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

JUN 14 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 05/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 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, interviews with staff, interviews with residents and family members, and record review the facility failed to ensure resident rooms and handrails were free from an accumulation of dust, free from offensive odors and kept clean. The facility failed to ensure bed frames, water faucets and commode seats were in good repair. The facility failed to ensure cove molding was intact; walls of resident rooms were free from torn wallpaper and peeling paint. The facility failed to ensure resident bathroom and resident room floors were clean. This was evident in 4 of the 5 resident care units. (Resident rooms #206, 208, 109, 111, 306A, 310, 502, 505, the day room in the secured unit, and hand rails in hallway of Unit 100) (Bathrooms shared by rooms 102-104,103-105, 110-112, 111-113, 205-207, 206- 208,302 - 304, 306-308, 310-312, 314-316, 305-307 ,502-504, 501-503, 101, 106, and 114) Findings included: Review of the resident council minutes revealed dated 2/22/11, 3/29/11 and 4/26/11 revealed concerns about unclean rooms. Observations on 4/30/11 at 6:10 p.m. revealed in room 206 peeling paint on the wall near the door. There were brown colored stains on the bathroom floor. The wall paper behind bed B had an	F 253	Colony Ridge Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiency and proposes the plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and the provision of quality care to residents. The plan of correction is submitted as written allegation of compliance. The below response to the Statement of Deficiency and plan of correction does not denote agreement with the citation by Colony Ridge Nursing and Rehabilitation Center. The facility reserves the right to submit documentation to refute the stated deficiency through informal appeals procedures and/or other administrative or legal proceedings.	5-30-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Arlene B. Palmer — TITLE: Administrator — (X6) DATE: 6/10/11

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 05/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 253	Continued From page 1 approximately 11inch length by 4 inch width tears. Observations on 4/30/11 at 6:15 p.m. revealed there was cove molding detached from the wall behind the bathroom commode and lingering urine odor used by rooms 103-105. Observations on 4/30/11 at 6:17 p.m. revealed room #101 ' s bathroom had a built-up toilet seat placed over the commode. The crossbar of the built-up toilet seat was chipped and rusty. There was cove molding missing and the exiting molding was detached from the wall. Peeling wall paper was noted on the wall near bed B. Observations on 4/30/11 at 6:30 p.m. revealed the bathroom door in room 106 had hole in the door measuring appropriately 5 inches long and 21-1/2 inches wide. There was a lingering urine odor in the bathroom 106-108. Observation on 4/30/11 at 6:40 p.m. revealed peeling and scratched wallpaper behind B bed in room 109. Interview on 4/30/11 at 6:45 p.m. with 2 family members revealed their parent was recently admitted to the facility on 4/29/11. There was a picture belonging to a previous resident hanging on the wall in room 111. The family members collectively indicated they had to bring cleaning products into the facility for cleaning the bathroom because the room was so dirty. Observation of the bathroom used by rooms 111 and 113 revealed the bathroom floor had a heavy build of a brown colored substance in the floor corners and strong lingering urine odor. Observation revealed the facility chair used by 111B bed had a	F 253	**F253** A) On 5-3-11 facility work orders, addressing the areas of concern for housekeeping and for maintenance, were completed by the Administrator and given to each department head for completion. All areas of concern were addressed and corrected for rooms 206 (peeling paint, missing cove molding and wallpaper torn), 208 (torn walls, peeling paint, loose headboard, missing cove base), 109 (peeling/scratched wallpaper), 111 (dirty AC unit, picture,chair, O scratched/peeling wallpaper), 306A (loose head and footboards), 310 (peeling paint), 502 (peeling wallpaper, rusty faucet, missing towel rack rod, cove molding not intact), 505 (unattached cove molding), day room in the secured unit (front and side panel of cabinet covering missing, chipped wall paint), 304 (ceiling stained), 101 (peeling wallpaper), 305 (peeling paint), 307 (peeling paint) and handrails in the hallway of Unit 100 (dusty) as of 5-25-11. The wall phone on Unit 100 was secured by maintenance on 5-9-11.	5-30-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 05/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 253	Continued From page 4 the bathroom shared by rooms 206- 208. Observation on 5/1/11 at 10:20 a.m. revealed the head and foot boards were loose on bed 306A. An alert and oriented resident at the time of the observation indicated that the bed boards had been loose for a while. There was an accumulation of dust on the window sill in room 306. This alert and oriented resident indicated the window sill had been dusty for a while. Observation in the bathroom shared by room 306-308 revealed a strong lingering urine odor. The bathroom floor had an accumulation of brownish colored substance in the corners of the floor. In room 310 there was peeling paint on the wall. The bathroom shared by rooms 310-312 revealed offensive lingering urine odors. There was an accumulation of brown substance in the floor corners. The floor was sticky. Observation on 5/1/11 at 10:35 a.m. revealed there was a strong urine odor that was lingering in the bathroom between rooms 314-316. The bathroom had an accumulation of white particles and an accumulation of dark brown substance in the corners of the floor. Observation on 5/1/11 at 10:42 a.m. revealed the bathroom shared by rooms 305-307 a dirty glove on the bathroom floor. Peeling paint was noted on the bathroom walls. There was a build-up of dust and dirt in the corners of the bathroom floor. Observation on 5/1/11 at 1:30 p.m. revealed the lingering urine odors persisted in bathroom used by rooms 106-108. Observation on 5/1/11 at 1:40 p.m. revealed urine	F 253	(F 253- continued) On 5-10-11 the maintenance department was inserviced by the administrator regarding the preventative maintenance program. Inservices will be completed monthly X 3 and as needed based upon the audits to identify areas of concerns. D) The Administrator, or designee, will complete random facility audits for housekeeping and maintenance monthly x 3 then quarterly x 3. Results will be reported to the QI Executive Committee monthly and action taken as needed.	5-30-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 05/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 253	Continued From page 5 odors persisted in the bathrooms joined by rooms 111-113 and 103-105. Interview on 5/1/11 at 1:45 p.m. with housekeeper #3(HK) on Unit 100 revealed she completed the removal of trash, wet mopped the floors, and dust mopped the floors, cleaned the bathrooms and dusted the window sills by 12:30 p.m. today (referring to 5/1/11). Additionally, HK#3 indicated that HK#4 was assigned to Unit 200 and ½ of Unit 100. HK#3 indicated that HK#4 completed her assignment and left at 1:30 p.m. on 5/1/11. Observation on 5/1/11 at 1:50 p.m. of the room 111 revealed the facility chair used by 111B bed continued to have an accumulation of dirt and dust in the corners of the chair arm. Room 111 continued to have large areas of scratched wall and peeling wall paper behind bed B that had an accumulation of dust within the peeling wall paper. The window sill in room 111 continued to have an accumulation of dust. The heating and air conditioning unit vents continued to have an accumulation of dust on the vents. Interview and observations on 5/1/11 at 2 p.m. with the District manager (DM) for_____(name of group) and interim HK supervisor was held. DM indicated the routine for the housekeeping staff was a morning walk thru to dust mop the floors, wet mop the floors and check the bathrooms. During the breakfast time for residents the housekeepers would clean the common areas. Then return to the units after the trays have been collect to do horizontal and vertical dusting. The DM revealed the previous HK supervisor was no longer working at the	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 05/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 253	Continued From page 2 visible accumulation of dirt, crumbs and dust in the corners of the chair arm. There was a large area of scratched wallpaper and peeling wall paper behind bed 111B. This wall paper had an accumulation of dust within the peeling wall paper. The window sill in room 111 had an accumulation of dust. The heating and air conditioning unit vents had an accumulation of dust on the vents. Observation of room 114 revealed the floor was sticky. The bathroom floor had an accumulation of a brown colored substance in the floor corners. The commode seat covering was peeling. Observations on 5/1/11 at 9:15 a.m. revealed the bathroom shared by rooms 502-504 revealed the bathroom floor continued to have a build-up of a dark brown and white substance in the corners of the room. Peeling wall paper was observed near the window in room 502. There was a heavy accumulation of dust on the window sill. There was a build-up of a brown substance in the floor corners of room 502. The faucet base in room 502 was heavily rusted. The handle for the hot water was heavily rusted. The towel rack rod was missing. The cove molding was not intact. Observations on 5/1/11 at 9:17 a.m. in the day room of the secured unit revealed a dried piece of cooked pasta stuck to the window sill. There were dried splatters on the wall near the door. The front and side panel of the cabinet surface covering were missing. There was a brown gritty substance on the floor. There was chipped wall paint. There was a strong fecal odor in the bathroom	F 253	(F 253- continued) The bathrooms shared by rooms 102-104 (dried splatters-cleaned), 103-105 (cove molding loose), 110-112 (buckling cove molding, wall peeling), 111-113 (odor and build-up on floor), 205-207 (cove molding loose), 206-208 (brown stains on floor), 302-304 (odor), 306-308 (odor and brown substance on floor), 310-312 (odor, brown substance on floor, sticky floor), 314-316 (odor, white particles and brown substance on floor), 305-307 (peeling paint, dust and dirt build-up on floor, glove-removed), 502-504 (build-up of white and dark brown substance), 501-503 (fecal odor), 101 (built up toilet seat -replaced, cove molding missing), 106 (hole in door), and 114 (peeling commode seat- replaced) were stripped and waxed and repairs completed as of 5-26-11.	5-30-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 05/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 253	Continued From page 3 shared by rooms 501-503. Observations on 5/1/11 at 9:20 a.m. revealed cove molding was not attached to the wall near 505 B. Observation on 5/1/11 at 9:35 a.m. revealed the wall phone located in the hallway near room 110 was partially detached from the wall. At 9:37 a.m. the assistant director of nurses (ADON) used the phone that was not affixed to the wall. The wood strip panel that affixes the handrails to the wall had a heavy accumulation of dust throughout unit 100. Observation on 5/1/11 at 9:40 a.m. revealed the cove molding was buckling in the bathroom shared by rooms 110-112. The wall under the sink has peeling wall. In the bathroom shared by rooms 102-104 revealed dried splatter on the walls. The bathroom floors had an accumulation of a brown colored substance in the corners. Observation on 5/1/11 at 10 am, revealed the bathroom shared by 205-207 rooms continued to have a strong lingering urine odor. The cove molding was loose and the floor has an accumulation of a brown colored substance in the floor corners. Observations on 5/1/11 at 10:15 a.m. revealed a strong lingering urine odor in the bathroom shared by rooms 302 - 304. In room 304 the ceiling was stained. The B bed ' s head board in room 208 was loose. The window sill had an accumulation of dust. There was a build up of a brown colored substance in the floor corners in	F 253	(F 253- continued) B) The administrator and housekeeping supervisor completed a facility tour audit, including all resident rooms and bathrooms, to address potential areas of concern, i.e. dust, dirty floors, odors, torn wallpaper, peeling paint, loose or missing cove base, and toilets. Identified areas of concern have been corrected. Monthly audits will be completed by the administrator or designee monthly x 3 then quarterly x 3. Identified areas of concern will be corrected as indicated. C) As of 5-3-11 all contract housekeeping staff have been inserviced by their District Manager regarding the proper procedure for cleaning rooms and bathrooms. All new housekeeping employees will be inserviced by the housekeeping supervisor, or designee, on cleaning residents rooms and bathrooms. Skills checklists were completed on all contract housekeeping staff by their District Manager as of 5-25-11. Skills checklists will be completed on all new housekeeping employees by the housekeeping supervisor, or designee.	5-30-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 05/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 253	Continued From page 6 facility since March 2011 and ____(name of employee) was the interim supervisor pending hiring of a housekeeping supervisor. At this time the DM indicated that daily " QCI " (Quality control inspection) forms are completed each day by the supervisor then faxed to her. An inquiry was made about the forms and the DM indicated that no forms were completed for the month of April and did not provide any previous months. The interim HK supervisor indicated he had a detailed cleaning schedule. The interim HK supervisor provided a detail cleaning schedule dated November 2009. The district manager and interim HK supervisor indicated that this was the calendar used for detailed cleaning. Observations during the time of these interviews confirmed that the above noted bathrooms continued to have a persistent lingering urine odor and the build up of an accumulation of dark brown/black substance in the corners of the each bathroom floor noted above. The district manager confirmed the existence of the bathroom odors, condition of the bathroom floors and the accumulation of dust on unit 100 handrails. Interview on 5/1/11 at 2:15 p.m. with maintenance director revealed the facility has renovated several rooms and painted. The maintenance director directed the surveyor to Room 208 that he had identified as having renovations completed. Observation of room 208 at the time of the interview revealed torn walls with peeling paint near Bed B. Cove molding was missing near the entrance to the bathroom. Interview on 5/1/11 at 3:20 p.m. vice president of operations (VP) and DM was held. The VP	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 05/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 253	Continued From page 7 revealed the corporation was managing the building and effective Oct 1, 2011 the County may take over the building therefore extensive renovations have not been done in the building. The VP indicated that the facility has done room painting. Observations on 5/2/11 starting at 9:00 a.m. revealed the status of the bathroom floors, commodes, faucet , accumulation of dust, detached and missing cove molding, peeling wall paper, peeling paint, lingering urine odors and crumbs in the chair remained. An interview on 5/2/11 at 10:10 a.m. with a corporate representative, VP, DM, administrator and director of nurses was held. During the meeting the director of maintenance joined the discussion and indicated he did not have a preventative maintenance program for checking the status of the bed/or bed frames. The director of maintenance indicated that " painting was done years ago. " The administrator and corporate representative indicated that the facility identified problems on 4/15/11with cleanliness of the bathroom, dust behind the furniture and put in place a manager ' s daily list and QIC but had not been implemented. The DM indicated that the project work refers to stripping and waxing hallways and resident rooms and has never stripped and re-waxed the bathroom floors. The DM indicated that deep cleaning consisted of wiping down the entire floor including corners and edges, bed frames, wheel chairs, chairs and over-bed table cleaning. The corporate representative indicated the expectation was to have a clean and safe environment for residents. The administrator indicated her expectation was	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 05/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 253	Continued From page 8 to have the facility clean, up to " par " and have a homelike environment. Interview on 05/02/11 at 9:10 a.m. with HK#7 revealed we informed as of yesterday about a new initiative starting yesterday (5/1/11)to clean the building and try to make it look as good as we can. " It is an old building, so we will do our best. " Interview on 05/02/11 at 9:12 a.m. with HK#1 revealed the DM instructed the HK staff to clean the corners, bathrooms and floors. Interview on 5/2/11 at 9:20 AM with HK#2 revealed the DM created a new deep cleaning plan for the facility which will be good because " we never had a plan on how or when to get things done. It will help make this building look better. " On 5/2/11/ at 9:30 a.m. with HK #5 and HK #6 revealed they were unaware of the facility ' s plan to ensure the building was clean until 5/1/11 and 5/2/11 when the DM spoke with them and provided directions. On 5/2/11 at 12:55 p.m. a " Deep clean schedule " for May 2011 and a " Managers Daily checklist " was provided by the DM who indicated this checklist should have been implemented but was not. The DM indicated this deep clean schedule was just created on 5/1/11.	F 253		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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.	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 05/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 9 This REQUIREMENT is not met as evidenced by: Based on observation, interviews with staff and record review the facility staff failed to apply barrier cream and antifungal powder to the resident ' s reddened skin. (Resident#7). This was evident in 1of 4 residents in the survey sample dependent on staff for care. Findings included Resident #7 has cumulative diagnoses which included progressive dementia, diabetes mellitus, blindness, and a history of cerebral vascular accident. Review of the medial record revealed physican orders dated 5/1/11 for Micro guard powder (antifungal) to the peri-area and buttock crease every day. Record review revealed no Minimum Data Set assessment. Interview with the assistant director of nurses on 5/2/11 at 12:55 p.m. revealed Resident#7 had impaired cognition, totally dependent on staff for all activities of daily living (bathing, toileting) and incontinent of bowel and bladder. Observation on 5/1/11 at 10:45 a.m. of incontinence care performed by (nursing assistant) NA#2 revealed Resident #3 had experienced a urinary incontinence episode. Observation of the resident ' s skin revealed reddened and irritated areas on each side of his groin, the scrotum and penis. NA#2 his groin,	F 312	F312 A) Resident #7's rash continued to be treated with Micro guard powder and showed improvement. Nurse #4 has been inserviced regarding reviewing orders to ensure treatments are followed per M.D. orders. Nas #2, #3 and #4 have been inserviced regarding proper incontinent care using soap and water, or disposable wipes, and applying barrier cream after each incontinent episode. B) A 100% skin audit of all residents was conducted 5-17-11 by nursing staff to ensure all skin breakdown had been identified and was being treated appropriately.	5-30-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 05/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 10 penis and scrotum with a _____(name of product) disposable wipes then placed a dry brief on the resident without the benefit of applying barrier cream. Interview on 5/1/11 at 3:05 p.m. with Nurse#3 (weekend treatment nurse) revealed barrier protective crème should be used after each incontinence episode. Nurse#3 indicated barrier cream was provided to each resident and that she located the barrier cream in Resident#7 ' s top bedside drawer. The weekend treatment nurse indicated that she assessed the resident ' s reddened perineal area (scrotum, buttocks. penis and groin) and new orders were obtained for Micro guard 2% (antifungal) powder to the perineal area and buttocks. Interview on 5/1/11 at 4:20 p.m. with the assistant director of nurses revealed confirmation that the facility practice was to apply barrier cream to the skin after each incontinence episode. Interview on 5/1/11 at 4:10 p.m. with NA#2 revealed she was employed by an outside agency and had not worked in the facility a while. During this interview NA#2 indicated that each resident had a " Resident Care Guide " posted inside of their closet that would let the aides know what type of care to provide. Continued interview revealed " Sorry I did not put the cream on " his assigned aide was going to give him a shower. Observation on 5/2/11 at 11:20 a.m. revealed Resident#7 had experienced a urinary incontinent episode. NA#3 and NA#4 removed his soiled brief and provided incontinence care using a _____(name of product) disposable wipes.	F 312	**(F312- Continued)** C) All licensed nurses and certified nursing assistants were inserviced by the Staff Development Coordinator, or designee, regarding prevention, treatment and reporting of skin breakdown to include incontinent care. These inservices were completed by 5-24-11. May 18-19, 2011 the Facility Wound Consultant reviewed all wound treatments and orders. The consultant also observed Nurse #4 performing wound care to ensure orders were being followed and treatments performed appropriately. D) Random incontinent audits will be performed weekly x 1 month then monthly x 3 by the Staff Development Coordinator. Treatments audits will be performed monthly X 3 and randomly thereafter by the Director of Nursing or Assistant Director of Nursing areas of concern will be corrected. Results of these audits will be reported to the monthly QI meetings and action taken as indicated.	5-30-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 05/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 11 Resident#7 ' s perineal area and buttocks were still red. Resident#7 was positioned on his right side. Nurse #4 (week day wound nurse) applied the Micro guard 2% antifungal powder to his buttock folds and placed the container on the bedside cabinet. An inquiry about whether or not the perineal area, penis and scrotum were going to be treated was made. Nurse#4 ' s response was the powder was only to be placed on the reddened skin. A request was made to reposition the resident by the surveyor. Nurse#4 observed redness on his scrotum; penis and perineal area then applied the antifungal powder. Interview with the wound care nurse immediately following the observation revealed she was off the weekend and thought the red areas was only the perineal area. An interview on 5/2/11 at 10:10 a.m. with a corporate representative, Vice president, DM, administrator and director of nurses was held. The director of nurses indicated her expectations for incontinence care was to cleanse the skin with soap and water or disposable wipes then apply barrier cream.	F 312		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: . Based on medication pass observation of 4 medication givers with 81 opportunities for errors,	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 05/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 332	Continued From page 12 interviews with staff, interview with the Consultant Pharmacist and record review the facility had 11 medication errors resulting in an error rate of 13.58%. Findings include: During an observation of the medication pass on 04/30/11 at 6:45 PM. revealed Nurse #1 administered Aldactone 25 mg (milligram) (antihypertensive drug) by mouth (PO) and Capoten 50 mg. (antihypertensive drug) PO to Resident #3. Record review of the Medication Administration Record (MAR) revealed the medications were scheduled to be given at 4:00 pm as ordered by the Physician, not at 6:45 pm. Medication pass observation with Nurse #1 on 4/30/11 at 6:50 pm. revealed she administered to Resident # 2 Coreg 12.5 mg. (antihypertensive drug) PO which should have been administered at 4:00 pm per the Physician order, not 6:50 pm. During an observation of a medication pass on 5/1/11 at 9:10 am, Nurse #2 administered to Resident #4 Lopressor 50 mg PO (antihypertensive drug), Effexor 37.5 mg. (anti-depressant drug) Accolade 20 mg PO (a drug that prevents asthma symptoms), Metformin 50-500 mg PO (drug for the treatment of type 2 diabetes), and Detrol ER PO (extended release) 4 mg. (a drug used for the treatment of an over active bladder). Nurse #2 entered Resident #6 ' s room instead of Resident #4 ' s room. Nurse #2 was about to administer these medications to Resident # 6 until the surveyor inquired. Nurse #2 was asked what room she was in and what was the resident ' s name? Nurse #2 stated, " Oh my God, I am so nervous " and proceeded to	F 332	**F332** A) On 4-30-11 Nurse #1 received a consultation from the Director of Nursing regarding untimely administration of medications. On 5-1-11 Nurse #1 was also inserviced by the Director of Nursing regarding timeliness of medication administration and was given recommendations to improve her performance. On 5-2-11 the administrator spoke with Nurse #2 via phone to discuss her untimeliness of medication administration. Nurse #2 (agency nurse) was reported to her agency on 5-2-11 and is no longer allowed to work at our facility. B) A 100% medication pass audit of all licensed nurses was completed by the Director of Nursing, or designee, by 5-24-11 to include timeliness and accuracy of medications being administered. As of 5-5-11 the Director of Nursing completed a 100% audit of the scheduled times for medication administration and made changes in the scheduled times of administration on the medication records as needed to ensure timeliness of medications. Orders , reflecting the changes, were obtained by the Director of Nursing.	5-30-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 05/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 332	Continued From page 13 the correct room for Resident #4. An observation of the medication passes continued on 5/1/11 at 9:55am. Nurse #2 administered Starlix 120 mg. (treatment of type 2 diabetes) PO, Insulin 100 ml. (milliliters) sub Q (injection), (treatment for type 2 diabetes) and Januvia 25 mg. (treatment of type 2 diabetes), PO to Resident #2. The Physician ' s orders revealed Starlix was to be given 3 times per day with meals. Insulin was to be given at 8am with breakfast. On 5/1/11 at 8:00 am an interview with Nurse #1 revealed she reported her mistakes (referring to the time of medication admindtrtion) to her Supervisor, the DON, Facility MD (medical director), and the Responsible Party (RP) and completed an incident report. On 5/1/11 at 8:25 a.m. the DON stated her expectations of medication administration are that the medications need to be given timely and to make sure the right medication is given to the right resident. She further stated Nurse #1 needs to check the arm band and the picture of the resident. On 5/2/11 at 11:55 am. The DON further stated, " We are going to do in services for all nurses regarding the proper medication administration techniques. " On 5/2/11 at 11:45 am the DON stated the inservice for medication administration would be started this am (5-1-11 no time noted). The DON further stated, "As far as time frame errors we are going to get together with the nurses and discuss starting one side of the hall at 8 am (could start an hour before to be in compliance) and the opposite side at 9:00 am. " The DON further revealed she would be speaking	F 332	**(D332-Continued)** C) All licensed nurses were inserviced by the Director of Nursing, or designee, regarding the changes in medication administration times on 5-6-11. One PRN licensed nurse was inserviced by the Staff Development Coordinator on 5-20-11. On 5-12-11 the consulting pharmacist inserviced licensed nurses regarding Medication Pass Administration policy. Additional inservices were presented on 5-16-11, 5-17-11, 5-19-11 to the remaining nurses by the Staff Development Coordinator. All licensed nurses received the inservice as of 5-19-11. All new licensed nurses and agency nurses will be inserviced on the policy for medication administration by the Staff Development Coordinator , or designee. Medication pass audits will be completed on newly hired licensed nurses and new agency nurses by the Director of Nursing, or designee. D) Medication pass audits will be completed on all licensed nurses monthly x 2 then quarterly x 3 by the Director of Nursing, or designee. Results will be reported to the QI Executive Committee and action taken if needed.	5-30-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 05/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 332	Continued From page 14 with Nurse #2 regarding giving medications in a timely manner and checking the MAR to make sure all medications are prepared for the Resident. On 5/2/11 at 9:30 am a phone interview with the Consultant Pharmacist, revealed that Insulin, Starlix and Januvia could cause a significant drug error as the blood sugar could be lowered significantly without meals. She further stated that all medications need to be given as ordered and timely so as not to cause significant medication errors. On 5/2/11 at 11:30 am an interview with the Administrator, and Facility Consultant regarding the medication passes completed on 4/30/11 and 5/1/11 was conducted . The administrator stated she had some work to do regarding proper medication administration.	F 332		
F 460 SS=D	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains. This REQUIREMENT is not met as evidenced by: Based on observation and interviews with staff, the facility failed to provide full visual privacy and the hooks failed to move freely through the	F 460		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 05/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 460	Continued From page 15 tracks. This was evident in of 4 of 5 units. (Resident rooms #111,505,208,304, 306, 309, 307, 305, 314 and the shower room in the secured unit). Findings included: Observations on 4/30/11 at 6:45 p.m. revealed resident rooms have a mirror attached to the wall. These mirrors are located directly in front of both beds. On 5/2/11 (no time provided) the maintenance director measured the mirrors as 30 inches wide and a height of 24 inches. Without the benefit of sufficient privacy curtains either bed A or bed B resident could be visible. Observation on 5/2/11 at 11:30 a.m. with the director of nurses in room 112 revealed she was able to stand in B bed side of the room and visible see A bed side due to insufficient curtains. Observation on 4/30/11 at 6:45 p.m. revealed insufficient privacy curtains in room 111. The insufficient privacy curtains created approximate 39 inch gap for bed A and B. Observations on 5/1/11 at 9:20 a.m. revealed insufficient privacy curtains creating a 50 inch gap in room 505. The hooks did not flow freely through the tracks. Observation on 5/1/11 at 9:25 a.m. the privacy curtain located in the corner of the secured unit shower room revealed the privacy curtain hooks would not flow freely through the tracks and became stuck while attempting the closure and opening of the curtains. Observations on 5/1/11 at 10:10 a.m. revealed there was a 39 inch gap in the privacy curtain	F 460	**F460** A) Sufficient privacy curtains have been installed in rooms 112, 111, 505, 208, 304, 306, 307, 310, 314, and 305 to ensure full visual privacy. Hooks have been assessed and replaced when needed to allow free flow through the tracks in rooms 505, 307, 309 and in the corner of the secured unit shower room. B) On 5-25-11 a 100% audit of all privacy curtains was completed by the housekeeping District Manager to ensure full visual privacy and free flow of curtain hooks on the tracks.	5-30-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 05/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 460	Continued From page 16 around bed B in room 208. Observations on 5/1/11 at 10:15 am revealed in room 304 there were insufficient privacy curtains around bed A creating a 27 inch gap. There was insufficient privacy curtain around bed B creating a 39 inch gap. Observation on 5/1/11 starting at 10:20 a.m. revealed in room 306 insufficient privacy curtains around bed A creating a 39 inch gap. There were insufficient privacy curtains around bed B in room 309 creating an approximate 46 inch gap. The hooks do not flow freely through the tracks. In room 307 there were insufficient privacy curtains around bed A and bed B. The insufficient curtains created a 39 inch gap and 42 inch gap respectively. In room 310 there were insufficient privacy curtains around bed B creating an approximate 42 inch gap. Observation on 5/1/11 at 10:35 a.m. revealed bed B in room 314 revealed insufficient privacy curtains around bed B creating a 60 inch gap and insufficient privacy curtains around bed A creating a 39 " gap. Observation on 5/1/11 at 10:42 a.m. revealed in room 305 there was insufficient privacy curtain around bed A and bed B thus creating a gap of 36 inches and 26 inches respectively. Interview and observations on 5/1/11 at 2 p.m. with the District manager (DM) for_____(name of group) and interim HK (house keeper) supervisor was held. The DM indicated that the housekeeping staff was responsible for checking whether or not the privacy curtains were soiled	F 460	(F460- continued) C) As of 5-25-11 all nursing staff and housekeeping was inserviced by the Staff Development Coordinator regarding the resident's right to privacy, provision of full visual privacy in bed or shower and reporting of defective curtain hooks on tracks. A QI monitoring tool to ensure complete visual privacy is provided to the residents will be completed monthly x 2 then quarterly x 3 by the housekeeping supervisor, or designee The maintenance supervisor, or designee, will include checking curtain hooks and tracks monthly in his preventive maintenance program. Any identified areas of concern will be reviewed during monthly QI meetings and corrected as needed. D) Results of audits will be reviewed by the QI Executive Committee to ensure continuous compliance.	5-30-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345226	A. BUILDING _____ B. WING _____	C 05/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONY RIDGE NURSING AND REHABILITATION CENTER	430 WEST HEALTH CENTER DRIVE NAGS HEAD, NC 27959

(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 460	Continued From page 17 and that the HK staff checks for insufficient privacy curtains when detailed cleaning of a room was completed. The DM and interim HK (house keeper) supervisor confirmed the insufficient privacy curtains and indicated that monthly monitoring of the privacy curtains was done. When inquiring about the last time monitoring was completed, the interim HK supervisor indicated he had not conducted one and was not aware of the last time one was done. An interview on 5/2/11 at 10:10 a.m. with a corporate representative, Vice president, DM, administrator and director of nurses was held. The DM indicated that deep cleaning included auditing privacy curtains (no details provided). The administrator indicated her expectation was to provide full visual privacy for each resident. The VP indicated she informed the staff to double the width of the privacy curtains and " we have begun already. " The VP indicated " we will get it fixed (referring to the insufficient curtains). "	F 460		