	F 315		

days;
*10/31/15 the report noted greater than 100,000 cfu/ml escherichia coli and greater than 100,000 cfu/ml proteus mirabilis treated with the antibiotic Augmentin 500 mg every 8 hours for 10 days.

A care plan last updated on 03/01/16 which addressed the potential for complications and infection related to the use of an indwelling catheter and closed drainage system. The goal was for the resident not to develop urinary tract infections. One of the interventions was "Never raise the drainage bag above the bladder to prevent urine flowing back into the bladder."

On 04/27/16 at 8:24 AM, Resident #87 was observed being transferred from a wheelchair to a low bed. The Assistant Director of Nursing (ADON) and Nurse Aide (NA) #1 were observed transferring Resident #87. During the transfer, the ADON removed the catheter bag from behind the resident's wheelchair and handed it to NA #1. During this exchange, the catheter bag was handed over to the NA #1 causing it to be above the resident's bladder. The ADON instructed NA #1 not to let it touch the floor. NA #1 stood there with the catheter bag at approximately the resident's face level until the they were set to transfer the resident.

Interview with NA #1 on 04/27/16 at 8:34 AM revealed she had been taught to make sure the catheter bag was kept off the floor. She further stated she did not know anything about keeping the catheter bag below the bladder.

Interview with the ADON on 04/28/16 at 8:14 AM revealed she was aware the catheter bag should be below the bladder. When asked why Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON STREET CHERRYVILLE, NC 28021

(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 315	Continued From page 11 #87's catheter bag was not kept below the bladder during the transfer, she stated she did not want it to touch the floor. She further stated she and NA #1 could have done a better job at keeping the catheter bag below the bladder during the transfer. Interview with the Director of Nursing on 04/28/16 at 11:22 AM revealed her expectation was that the catheter drainage bag would remain below the resident's bladder level even during a transfer.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to apply a carrot and a hand roll to prevent worsening of contractures and skin breakdown for 1 of 2 residents reviewed for range of motion (Resident #55). The findings included: Resident #55 was admitted to the facility on 08/31/09 with current diagnoses of muscle weakness and chronic pain. Review of the quarterly Minimum Data Set (MDS) dated	F 318	Carolina Care Center ensures that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Corrective action was achieved during survey for Resident#55 by hand roll and carrot placed in her hands as ordered. 4/28/16	5/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON STREET CHERRYVILLE, NC 28021

(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 318	Continued From page 12 04/22/16 revealed Resident #55 had moderately impaired cognition and required extensive assistance with dressing and personal hygiene. Review of the care plan dated 04/25/16 revealed Resident #55 received passive range of motion to lower extremities six times a week and had limitations of right knee, left ankle, bilateral shoulders and bilateral fingers. The goal was to prevent further breakdown in range of motion. The interventions included skin to be checked for red/open areas, notify nurse of any signs or complaints of pain during therapy, nursing to apply hand rolls bilaterally, document any refusals or with holds and the reason why and quarterly range of motion screens. Review of the April 2016 Physician Orders revealed the following orders for Resident #55: - Clean both hands with soap and water and dry thoroughly, then reapply hand rolls every day. - Right hand roll and left hand carrot as tolerated, to be worn at all times with the exception of activities of daily living. Observations of Resident #55 throughout the survey revealed the following: - 04/26/16 3:12 PM observed Resident #55 lying in bed, no hand roll in right hand, no carrot in left hand. - 04/27/16 8:31 AM observed Resident #55 sitting in her geri chair in her room with no carrot in left hand and no hand roll in right hand. - 04/28/16 8:50 AM observed Resident #55 sitting in her geri chair in her room, no carrot in left hand, no hand roll in right hand. During an interview conducted on 04/28/16 at 8:41 AM Nurse Aide (NA) #3 stated Resident #55	F 318	Corrective actions for those residents having potential to be affected by the alleged deficient practice include: - Residents with order for nursing applied assistive devices checked for placement of devices. No areas of concern were noted 4/28/16 -All residents with contractures evaluated for assistive devices in place. No areas of concern were noted. 4/28/16 Measures put into place to ensure alleged deficient practice does not recur include: - Range of Motion Exercise procedure updated. 4/29/16 - In-service on Range of Motion of all joints, importance of keeping joints moving, and reasoning of assistive devices with proper placement for nursing personnel. Location of assistive devices listed under alerts in Point of Care.5/16/16 Monitors put into place to ensure alleged deficient practice does not recur include: - Treatment nurse will continue to check for placement of assistive devices and initial daily. - Medication nurse and CNA will check placement of assistive devices frequently	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON STREET CHERRYVILLE, NC 28021

(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 318	Continued From page 13 was out of bed when she started her shift and had her carrot in her left hand. NA #3 further stated she was not aware Resident #55 needed a hand roll in her right hand. An interview conducted on 04/28/16 at 9:05 AM with the Restorative Nurse revealed she continued to assess Resident #55 on a daily basis but occupational therapy was working with her as well. The Restorative Nurse stated it was the nurse aides (NAs) or the nurse's responsibility to make sure the carrot was in Resident #55's left hand and hand roll in her right hand. During the interview the Restorative Nurse placed the carrot in Resident #55's left hand and agreed her fingernails had made indentions in her palm and that the fingernails needed to be trimmed. She could not find the hand roll for the right hand and stated she would get one and place it in her hand. An interview conducted on 04/28/16 at 9:45 AM with Nurse #3 revealed the Treatment Nurse cleaned Resident #55's hands and applied her carrot and hand roll on a daily basis. During an interview conducted on 04/28/16 at 9:53 AM Nurse #2 (Treatment Nurse) stated she assessed and cleaned Resident #55's hands Monday through Friday and applied her carrot and hand roll. She stated she did not recheck for placement of the carrot or hand roll throughout the day and it was the NAs or nurse's responsibility to put them back in place if they were removed. Nurse #2 stated the care card on the kiosk informed the NAs that the carrot needed to be in the left hand and the hand roll needed to be in the right at all times except during activities of daily living. Nurse #2 further stated she had not observed the indentions or redness on Resident	F 318	to monitor for compliance. Medication nurse will document any refusal for self removal of devices in the progress notes and notify physician if resident continues to refuse. 4/28/16 - Assistive Devices will continue to be monitored by management nurses weekly. All Residents will be audited. Each Management Nurse reviews approximately 10 residents according to census, with back up nurse scheduled if needed. Concerns will be reported in Weekly Tracking Meeting. Tracking committee reports are reviewed in monthly Quality Assurance and Assessment committee for recommendations or changes needed to plan. Quality Assurance and Assessment Committee reviews tracking reports for a period of one year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON STREET CHERRYVILLE, NC 28021

(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 318	Continued From page 14 #55's left palm. During an interview conducted on 04/28/16 at 11:20 AM the Director of Nursing (DON) stated it was her expectation that all direct care staff that worked with Resident #55 make sure her carrot and hand roll were in her hands at all times except during meals and showers. The DON further stated staff needed to assess Resident #55's skin integrity and length of her fingernails to prevent skin breakdown from keeping her left fist clenched.	F 318		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to assess and address weight loss for 1 of 3 residents sampled for nutritional status (Resident #11). The finding included: Resident #11 was admitted to the facility on	F 325	Carolina Care Center ensures that residents maintain acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible and receives a therapeutic diet when there is a nutritional problem.	5/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON STREET CHERRYVILLE, NC 28021

(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 325	Continued From page 15 10/23/13. His diagnoses included multiple nodules with suspected pulmonary metastasis, chronic obstructive pulmonary disease, schizophrenia. A significant change Minimum Data Set (MDS) dated 10/23/15 noted he was cognitively intact, had no mood or behaviors, needed limited assistance with most activities of daily living skills (ADL) and his weight was 214 pounds. The Care Area Assessment Summary for ADL dated 10/27/15 noted he had a change in his ADL. Resident #11 received a regular diet. The next quarterly MDS dated 01/22/16 noted no changes other than his weight of 204 pounds and checked no significant weight loss. There were no dietary notes relating to this weight loss. The monthly weight in the vital sign section of the medical record showed Resident #11 weighed 209 pounds on 01/26/16. The next monthly weight noted in the medical record was on 02/23/16 at which time his documented weight was 199.6 pounds. There were no dietary notes relating to this weight loss. Interview with the Dietary Manager (DM) on 04/28/16 at 11:58 AM revealed that the facility's computer system triggered weight loss per month at 4 percent even though 5 percent weight loss in one month was considered significant weight loss. This triggered her to identify weight loss before it became significant at 5 percent in one month. The DM stated that she reviewed the triggered weight loss and made a decision if there was an intervention needed. She stated she relied on talking to the resident, reviewing their	F 325	Corrective action for resident #11 was achieved during survey by physician evaluating resident 4/28/16. Resident#11 has diagnosis of Malignant Neoplasm of Lung and under Hospice care. No new orders received for weight loss. 4/28/16. Corrective action for other residents having the potential to be affected by the alleged deficient practice include: - In-house residents reviewed for significant weight loss or gain of weight. No other residents found to have significant weight variance without intervention 4/29/16 - Residents with significant weight loss or gain of 4% in one month,7% in 3 months, or 10% in 6 months according to weight variance report is provided to RD monthly. Measures put into place to ensure alleged deficient practice does not recur include: - Registered Dietician to develop and implement Weight Protocol for physician standing orders. 5-16-16 -Residents with significant loss or gain evaluated by Registered Dietician monthly for recommendations. - In-service on weight loss protocol for Dietary Manager and Restorative Nurse. 4/28/16 - EHR alerts staff on a daily basis of 4% in one month, 7% in 3 months and 10% in 6	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON STREET CHERRYVILLE, NC 28021

(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 325	Continued From page 16 intakes, reviewing their skin condition etc. The DM stated she did not necessarily make a note of her assessment and/or decision making. She would normally note if she took action such as adding a supplement, ice cream with meals, etc. The DM further stated there was a weekly tracking meeting held with department heads that identified residents with significant weight loss and the team discussed interventions. The DM stated that on 02/23/16 Resident #11 triggered for 4.5 percent weight loss. The DM stated she spoke with Resident #11 after this triggered weight loss because he was very alert and could tell you his preferences. At that time Resident #11 stated he did not want a supplement that tasted like minerals, loved a particular soda, and was eating about his usual amount. The DM stated that she talked to his family and requested they bring him his favorite soda and she would then monitor his weights. The DM also stated that the Registered Dietician (RD) came monthly. The DM was out the day the RD came (02/26/16) but she provided her with the weight variance report which noted Resdient #11 with a 4.5 percent loss in one month. The RD made no notes in the medical record related to Resident #11. His next documented weight in the medical record was on 03/22/16 when he weighed 190.4 pounds. There were no dietary notes relating to this weight loss which was 4.6 percent in one month and significant weight loss in 3 months of 8.89 percent (since 01/26/16). Further interview with the DM on 04/28/16 at 11:58 AM revealed that Resident #11 triggered significant weight loss on 03/22/16 and she stated she did not do anything to address this further	F 325	months. - New Weight Loss-Gain Recommendation Weekly Audit form implemented. 5/12/16 -Weight change interventions from previous week reviewed in Weekly Tracking Committee. - Significant changes reviewed in Stand up meeting.5/4/16 Monitors put into place to ensure residents with significant weight loss/ gain are identified include: After completion of monthly Dietary Audit Form, it will be compared with the significant weight loss/gain Recommendation weekly audit form to ensure that RD has addressed all concerns. Comparison will be reviewed by Dietary Manager and any omissions will be report to Administrator. -Recommendations of significant weight loss or gain will be reported in QA Tracking meeting weekly. Weight interventions put into place from previous week reviewed. 5/3/16 The results of the weekly Tracking Report are reviewed monthly in Quality Assurance and Assessment Committee to determine effectiveness or change in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON STREET CHERRYVILLE, NC 28021

(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 325	Continued From page 17 weight loss. She stated the RD would have come in on 03/25/16 and reviewed the weight variance reports but the DM was not in the facility during this visit. The DM provided no explanation for not addressing Resident #11's significant weight loss in March 2016. During an interview with the Assistant Director of Nursing (ADON) on 04/28/16 at 3:08 PM, the ADON reviewed the weekly tracking meeting. Resident #11 was noted as having had significant weight loss during the meeting reflecting the week of 03/21/16 to 03/27/16. The ADON stated she would have expected the DM to put in some intervention to address this weight loss. If the DM was not present at this meeting then the assistant DM would have come and she would put interventions in place. The ADON stated that the tracking meetings discuss week to week progress but there was no system to discuss the previous weeks findings to see if an intervention was put into place. On 04/28/16 at 3:24 PM the MDS Coordinator provided a referral form she had given to therapy on 03/29/16 for an overall decline including weight loss, incontinence, and decline in bed mobility, transfers, and walking. Therapy noted on 04/12/16 no action was taken regarding this referral due to the resident being hospitalized. Resident #11 was hospitalized on 04/11/16 for chest pain and hypoxia. A phone interview with the RD on 04/28/16 at 4:31 PM revealed that the DM was very good about informing her of weight loss in the facility. The RD was unable to explain why she did not address Resident #11's weight loss during her February or March visits.	F 325	procedure or plan. Quality Assurance and Assessment Committee reviews Tracking Report for a period of one year.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON STREET CHERRYVILLE, NC 28021

(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 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff	F 431	Carolina Care Center uses drugs and	5/19/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON STREET CHERRYVILLE, NC 28021

(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 431	Continued From page 19 interviews, manufacturer specifications, and facility policy, the facility failed to discard an expired Lantus insulin vial from 1 of 4 medication carts. Findings included: Manufacturer specifications for Lantus insulin per the package insert included, "Opened vials, whether or not refrigerated, must be used within 28 days after the first use. They must be discarded if not used within 28 days." A review of the facility's undated Medication Storage policy stated "The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed." During an observation on 04/27/16 at 12:25 PM, an opened vial of Lantus insulin marked with an open date of 3/24/16 and an expiration date of 10/31/18 was found in medication cart #4. The Staff Development Coordinator (SDC) confirmed the vial was for Resident #115 and it was the only vial of Lantus insulin in the cart for this resident. The SDC indicated the insulin was to be given once daily at bedtime. Record review of the monthly physician orders for the month of April 2016 indicated Resident #115 was to receive Lantus insulin 50 units subcutaneously once daily at bedtime for the diagnosis of Diabetes Mellitus. Record review of the Electronic Medication Administration Record (EMAR) for April 2016 for Resident #115 indicated Lantus insulin was given at bedtime once nightly from 04/01/16 through 04/26/16.	F 431	biological labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Corrective action for expired insulin vial found on Cart #4 was achieved during survey by expired insulin sent back to pharmacy and new prescription obtained. 4/27/16 Corrective action for other residents having the potential to be affected by the alleged deficient practice was corrected by medication carts audited for expired or beyond date medications. No expired or beyond date medications were found. 4/27/16 Measures put into place to ensure alleged deficient practice does not recur include: - In-service completed for licensed personnel of Safe Drug Storage and disposal of drugs with expired or beyond use date. -Procedures on Storage of Medication, Administering Medication, and Expiration of Medication Beyond Use Dates were updated. - Discard Date Graph on each medication cart was updated.4/28/16 -Medication cart audit added to weekly audit for Management Nurses.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	04/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON STREET CHERRYVILLE, NC 28021

(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 431	Continued From page 20 In an interview with Nurse #2 on 04/28/14 at 10:00 AM, Nurse #2 admitted that she had administered the expired Lantus insulin to Resident # 115 on 4/22/16 at bedtime. Nurse #2 stated Lantus insulin should be dated when opened and it should be discarded from the medication cart at the time of expiration or after 28 days. Nurse #2 acknowledged the Lantus insulin was outdated it should be removed from the medication cart. An interview with the Director of Nursing (DON) was conducted on 04/28/16 at 10:25 AM. The DON stated that nursing staff who ran the medication cart were expected to check the expiration of insulin vials each time before they administered to the residents. The DON indicated her expectation was all unopened vials of Lantus insulin should be stored in the medication storage refrigerator until they were needed on the medication cart. Once a vial of Lantus insulin was opened, it should be dated. The DON specified that the facility's policy was to discard opened vials of Lantus insulin 28 days from the date opened in accordance with the manufacturer's recommendations.	F 431	Monitors put into place to ensure proper storage of drugs include: Medication carts audited for expired and beyond date medications, daily for one week, then weekly thereafter by Management Nurses during their weekly audit and will be reported in Weekly Tracking Meeting. The results of the weekly tracking reports are reviewed monthly in the Quality Assurance and Assessment committee to determine the effectiveness or change in procedure or plan. Quality Assurance and Assessment Committee reviews Tracking Reports for a period of one year. -	