

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

PRINTED: 06/15/2011
FORM APPROVED
OMB NO. 0938-0391

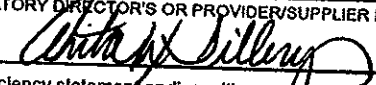
06/15/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345184	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/09/2011
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NAME OF PROVIDER OR SUPPLIER GUARDIAN CARE OF ELIZABETH CIT	STREET ADDRESS, CITY, STATE, ZIP CODE 901 S HALSTEAD BLVD ELIZABETH CITY, NC 27909
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to provide a dose of medication ordered to be given immediately by the physician for 1 of 1 (resident #117) sampled residents. Findings include:</p> <p>Resident #117 was re-admitted to the facility on 1/14/11 with diagnoses including anxiety and insomnia.</p> <p>Review of Resident #117's medical record revealed a Physician's Telephone Order dated 5/31/11 at 2:30 PM for ativan (a medication given to prevent anxiety) 1 milligram (mg) by mouth now and signed by nurse #2.</p> <p>Review of Resident #117's Medication Sheet dated May 2011 showed a blank where the initials of the nurse administering the medication would be placed. Other medications listed were seroquel (an anti-psychotic) 75mg by mouth every hour of sleep, prozac (an anti-depressant) 20mg by mouth every day and klonopin (a medication used for manic episodes) 0.5mg by mouth three times per day.</p> <p>In an interview on 6/8/11 at 3:15 PM, nurse #2 indicated that she had written the order for the ativan and provided the information to nurse #4.</p>	F 281	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F281</p> <ol style="list-style-type: none"> 1. Resident #117 medication orders were clarified with MD on 6/9/11. 6/24/2011 2. Residents with "now" or "give immediately" MD orders have been identified as having the potential to be affected. 6/24/2011 3. DNS or SDC will in-service licensed staff on proper procedure for administering medications as ordered by then physician. DNS, SDC or RN supervisor will perform audit of "now" or "give immediately" medication orders five times weekly in clinical rounds to validate order is transcribed to the Medication Administration Record and subsequently administered for 4 weeks, then 1 time a week for 2 months. 6/24/2011 4. Results of audits will be incorporated into centers' Performance improvement committee for a minimum of 3 months. Further recommendations will be made as needed. 6/24/2011 	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 6/24/11
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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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued am participation.

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NAME OF PROVIDER OR SUPPLIER GUARDIAN CARE OF ELIZABETH CIT			STREET ADDRESS, CITY, STATE, ZIP CODE 901 S HALSTEAD BLVD ELIZABETH CITY, NC 27909		
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F 281	<p>Continued From page 1</p> <p>In an interview on 6/8/11 at 4:05 PM, the Director of Nursing (DON) stated that nurse #4 who was caring for Resident #117 on the day shift on 5/31/11 was no longer employed by the facility. The DON stated that the nurses caring for Resident #117 did not follow through and complete the order for the now dose of ativan. It was her expectation that the hall nurse would administer a now order of medication as soon as the medication was available. She also indicated that she would expect the nurse to follow-up with the pharmacy to see when the medication would be delivered. She would expect follow through on all orders.</p> <p>In an interview on 6/9/11 at 9:50 AM, the facility Social Worker (SW) stated that on 5/31/11 she received a call from a family member of Resident #117's that there had been a death in the family. The family member felt that Resident #117 might need to be medicated prior to being informed of the death. The SW approached nurse #4 and explained the situation. Nurse #4 informed the SW that she would take care of it.</p> <p>In an interview on 6/9/11 at 1:40 PM, nurse #3 indicated that she was told in report at the beginning of her shift starting at 3:00 PM on 5/31/11 that the ativan for Resident #117 had not yet been given. She stated that she knew pharmacy delivery was usually between 7:30-8:30 PM but was not aware a house supply of ativan had been delivered and was available. She stated that she had not contacted Resident #117's physician to make him aware that the medication had not been given.</p>	F 281	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323	<p>F323</p> <ol style="list-style-type: none"> Resident #89 had floor mat placed beside his bed on 6/9/11. 6/24/2011 Medical records of current residents were reviewed and residents at high risk for falls were identified by their falls risk assessment scores. These identified residents' care plans and resident care cards were reviewed to validate current interventions were documented and implemented. 6/24/2011 DNS, SDC or RN supervisor will in-service licensed and certified staff regarding implementation of fall interventions per plan of care. DNS or designee will perform audit of residents identified as high risk for falls to validate interventions are implemented 5 times / week for 4 weeks, then 1 time a week for 2 months. 6/24/2011 Results of audit will be incorporated into centers' Performance improvement committee for a minimum of 3 months. Further recommendations will be made as needed. 		

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NAME OF PROVIDER OR SUPPLIER GUARDIAN CARE OF ELIZABETH CIT			STREET ADDRESS, CITY, STATE, ZIP CODE 901 S HALSTEAD BLVD ELIZABETH CITY, NC 27909		
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F 323	<p>Continued From page 2</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and record review, the facility failed to implement new fall interventions of placing a floor mat beside a resident's bed for 1 of 4 sampled residents (Resident # 89) that experienced falls. Findings include:</p> <p>Resident #89 was admitted to the facility on 12/13/07 with diagnoses of cerebral vascular disease, hypertension, and Alzheimer's disease.</p> <p>Care Assessment Area's (CAA's) completed on 12/21/10 identified Resident #89 as being at risk for falls with potential for injury.</p> <p>A quarterly Minimum Data Set (MDS) assessment completed on 03/07/11 identified Resident #89 as having severe cognitive impairment and requiring extensive assistance from one staff member for transfers and in room ambulation. Resident #89's balance was documented as not steady and only able to stabilize with human assistance on the assessment.</p> <p>A Fall Risk Assessment, dated 03/08/11, scored</p>	F 323			

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F 323	<p>Continued From page 3</p> <p>Resident at a 16 (score greater than 14 is at high risk).</p> <p>A review of a Resident Progress Note entered on 03/31/11 at 10:30 PM documented Resident #89 was found on the floor next to his bed sitting with his back against the walker. The note stated Resident #89's tab alarm had been removed from the gown.</p> <p>A POST FALL EVALUATION form completed on 03/31/11 documented under the Summary of Interdisciplinary Team section that a bedside mat was to be in place as a new intervention as result of the fall.</p> <p>Review of Resident #89's Care Plan, updated 03/31/11 indicated he had a fall and interventions included a low bed and falling star program (facility program to alert staff a resident is at risk for falls). Resident #89's RESIDENT CARE CARD (tool used to alert staff of resident need's) documented Resident #89 was to have a tab alarm, low bed, and falling star program.</p> <p>An observation was made of Resident #89 on 06/07/11 at 8:42 AM. Resident #89 was lying on his back in a low bed. A tab alarm was clipped to his clothing. There were no floor mats in place next to Resident #89's bed.</p> <p>In an interview conducted with Nurse #1 on 06/08/11 at 3:55 PM, Nurse #1 said Resident #89 required staff assistance to stand and was very unsteady on his feet. Nurse #1 said Resident #89 would try to get up at times on his own and was unable to call for staff assistance. Nurse #1 said a tab alarm was used on Resident #89 to</p>	F 323			

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F 323	<p>Continued From page 4</p> <p>alert staff if he tried to get up and his bed was to be in a low position.</p> <p>During an interview with the Director of Nurses (DON) on 06/08/11 at 4:38 PM, the DON said when a resident is identified at risk for falls, they are put in a low position bed and placed on the falling star program where a star is placed on their chart and doorway to alert staff that a resident is at risk for fall. The DON said different fall interventions are added as needed for individual residents or after a fall had occurred.</p> <p>On 06/09/11 at 7:45 AM, Resident #89 was observed lying in a low bed. There were no floor mats in place next to his bed.</p> <p>In an interview with Nurse Aide (NA) #1 on 06/09/11 at 8:40 AM, NA #1 said Resident #89 did not have any floor mats. NA #1 checked Resident #89's closet and said there were no floor mats present in the room and she had never seen a mat on the floor next to Resident #89.</p> <p>In an interview with Nurse #2 on 06/09/11 at 9:25 AM, she said after review of Resident #89's chart that he should have had a floor mat put in place after he was found sitting on the floor on 03/31/11.</p> <p>During an interview with the facility Staff Development Coordinator (SDC) on 06/09/11 at 10:05 AM, the SDC stated the expectation was for new interventions to be put in place each time a resident had a new fall. The SDC said if a resident is identified at risk, they are placed in a low bed and if they experience a fall, then bedside mats are expected to be put in place when a resident is in the bed.</p>	F 323			

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F 323	Continued From page 5 In an interview with the DON on 06/09/11 at 11:00 AM, the DON said it was her expectation that Resident #89 should have had floor mats in place after he was found on the floor on 03/31/11.	F 323			

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NAME OF PROVIDER OR SUPPLIER GUARDIAN CARE OF ELIZABETH CIT			STREET ADDRESS, CITY, STATE, ZIP CODE 901 S HALSTEAD BLVD ELIZABETH CITY, NC 27909		
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F 000	INITIAL COMMENTS No deficiencies were cited as result of the complaint invesigation Event ID #P7ND11.	F 000			

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

Chita W. Kelley

Executive Director

TITLE

6/29/11

(X6) DATE

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 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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345184	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/29/2011
NAME OF PROVIDER OR SUPPLIER GUARDIAN CARE OF ELIZABETH CIT			STREET ADDRESS, CITY, STATE, ZIP CODE 901 S HALSTEAD BLVD ELIZABETH CITY, NC 27909	
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K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 6/29/2011 the required exit from the 300 hall has a solid asphalt surface from its exit discharge to the public way. This solid surface is not in good repair as grass and soil has creep onto its surface. This exit discharge path must be maintained in good repair.	K 038	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
K 147 SS=E	CFR#: 42 CFR 483.70 (a) 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 the observations and staff interview during the tour on 6/29/2011 the facility did not have the restorative range in the therapy area of the facility properly locked out to prevent accidental turning on of the range. CFR#: 42 CFR 483.70 (a)	K 147	1. Grass and soil removed from 300 hall and all solid asphalt surfaces from exit discharge to public way. 7/29/2011 2. Solid asphalt surfaces from exit discharge to public way will be inspected for grass and soil by Maintenance Director weekly for 3 months, then quarterly for 1 year. 7/29/2011 3. Results of inspection will be incorporated in center's Preventative Maintenance logs. 7/29/2011 4. Preventative Maintenance logs will be reviewed by center's safety committee to ensure continued compliance. 7/29/2011 K 147 1. Restorative range in therapy had lock out mechanism installed. 7/29/2011 2. Maintenance Director will inspect restorative range weekly for 4 weeks to ensure compliance. 7/29/2011 3. Results of inspections will be incorporated into center's Preventative Maintenance program. 7/29/2011 4. Preventative Maintenance logs will be reviewed by center's safety committee to ensure continued compliance. 7/29/2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Christa Kelley, Executive Director TITLE *7/2/11* (X6) DATE

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