STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345265	A. BUILDING _____ B. WING _____	C 07/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON ST 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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation in this survey, event ID # F37111	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations, and staff interviews the facility failed to systematically reduce or attempt to use less restrictive alternatives to a soft lap belt restraint for one (1) of two (2) residents reviewed for restraints. Resident #3 The findings are: Resident #3 was admitted to the facility 10/24/2010 with the diagnoses: dementia, hypertension, and history of cerebrovascular accident. The most recent Minimum Data Sheet (MDS) revealed that Resident #3 was cognitively impaired and needed extensive assistance with activities of daily living. The MDS also revealed that a restraint was used daily while Resident #3 was in a chair. A review of Resident #3's care plan dated 05/17/2011 revealed Resident #3 used a soft belt restraint while in her wheel chair due to the diagnoses of dementia with poor safety	F 221	*Carolina Care Center ensures residents are free from restraints unless required by physician's order to treat medical symptoms. *Resident #3's soft bet restraint was reduced on 8/08/11 after consultation with physician, family and care plan members. The physician's orders documents unsteady gait and lower extremity weakness as medical symptoms of Resident #3's need for a restraint as of 7/21/11. * The three other residents restrained were not affected by the alleged deficient practice. However, each of these residents have been reviewed in weekly tracking committee meeting and interdisciplinary care planning team for elimination or reduction of restraint.	8/08/11 8/18/11

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

Jerilee B Bean, NHA — Administrator — 8/15/11

RECEIVED
AUG 16 2011
BY: MH

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.

Original Signature Date: 8-10-11

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F 221	Continued From page 1 awareness and unsteady gait. Interventions included were to review the restraint quarterly for elimination of restraint or decrease to a less restrictive device. A physician's order dated 05/25/2011 read "soft belt when out of bed in wheel chair related to poor safety awareness secondary to dementia." A quarterly restraint assessment completed 05/17/2011 revealed the medical condition which impacted the use of a restraint was an unsteady gait with a history of a fall related to an injury. On 05/11/2011 thru 05/13/2011 a "daily review" of the soft belt restraint was done. Each day during the review the soft belt restraint was removed by a restorative nursing assistant. Each time the restraint was removed Resident #3 attempted to stand and the soft belt restraint was reapplied. No less restrictive interventions were documented as having been attempted. An observation was made on 07/20/2011 at 8:30 a.m. of Resident #3 in the dining room eating breakfast. Resident #3 was wearing her soft lap belt restraint while sitting in her wheel chair. An observation was made on 07/20/2011 at 10:44 a.m. of Resident #3 in the activity room wearing her soft lap belt restraint while sitting in her wheel chair. An interview was conducted on 07/21/2011 at 9:56 a.m. with Nursing Assistant (NA) #1. She reported that Resident #3 has always had a belt restraint. She wore the belt restraint to keep her from standing up.	F 221	* Measurese put into place to ensure that deficient practice does not recur include the following: A. Resident Restraint Assessment process has been reviewed and nurses responsible for restraint and restraint reduction assessments have been clearly identified. B. Procedure for restraint reduction has been developed and staff re-educated to ensure restraint review/reduction are occurring quarterly. (See Attachment) * The Quality Assurance and Assessment Committee reviews minutes from the Tracking Committee each month to evaluate the effectiveness of restraint reduction and make recommendations for changes needed.	8/18/11

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CAROLINA CARE CENTER

PROCEDURE FOR RESTRAINT REDUCTION

1. MDS Nurse completes Restraint Reduction Assessment on a quarterly basis, or more frequently dependent upon the residents condition.

2. Restraint reduction trial is presented to the Care Plan Committee for review/ recommendation.

3. MDS nurse contacts Physician for an order to "Reduce restraint to_____ due to medical symptoms of _____."

4 Responsible Party is contacted for verbal consent until written consent is obtained by MDS nurse. MDS nurse documents verbal consent.

5. The Patient Care Plan is updated to indicate restraint reduction.

6. Social Worker calls the responsible party for an appointment time to sign written consent for new restraint.

7. If the resident develops complications from the restraint reduction, Hall nurse documents complications and the physician and responsible party are contacted. MDS is notified of complication and any order changes.

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F 221	Continued From page 2 An interview was conducted on 07/21/2011 at 10:00 a.m.with restorative NA #2. She reported that Resident #3 had a restraint because she tries to stand up and leans over in wheel chair and tries to pick things up. She reported that restorative nursing assistants do trials and take residents' restraints off and watch how they will act without a restraint. She further reported that if the resident tried to stand up the restraint is reapplied. An interview was conducted on 07/21/2011 at 10:55 a.m. with Licensed Nurse (LN) #1. LN #1 reported that with trial reduction the resident's restraint is taken completely off. The resident is them monitored to see if they get up, lean forward or if they slide down in their chair. This is done for three consecutive days. LN #1 further reported that if the resident is constantly trying to get up unassisted then the restraint is reapplied. An interview was conducted on 07/21/2011 at 1:30 p.m. with the Director of Nursing (DON). The DON reported that Resident #3 was admitted with the soft belt restraint from another facility in October of 2010. She further reported that it is the care planning team and MDS nurses' responsibility to review and attempt restraint reduction if possible. The DON reported that it was her expectation that less restrictive interventions would have been attempted.	F 221		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226	Carolina Care Center develops written policy and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property.	

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F 226	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on administrative interview and review of the facility policy, the facility failed to include 1 of 7 components (Protection) in the development of the facility's policy and procedures regarding abuse and neglect. Findings include: On 07/20/2011, review of the undated facility abuse policy revealed it lacked the Protection component of how the resident would be protected during an abuse investigation. Review of an alleged abuse investigation (dated 06/11/2011) completed by the facility revealed the investigation was in compliance with the regulatory requirements and included a description of how the resident was protected. On 07/21/2011 at 2:08 p.m., the Administrator, Assistant Administrator #1 and Assistant Administrator #2 were interviewed about the facility Abuse Policy and the missing component about protection. The Administrator and Assistant Administrator #1 indicated it was the most current policy. Assistant Administrator #2 reviewed the facility's computerized policies but was unable to find anything more current. They were unable to provide an Abuse Policy that included the Protection component.	F 226	* The facility abuse policy was updated 7/26/11 to include the component of protection of residents during abuse investigations. * No residents were affected by the alleged deficient practice of the missing policy protection component. However, staff has been re-educated regarding facility procedures for protecting residents during abuse investigations. Updated policy has been added to orientation of new employees. * Measures put into place to ensure that the deficient practice does not recur include the following: A. Policy and procedures will be reviewed annually or more frequently by Quality Assurance and Assessment Committee to be in compliance with regulation requirements. B. The Administrator reviews CMS transmittals to ensure new policies are developed when required by new regulations. * Policy updates or changes are provided to Quality Assurance and Assessment Committee for review and recommendations.	8/18/11
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and	F 311		

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F 311	Continued From page 4 services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to provide a dining table at a height to maintain independence in eating for one (1) of twenty (20) sampled residents (Resident #14). The findings are: Resident #14 was admitted to the facility on 10/05/2010 with diagnoses which included Dementia and Osteoarthritis. Resident #14's most recent quarterly Minimum Data Set dated 05/20/2011 assessed moderately impaired cognition with tray set up required for independent eating. Continuous observation on 07/21/2011 from 7:53 a.m. to 8:20 a.m. of the breakfast meal revealed Resident #14's shoulders at table height while seated in a wheelchair. Resident #14 reached up and over the table and meal tray edge and brought the milk up and over to her lap. Resident #14 consumed 100% of the milk and rested the glass on her lap between sips. After placing the emply milk glass over the tray edge in front of the orange juice, Resident #14 reached up and attempted to obtain the orange juice. After two minutes, Resident #14 reached up over the table edge and pushed the emply milk glass toward the orange juice glass. After three pushes of the emply glass to the orange juice, Resident #14 placed both hands in her lap. Observation of	F 311	Carolina Care Center provides appropriate treatment and care services to maintain or improve resident's abilities in ADL's. * Resident #14 was provided a Table with lower height effective 7/22/11. * No other residents were affected by the alleged deficient practice. However, a dining room seating audit was conducted to ensure all other residents had tables at appropriate height on 7/22/11. * Measures put into place to assure that the deficient practice does not recur include: A. Continued assessment by Occupational Therapist for residents referred by Nursing, Dietary, or Care Plan team for positioning or ADL assistive devices. B. The Restorative Nurse observes meals three (3) days weekly for residents in need of positioning or ADL devices at mealtime. Restorative Nursing submits these observations	8/16/11

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F 311	Continued From page 5 Resident #14's breakfast meal revealed consumption of approximately 25% of grits in addition to 100% of the milk. Observation on 07/21/2011 at 8:21 a.m. revealed Resident #14 nodded yes in response to the Director of Nursing's (DON) offer of assistance with the breakfast meal. At 8:22 a.m., NA #3 began to feed Resident #14. Interview with NA #3 on 07/21/2011 at 8:25 a.m. revealed Resident #14 ate at the same table every meal. NA #3 explained Resident #14 was independent in eating but required help at times. She thought help was needed because Resident #14 became tired during the meal and had difficulty reaching the food. Interview with NA #4 on 07/21/2011 at 8:30 a.m. revealed Resident #14 required eating assistance since a move from the other section of the dining room. NA #4 reported Resident #14 began meals independently then required total assistance. Interview with the DON on 07/21/2011 at 8:40 a.m. revealed Resident #14's position at the dining table was too low for independent eating. Interview with Licensed Nurse (LN) #1, the Restorative Nurse, on 07/21/2011 at 8:55 a.m. revealed the table height changed when Resident #14 moved to another section in the dining room. She could not remember when the dining room seating change occurred "but it was awhile ago." LN #1 explained she tried an over the bed table for Resident #14's use in the dining room which lowered to a height for Resident #14 to eat	F 311	to the weekly tracking committee for review and implementation of devices by therapy or restorative nursing. * The Tracking Committee monitors the implementation and utilization of positioning devices on a weekly basis. Devices and concerns are documented on the Safety/ADL audit sheets which are reviewed in tracking. Concerns are referred to the MDS nurse for updates to care planning. The Tracking Committee minutes are submitted to the monthly Quality Assurance and Assessment committee for review and any recommendation needed for residents or monitoring regarding positioning or ADL devices. The Rehabilitation Director also attends Quality Assurance and Assessment committee meetings to report status or referrals to therapy.	8/18/11

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F 311	Continued From page 6 independently. She explained Resident #14 did not like the over the bed table. LN #1 reported she did not refer Resident #14 for a therapy referral for positioning or change the dining table height. Interview with the Occupational Therapist on 07/21/2011 at 9:45 a.m. revealed residents referred for positioning evaluations received wheelchair and table height assessments to ensure proper height to maintain independence with eating.	F 311		
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. This REQUIREMENT is not met as evidenced by: Based on medical record review, observations, and staff interviews the facility failed to rinse the soap from a resident's body after performing incontinence care for one (1) of eight (8) residents observed for incontinence care. Resident #3 The findings are: Resident #3 was admitted to the facility 10/02/2011 with the diagnoses dementia, hypertension, and history of cerebrovascular accident. The most recent Minimum Data set dated 05/10/2011 revealed Resident #3 was	F 312	Carolina Care Center provides necessary services to maintain good nutrition, grooming and personal care and oral hygiene. * Intervention for Resident #3 was corrected immediately by the CNA #1 rinsing gel soap off the residents peri area after reviewing gel soap label. CNA #1 was re-educated.7/22/11 as to Incontinent Care Procedure. * No other residents were affected by the alleged deficient practice. However, all CNA's have been re-	8/18/11

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F 312	Continued From page 7 cognitively impaired and needed extensive assistance with toileting. Resident #3 was also coded as continent of bowel with occasional incidences of urinary incontinence. Further review of Resident #3's medical record revealed that a physician's order was written 06/01/2011 for a urinalysis with culture and sensitivity due to burning and frequency. Physician orders were written on both 06/09/2011 and 06/14/2011 for urinalysis to be done. On 06/20/2011 a physician's order was written for a urology consult. A review of Resident #3's care plan dated 05/17/2011 revealed a problem entitled urinary incontinence with interventions that included resident would be taken to the bathroom every two hours. A review of the facility policy entitled Incontinent Care Procedure (undated) revealed that the purpose of providing incontinence care is to keep skin clean, dry, and free from irritation and odor. An observation was made on 07/20/2011 at 12:55 p.m. of Nursing Assistant (NA) #1 and NA #2 performing incontinence care on Resident #3. NA #1 and NA #2 transferred Resident #3 to the toilet using a gait belt. After Resident #3 used the bathroom, NA #1 and NA #2 cleaned Resident #3's peri-area using body gel soap, rinsed and dried the resident. Resident #3 then reported she needed to use the bathroom again. After Resident #3 used the bathroom NA #1 cleaned Resident #3's peri-area using a generous portion of body gel soap. NA #1 then dried Resident #3 peri-area and pulled up her pants.	F 312	educated on incontinent care procedures. * Measures put into place to ensure the alleged deficient practice does not recur include: A. Staff Development Nurse spot checks incontinent care once on each shift to monitor CNA's procedures for proper incontinent care and corrects if needed. Spot checks are reported to Director of Nursing weekly for any additional training or counseling needed. B. Weekend Supervisor conducts spot checks on incontinent care once each 12 hour shift and reports to Director of Nursing each Monday. The Supervisor re-educates or councels CNA Immediately for any errors found in providing incontinent care. * The Director of Nursing reviews results of incontinent care checks at the monthly Quality Assurance and Assessment Committee meeting for recommendations and any	8/18/11

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F 312	Continued From page 8 An interview was conducted on 07/20/2011 at 1:20 p.m. with NA#1 and NA #2. When asked, NA #2 read the bottle of soap and reported that the body gel shampoo was to be rinsed thoroughly. NA #1 reported she should have rinsed Resident #3's peri-area after cleaning her with thebody gel soap. An interview was conducted on 07/20/2011 at 4:40 p.m. with the Director of Nursing (DON). The DON reported it is her expectation that the NAs should have rinsed the gel soap off of Resident #3 after cleaning her.	F 312	changes needed in incontinent care procedure.	8/18/11
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.	F 431	Carolina Care Center provides locked, permanently affixed compartments for storage of controlled drugs and other drugs subject to abuse unless drug is maintained in single unit dose systems.	

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F 431	Continued From page 9 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 observation, staff interview and manufacturer's recommendations, the facility failed to remove a bottle of expired Lorazepam (a benzodiazepine) from use in a medication refrigerator located in one of one medication rooms. The findings are: Resident #28 was admitted to the facility on 05/09/2008 with diagnoses including Congestive Heart Failure, Diabetes and Anxiety. Review of the most recent annual Minimum Data Set (MDS) dated 04/15/2011 revealed Resident #28 was usually understood, usually understands and was cognitively intact with daily decision making. Review of the manufacturer's recommendation documented on the product insert for liquid Lorazapam Intensol revealed instructions to discard opened bottle after ninety (90) days of opening.	F 431	* Resident #28 was not affected by the alleged deficient practice. The liquid Lorazepam was returned to the pharmacy for discard on 7/20/11 and the drug was discontinued by the physician. * No other residents were affected by the alleged deficient practice. However, the medication room and refrigerator were reviewed by nursing to assure all other medications were in date on 7/20/11. * Measures put into place to ensure the deficient practice does not recur include: A. A weekly medication room audit by the Staff Development Nurse to check for expired products.	8/18/11

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F 431	Continued From page 10 On 07/19/2011 at 4:55 p.m. the medication refrigerator in the medication room was observed to contain an opened thirty (30) millimeter multi-use bottle of Lorazepam oral concentrate. The medication was stored in the locked section of the refrigerator and labeled for Resident #28's use. There were no labels indicating the date the bottle was opened on the packaging or the medication bottle. The pharmacy issue date on the product label was 08/26/2010. Review of a form used by the facility for signing out dosages of controlled medications indicated an initial dose of the Lorazapam was given to Resident #28 on 09/07/2010. Resident #28 also received additional doses on 10/11/2010, 10/13/2010 and 01/26/2011. On 07/20/2011 at 1:12 p.m. the Director of Nursing (DON) was interviewed and confirmed the Lorazapam was indicated for Resident #28. She further stated the Lorazapam was opened on the date the first dose was given which was 09/07/2010. During the interview the DON indicated the medication nurses are responsible for documenting open dates on multi-use medications and monitoring for expiration dates. The DON further revealed she would expect the medication nurses to read the package insert information and directions regarding expiration dates especially when a medication is not frequently used. Interview with the consulting pharmacist on 07/19/2011 at 2:15 p.m. revealed the medication nurses open, date and administer the medications from multi-dose containers. He further stated he would expect the medication	F 431	B. Consultant Pharmacist in-serviced Licensed Staff on 7/28/11 and provided a list of manufactor's expiration dates on drugs and solutions. The list of expiration dates was laminated and placed in the Medication Administration and Treatment notebooks. Also, a list was posted in the medication room. New licensed nurses employed will receive date list during their orientation. C. The Pharmacy Consultant will update the list annually or more often as needed for the facility. * Weekly audits by the Staff Development Nurse of the medication room will be submitted to the monthly Quality Assurance and Assessment committee for review, effectiveness of the plan, and recommendations. In addition, Pharmacy Consultant reports received each month will also be reviewed at the Quality Assurance and Assessment committee meeting for any information related to drug expirations and	8/18/11

Carolina Care Center's response to the Statement of Deficiencies with Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate.

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 _____	C 07/21/2011

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

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F 431	Continued From page 11 nurses to refer to the package insert for storage information.	F 431	corrections needed.	8/18/11

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