STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345281	A. BUILDING _____ B. WING _____	03/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STANLY MANOR	626 BETHANY CHURCH RD BOX 38 ALBEMARLE, NC 28001

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329 SS=D	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 observation, record review and staff interviews the facility failed to prevent excessive dosing a resident receiving anticoagulant therapy for 1 of 10 residents receiving unnecessary drug review. (Resident #34) Findings include: Resident #34 was admitted to the facility on	F 329	Resident #34 was assessed daily on 3/15, 3/16, 3/17 during the time that the Coumadin dosage error was administered. No adverse signs or symptoms were noted by resident or staff. On 3/18/11 the error was noted by staff and immediate action was taken to notify the physician and an order was received to obtain a PT INR to monitor resident's levels. Physician visited resident and stated in progress note resident was stable and appears comfortable. Nursing staff continued to monitor closely resident #34 with no adverse signs /symptoms noted. 3/21/11 A PT INR was obtained and physician was made aware of results. Facility implemented further instructions by physician.	3/18/11 3/20/11 3/21/11 3/21/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stephanie Herrin Honeycutt | TITLE: Administrator | (X6) DATE: 4-21-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 329	Continued From page 1 1/27/11. Diagnoses included; Thrombocytopenia, status post repair of right hip fracture and anemia. A review of the MAR (Medication Administration Record) for March 2011 for Resident #34 revealed, the resident was receiving 5mg (milligrams) of Coumadin (anticoagulant medication) daily at 5:00pm. On 3/7/11 laboratory results showed the INR (International Normalized Ratio) was 4.6 (the normal range was 0.9 - 1.2) The NN (nurses note) dated 3/7/11 at 6:30pm revealed the physician was notified regarding the high INR and a new order was received to hold the Coumadin. A physician order dated 3/7/11 at 6:30pm read hold Coumadin 3 days, check PT/INR on 3/10/11. "Do Not give Coumadin until Dr. ----- aware of PT/INR results on 3/10/11." A review of the MAR (Medication Administration Record) for the month of March 2011 revealed Resident #34 was not given Coumadin 5mg on 3/8, 3/9, and 3/10/11. A review of the NN for 3/8, 3/9 and 3/10 revealed the resident was assessed daily and there were no signs or symptoms of bleeding documented. The laboratory results on 3/10/11 showed the INR was 5.0. This result documented that it was collected at 7:05am. The laboratory result had a hand written note that read "faxed 3/10/11 at 10:00am" A physician order dated 3/10/11 read Stat (immediately) repeat PT/INR." The laboratory results on 3/10/11 showed the INR was 4.8. The result documented that it was collected at 10:40am. The laboratory results had a hand written note that read "called to MD (medical doctor) on 3/10/11 at 1:15pm." A physician order dated 3/10/11 read "Hold	F 329	Pharmacy was contacted to place Coumadin orders on separate MAR from routine and PRN medications to ensure accuracy of administration of medication and assist with prevention of future med error. Weekly QA Safety meeting met and discussed Coumadin error and further actions to be taken. SDC/QA RN was directed to re-educate all nursing staff on practice of writing orders, reviewing orders, and reviewing Coumadin lab results. All licensed nursing staff had completed Coumadin educational sessions. All residents receiving Coumadin had their orders reviewed to ensure accuracies. SDC/QA RN will review monthly all Coumadin orders to address any further issues for educational opportunities. SDC/QA will bring findings to the Monthly QA meeting for evaluation until three months of compliance is sustained and goals are met.	3/21/11 3/21/11 3/21/11 3/21/11 3/23/11 3/21/11

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F 329	Continued From page 2 Coumadin until Monday (3/14/11). Re-check INR Mon. (Monday 3/14/11)." A review of the MAR dated March 2011 revealed Coumadin 5mg was held on 3/11, 3/12 and 3/14/11. A review of the NN from 3/11, 3/12, 3/13 and 3/14 revealed the resident was assessed daily and there were no signs or symptoms of bleeding documented. The laboratory results dated 3/14/11, collected at 7:30am showed the INR was 1.6. A hand written note on the laboratory result read "faxed 3/14/11 at 11:50am." A physician order dated 3/15/11 read Coumadin 2.5mg by mouth every HS (hour of sleep). Re-check PT/INR on Friday 3/18/11. A review of the MAR dated March 2011 revealed Coumadin 5mg was given to Resident #34 on 3/14, 3/15, 3/16 and 3/17/11 at 5:00pm. Also Coumadin 2.5mg was given at 9:00pm on 3/15, 3/16, and 3/17/11. The Coumadin 5mg was documented on the MAR as being discontinued on 3/18/11. A review of the NN dated 3/15, 3/16, 3/17 and 3/18 revealed the resident was assessed daily and there were no signs or symptoms of bleeding documented. A laboratory result dated 3/18/11, collected at 6:50am showed the INR was 4.3. A hand written note at the bottom of the laboratory results read "faxed 3/18/11 at 12:15pm." A physician order dated 3/18/11 at 8:30pm read "discontinue Coumadin 5mg, Discontinue Coumadin 2.5mg, PT/INR 3/21/11"	F 329	Pharmacist in-serviced license staff on medication administration error prevention.	4-4-11

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F 329	Continued From page 3 A review of the physician progress note dated 3/20/11 revealed the resident was seen. The progress note documented "Unfortunately Coumadin was not stopped as ordered last Monday and Friday, INR up. Coumadin again ordered to be held. Re-check PT/INR tomorrow 3/21/11. At this time resident stable and appears comfortable." A laboratory result dated 3/21/11, collected at 7:40am showed the INR was 4.0. A hand written note at the bottom read "called to MD 3/21/11 at 2:00pm. On 3/23/11 at 9:51am the resident was observed lying in bed. There were no bruises or skin coloration observed any where on the resident. On 3/23/11 at 3:37pm an interview with nurse #1 revealed she received a call from the physician ' s office questioning the resident ' s dose of Coumadin. Two separate faxes had been sent to the physician ' s office and each fax had a different dose of Coumadin written on it. "I checked the MAR's and discovered the resident was receiving both 5mg and 2.5mg of Coumadin. The nurse on day shift who wrote the order did not discontinue the prior order and the nurse on the medication cart giving the medication did not catch the error. On 3/23/11 at 4:39pm an interview with the ADON (assistant director of nursing) revealed that a new system was in place. "It was put in place before this incident occurred. The process was all pink copies of physician orders were to be kept at the nursing station and the hall nurse was to go through and double check the orders. The	F 329		

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F 329	Continued From page 4 pink copies are to be checked within 24 hours but I would expect they would be checked no later than 2 days after the order was written. I would have hoped these types of errors would have been caught but it was not. We have not written this up as an official policy yet." On 3/24/11 at 11:53am an interview with nurse #2 revealed she had taken the order from the physician for Coumadin 2.5mg. "I remember taking the order. I had so many interruptions that day I was training a new med-aide. I must have just not gotten back to discontinue the other order. I just can not think of any other way it could have happened."	F 329		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based resident and staff interviews, record reviews and a test tray observation, the facility failed to serve foods that were palatable and at appropriate temperatures to residents who participated in the facility's meal services. A review of the facility's Complaint/Concern Reports revealed the most recent food complaints were concerning the palatability of the food. During an interview on 3/22/11 at 9:08am, Resident #4 stated that sometimes the meat was	F 364	Resident #4, #117, #84 will be interviewed for likes, dislikes and any issues they may have with the quality of food services to ensure satisfaction and expectation dietary services are met.	4/16/11

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F 364	Continued From page 5 cooked too hard (beef and pork roast); but, the chicken was not well cooked. During an interview on 3/22/11 at 9:40am, Resident #117 stated that the breakfast served in his room was usually cool/cold. During an interview on 3/22/11 at 2:48pm, Resident #84 stated that the salad greens served had no seasoning and sometimes the meat was not well cooked. The resident revealed that he ate his meals in his room and most of the time food the food was served cold. During an observation of the meal tray serving line in the kitchen on 3/23/11 at 11:40 am, the temperatures of all of the hot food items were above 135 degrees Fahrenheit and the temperature of the milk was 40 degrees Fahrenheit. The dinner plates were maintained in a plate warmer next to the meal serving line until used. Each resident ' s plated meal was covered with a tray lid cover and bottom, and then placed on individual meal service trays. Each meal service tray was placed in an open-sided, stainless steel, multi-shelved delivery cart. During a dining room observation and interview on 3/23/11 at 12:55pm, Resident #117 stated that the chicken had "no taste, wasn't cooked". On 3/23/11 at 1:05pm, a meal test tray observation was conducted. The last meal tray was served to a resident on the 500 hall at 1:13pm. Temperatures were taken and food items of regular consistency were tasted on a test meal tray at 1:14pm with the assistance of the Dietary Manager and a staff nurse. The temperatures of the chicken, corn, cabbage, and	F 364	The facility has purchased new electronic dietary software for menu, recipes, and tray line cards to ensure all likes and dislikes are being honored, increase the selection of menu items and reduce the opportunity for manual errors with tray card set up, and also expedite food service delivery. CDM will have meeting with dietary staff to discuss meal service and educate on seasoning, temperatures and timeliness of meal delivery. Trayline wells were de-limed also to ensure wells are working at capacity to keep food temperatures hot. Dietary Manager will take food temps off dummy tray weekly on hall to ensure temps are warm and acceptable. This tray will be the last tray served off the hall cart at meal time. All six halls will be surveyed, one per week by temp checks. The Dietary Manager will also have staff taste test the dummy tray to ensure the palatability and temperature of food. The Dietary Manager will immediately address any concerns and report to the administrator. A log of temperatures and times of testing will be maintained for three consecutive months until sustainable results are met with no further complaints. Results of audit will be discussed at monthly QA meeting to ensure compliance.	4/21/11 4/15/11 4-19-11

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F 364	Continued From page 6 chilibeans ranged from 118 degrees Fahrenheit to 147 degrees Fahrenheit. The taste tests of the food items on the meal tray revealed the chicken was warm, but was not appetizing (no seasoning), and the cabbage was lukewarm. During an interview on 3/23/11 at 1:30pm, the DM (Dietary Manager) revealed that she conducted meal test tray observations every month. The DM also indicated that she and the Administrator were planning to purchase the metal inserts for the domed lid covers/bottoms due to residents' complaints of food not being warm enough when served in their rooms.	F 364	Resident Liaisons will notify weekly any grievances relating to food issues to the weekly QA Safety Committee Meeting to ensure residents needs are being satisfied. The facility will also discuss monthly grievances at the monthly QA meeting to ensure compliance. Resident Council will also be interviewed to ensure food temperatures are acceptable. and residents are satisfied with meal services These minutes will be shared with the Dietary Manager and Administrator and discussed in the monthly QA meeting. This discussion will be held monthly for three consecutive months until sustainable results are met with no further complaints in resident council regarding palatability of meals and food temperatures by the majority of residents being served. Facility made purchase of pellet underliner system for tray line. This system will keep food hot while in transition of being served from trayline to residents rooms.	4/21/11 4/21/11 5-20-11

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

PRINTED: 05/06/2011
FORM APPROVED
OMB NO. 0938-0391

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	345281	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/04/2011

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K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observations and staff interview at 8:30 am onward, the following items were noncompliant, specific findings include: staff only room in kitchen was held open with wooden wedge, also door going into kitchen was held open with cart, preventing door to close for smoke tight seal. 42 CFR 483.70(a)	K 018	Wedge was removed and cart preventing door from closing was removed. The monthly walk through audit was revised to include this element to review each month by maintenance director. A monthly walk through will occur throughout the facility. Dietary staff will be in-serviced on proper door closure by Certified Dietary Manager. The walkthrough will be reviewed monthly at the QA meeting to ensure compliance is met	6/1/2011
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section	K 038		

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

Stephanie Hu-Honeycutt | Administrator | 5-13-11

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K 038	Continued From page 1 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview at 8:30 am onward, the following items were noncompliant, specific findings include: Med. room on left side of 100 hall and resident office requires two motion of hand to open door into exit egress. 42 CFR 483.70(a)	K 038	Inappropriate locks were immediately removed. The monthly walk through audit was revised to includes reviewing facility locks to ensure compliance by maintenance director. A monthly walk through will occur throughout the facility. The walkthrough will be reviewed monthly at the QA meeting to ensure compliance is met.	6/1/11
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observations and staff interview at 8:30 am onward, the following item was noncompliant, specific findings include: multi plug outlet was used for TV to be plug into. 42 CFR 483.70(a)	K 147	Facility removed multi-plug outlet. The monthly walk through audit was revised to include inspecting facility to ensure muti-plug outlets are not present by maintenance director. A monthly walk through will occur throughout the facility. The walkthrough will be reviewed monthly at the QA meeting to ensure compliance is met.	6/1/11
K 211 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft	K 211		

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K 211	Continued From page 2 from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observations and staff interview at 8:30 am onward, the following item was noncompliant, specific findings include: an alcohol hand rub in Main Dining Hall was six inches of light switch. 42 CFR 483.70(a)	K 211	Facility removed alcohol rub in main dining hall. The monthly walk through audit was revised to include inspecting facility for alcohol hand rub stations to ensure appropriate placement by maintenance director. A monthly walk through will occur throughout the facility. The walkthrough will be reviewed monthly at the QA meeting to ensure compliance is met.	6/1/11