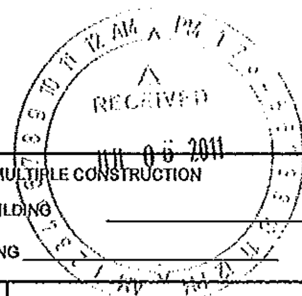

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345051	A. BUILDING ______ B. WING ______	06/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSON COMMUNITY HOSPITAL SNF	600 MORVEN RD WADESBORO, NC 28170

(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 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, resident and staff interviews, the facility failed to honor the food preferences of 1 of 3 sampled residents reviewed for choices. Resident #69. Findings included: Resident #69 was admitted to the facility on 7/1/07 with diagnoses which included: cardiomegaly; vascular heart disease; coronary artery disease; hypertension; chronic anemia; osteopenia; and, depression. Review of the annual Minimum Data Set (MDS) dated 3/3/11 indicated Resident #69 was cognitively intact, and was independent with eating requiring meal tray set-up help, only. The Quarterly Dietary Assessment dated 5/20/11 revealed Resident #69 was to receive a 1500 calorie diet of regular consistency and was able to feed herself; but, generally would leave the meat/protein food uneaten. The resident also had a general dislike of alternates.	F 242	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 this 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. **F242** Resident #69 was immediately offered a substitute for the noodles that she received on her meal tray. Tray cards for other residents having the potential to receive a "dislike" food will be checked prior to each meal by the dietary supervisor to insure that residents do not receive items of food that they have listed as a "dislike". In the event of an error, nursing staff will remove the food tray, dietary department will be notified, and a new food tray will be provided for the resident. The Registered Dietician and Food Services Manager will review tray cards prior to each meal. If the food on the menu is one that the resident dislikes, the current tray card will be removed and a handwritten one will be placed on the serving line listing the food to be substituted for this meal.	7/8/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Fred G. Thompson PhD	President	06/30/2011

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.

Fred G. Thompson PhD

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F 242	Continued From page 1 Review of the Care Plan (updated 6/1/11) indicated Resident #69 required set-up assistance with meal trays. During the dining observation on 6/6/11 at 12:20pm, Resident #69 was observed in the main dining room eating lunch. The meal consisted of beef macaroni, green beans, a bread roll, lemon meringue pie, and iced tea. The resident fed herself, but did not eat any of the beef macaroni noodles. The resident revealed that she did not like noodles and she had been served beef macaroni before and told the staff that she did not like it. During this meal, the resident was offered something else to eat, but she refused and stated that she was not hungry. Resident #69 ate the green beans and pie. On 6/6/11 at 12:25pm, the observation of Resident #69's Meal Card, which was on her meal tray with her plated meat, indicated the resident was not to receive oatmeal at breakfast, and no noodles or au gratin potatoes. Review of the "Food Preferences" sheet included noodles/pasta as a food item dislike of Resident #69. On 6/8/11 at 5:35pm, Resident #69 was observed feeding herself in bed. The resident's meal consisted of turkey, squash, noodles, marble cake, skim milk and iced tea. Resident stated that she did not like noodles or squash and had informed facility staff in the past, but continued to receive noodles during meals. The resident could not remember which facility staff she told that she did not want noodles served to her. The Registered Dietician (RD) confirmed there were	F 242	Continued from page 1 Each dietary department employee has been educated on this new process. A monitoring tool has been developed and implemented to make sure that this new process is adhered to. Meals will be monitored by the dietary supervisor over the next ninety (90) days. Findings of these monitoring activities will be reported to the Registered Dietician weekly and to the facility Quality Assessment and Assurance Committee monthly. Re-education will be conducted as indicated. After 90 days, if compliance is maintained, this tool will become a permanent part of the dietary Quality Assessment and Assurance Program and monitoring will occur monthly.	

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F 242	Continued From page 2 noodles on the resident's plate during this meal. During an interview on 6/8/11 at 5:45pm, the RD revealed that she was responsible for documenting the residents' food preferences. The RD also indicated that she had been made aware, by Resident #69 as well as her family, that the resident did not like or want noodles with her meals; and the resident should not have received any.	F 242		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures;	F 272	**F272 Comprehensive Assessments** Resident #43 has been assessed for his complaints of insomnia by his attending physician who spoke with him and explained that he was not adding medication to his drug regime because of his complex diagnoses and medical condition. The resident accepted this information. His plan of care has been reviewed and updated and non-medical interventions have been offered. Areas of concern for other residents have been reviewed and discussed by the Interdisciplinary Care Plan Team and indicated interventions have been included in their plan of care. The MDS Coordinator has conducted education for the members of the Interdisciplinary Care Plan Team regarding the need to address any areas of concern whether observed or reported by the resident and to present these areas for	7/8/2011

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F 272	Continued From page 3 Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident interview and staff interviews, the facility failed to complete an assessment for a resident with insomnia (Resident #43) and to complete an annual assessment (Resident #58) for 2 of 22 sampled residents. Findings include: 1. Resident #43 was admitted to the facility on 5/11/05 and re-admit on 1022/10. Diagnoses included; Hypertension, PVD (peripheral artery disease), Hyperlipidemia, Cerebrovascular Accident, Depression, Below the Knee Amputee, Atherosclerosis and Chronic Kidney Disease. A review of the annual MDS (Minimum Data Set) dated 5/19/11 revealed resident had no memory problems and cognitive skills were intact. The functional status for dressing, eating, toilet use, personal hygiene, bathing and bed mobility required extensive assistance by 2 persons. The interview conducted for the residents mood	F 272	Continued from page 3 discussion at the weekly Interdisciplinary Care Plan Team Meeting. The MDS Coordinator or the Nurse Manager will, on a weekly basis during the Interdisciplinary Care Plan Team Meeting, monitor to insure that all areas of concern are addressed and incorporated into the resident care plan as appropriate. Documentation of this monitoring will be maintained and will be shared with the Director of Nursing weekly and with the facility Quality Assessment and Assurance Committee monthly. Resident #58 has had a comprehensive assessment completed, transmitted and accepted on 6/15/2011. A query has been completed to confirm that residents in the facility have had their MDS Assessments completed timely and in sequence. Any discrepancy has been corrected. The MDS Coordinator will review the MDS Assessment schedule weekly to insure that any changes required due to resident condition or status will be implemented appropriately. A monthly query of the MDS software will be completed to insure that resident assessments are completed timely and in sequence.	

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F 272	Continued From page 4 revealed he had trouble falling or staying asleep 2-6 days per week, feeling tired or having little energy 12-14 days (nearly every day), and trouble concentrating on things 2-6 days.. A review of the Care Area Assessment Summary (CAA) dated 5/19/11 revealed that Mood was triggered and it indicated no care plan completed. Further review revealed the area titled 'analysis of findings' documented that "triggered due to total score increased over previous review. Resident stated he has difficulty sleeping, is tired with difficulty concentrating with period of restlessness." This form also indicated no for completing a care plan with a rational of "will not proceed to care plan as factors which increased his score are care planned in other areas." There was no documentation of an assessment for causes, risk factors or conclusion regarding inability to sleep resulting, being tired with difficulty concentrating and periods of restlessness. A review of the nurses' notes during the basement period of 5/5/11 through 5/19/11 revealed no documentation regarding residents sleep patterns. On 6/7/11 at 3:11pm resident was observed lying in bed. When asking if he would consent to an interview, he responded "I do not want to talk right now. I want to take a nap." On 6/9/11 at 3:30pm an interview with NA#1 (nurses aide) who routinely provides care for Resident #43 revealed he had shown improvement since admission. The resident does more for himself than before, but he does take a	F 272	Continued from page 4 The MDS Coordinator or the Nurse Manager will, on a weekly basis during the Interdisciplinary Care Plan Team Meeting, monitor to insure that all areas of concern are addressed and incorporated into the resident care plan as appropriate. Documentation of this monitoring will be maintained and will be shared with the Director of Nursing weekly and with the facility Quality Assessment and Assurance Committee monthly.	

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F 272	Continued From page 5 nap almost every afternoon. On 6/9/11 at 4:00pm an interview with Nurse #3 who completed the CAA Summary of 5/19/11 revealed the residents "main problem was sleeping." Nurse #3 reviewed the residents current CAA and confirmed there was not an assessment for the residents inability to sleep. On 6109/11 at 9:00am an interview with Resident #43 that he wanted to take a nap, however agreed to talk for a minute. When asked how well he slept at night, the response was "I just can not sleep. I am awake 2-3 nights a week. I did not sleep well last night and was sleepy this morning." 2. Resident #58 was admitted on 5/16/06 with diagnoses which included: multiple cerebrovascular accidents; hypertension; paraplegia; spastic contracture; dementia with agitated features; diabetes mellitus and, congestive heart failure. The review of the clinical records revealed there was no comprehensive assessment of Resident #58's functional capacity and health status. The most recent annual Minimum Data Set (MDS) for the resident was completed in 2009. Upon review of the facility's records, the MDS Coordinator confirmed the facility had not completed an annual MDS during the 2010 year. On 6/6/11 at 4:44pm, Resident #58 was observed asleep, lying in a fetal position, in her bed. The resident made a continuous chewing motion with her mouth. On 6/8/11 at 8:53am, Resident #58 was observed	F 272		

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F 272	Continued From page 6 in her room, asleep in a reclined geri-chair. The resident's hands and legs were contracted. During an interview on 6/8/11 at 9:30am, the MDS Coordinator revealed that Resident #58 was not placed on the routine MDS schedule because when the resident was hospitalized and returned to the facility in October 2010, she only qualified for the Medicare 5 day assessment which was completed; but the resident's annual MDS was overlooked.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by:	F 279	**F279 Comprehensive Care Plans** Resident #48 has had her risk for falls addressed in her plan of care and measureable goals are included. Resident #26 has had her risks for falls addressed in her plan of care and measurable goals are included. Resident #43 has had an evaluation by his attending physician regarding his complaints of insomnia and non-medical interventions have been offered and have been included in his plan of care. Resident #58 has been screened by the Speech Therapist and her risks for aspiration have been addressed in her plan of care. Care plans for all residents have been reviewed to insure that goals are measurable and that all areas of	7/8/2011

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F 279	Continued From page 7 Based on record review and staff interview, the facility failed to develop a care plan with measurable objectives to meet residents' fall risk needs, failed to develop a care plan for a resident who had insomnia, and failed to develop a care plan to address a resident's risk for aspiration for 4 of 22 sampled residents (Residents #48, #26, #43, and #58). Findings include: 1. Resident # 48 was admitted to the facility 12/15/08 with diagnoses that included Hypertension, Anxiety, Alzheimer's, and on 4/22/09 had a diagnosis of Dementia with Psychosis added. The most recent Minimum Data Set (MDS) dated 3/10/2011 indicated that Resident #48 needed extensive assistance from one person for bed mobility and had not transferred from the bed or walked in the previous seven days. The MDS also revealed that Resident #48 had one fall since the previous assessment. The most recent Fall Risk Assessment dated 6/2/2011 indicated that Resident #48 had a high risk for falls. Review of the Care Plan dated 3/16/2011 listed a problem for Resident #48 as having the potential for falls secondary to impaired mobility requiring assistance with transfers. The Goal read "Resident will have reduced risk for falls daily over the next review." On 6/8/2011 at 3:54 pm the Nurse responsible for Care Plans, Nurse #1, admitted in an interview that the Care Plan goal related to potential falls for Resident #48 was not measurable.	F 279	Continued from page 7 concern have been addressed by the Interdisciplinary Care Plan Team. The MDS Coordinator has conducted education for the members of the Interdisciplinary Care Plan Team regarding the need to address any areas of concern whether observed or reported by the resident and to present these areas for discussion at the weekly Interdisciplinary Care Plan Team Meeting including goals which are measurable. The MDS Coordinator or the Nurse Manager will, on a weekly basis, during the Interdisciplinary Care Plan Team Meeting, monitor to insure that all areas of concern are addressed and incorporated into the resident care plan and that goals are measurable. Documentation of this monitoring will be maintained and will be shared with the Director of Nursing weekly and with the facility Quality Assessment and Assurance Committee monthly.	

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F 279	Continued From page 8 2. Resident # 26 was admitted on 2/15/07 and re-admitted 12/1/2010 with diagnoses that included Congestive Heart Failure, Hypertension, Right Below the Knee Amputation and Lung Cancer. She was placed on Hospice on 7/22/2010. The most recent Quarterly Minimum Data Set (MDS) dated 5/12/2011 indicated that Resident #26 was totally dependent on one person for dressing and totally dependent on two persons for toileting and personal hygiene. The MDS also revealed that Resident #26 did not get out of bed in the past seven days. Furthermore, the MDS indicated that she had no falls since the last assessment. Review of the Care Plan dated 1/28/10 and reviewed 5/18/11 revealed a problem for Resident #26 as having the potential for falls secondary to impaired mobility (requiring total assistance with transfers), a history of falls, and behavioral problems. The Goal read "Resident will have reduced risk for falls daily over the next review." On 6/8/2011 at 3:54 pm the Nurse responsible for Care Plans, Nurse #1, admitted in an interview that the Care Plan goal related to potential falls for Resident #26 was not measurable. 3. Resident #43 was admitted to the facility on 5/11/05 and re-admit on 1022/10. Diagnoses included; Hypertension, PVD (peripheral artery disease), Hyperlipidemia, Cerebrovascular	F 279		

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F 279	Continued From page 9 Accident, Depression, Below the Knee Amputee, Atherosclerosis and Chronic Kidney Disease. A review of the annual MDS (Minimum Data Set) dated 5/19/11 revealed resident had no memory problems and cognitive skills were intact. The functional status for dressing, eating, toilet use, personal hygiene, bathing and bed mobility required extensive assistance by 2 persons. The interview conducted for the residents mood revealed he had trouble falling or staying asleep 2-6 days per week. A review of the Care Area Assessment Summary (CAA) dated 5/19/11 revealed that Mood was triggered and it indicated no care plan completed. Further review revealed the area titled 'analysis of findings' documented that "triggered due to total score increased over previous review. Resident stated he has difficulty sleeping, is tired with difficulty concentrating with period of restlessness." This form also indicated no for completing a care plan with a rational of "will not proceed to care plan as factors which increased his score are care planned in other areas." There was no documentation of an assessment for causes, risk factors or conclusion regarding inability to sleep resulting, being tired with difficulty concentrating and periods of restlessness. A review of the current care plans with a review date of 6/1/11 did not reveal any identified problems, goals, or interventions related to not sleeping. A review of the nurses' notes during the basement period of 5/5/11 through 5/19/11	F 279		

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F 279	Continued From page 10	F 279		

revealed no documentation regarding residents sleep patterns.

On 6/7/11 at 3:11pm resident was observed lying in bed. When asking if he would consent to an interview, he responded "I do not want to talk right now. I want to take a nap."

On 6/9/11 at 3:30pm an interview with NA#1 (nurses aide) who routinely provides care for Resident #43 revealed he had shown improvement since admission. The resident does more for himself than before, but he does take a nap almost every afternoon.

On 6/9/11 at 4:00pm an interview with Nurse #3 who completed the CAA Summary of 5/19/11 revealed revealed "the residents "main problem was sleeping and I did not care plan it because it was covered on other area's." Nurse #3 reviewed the residents current care plans and confirmed there was no information in any care plan related to the residents inability to sleep.

On 6109/11 at 9:00am an interview with Resident #43 that he wanted to take a nap, however agreed to talk for a minute. When asked how well he slept at night, the response was "I just can not sleep. I am awake 2-3 nights a week. I did not sleep well last night and was sleepy this morning."

4. Resident #58 was admitted on 5/16/06 with diagnoses which included: multiple cerebrovascular accidents; hypertension; paraplegia; spastic contracture; dementia with agitated features; diabetes mellitus and, congestive heart failure.

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F 279	Continued From page 11 Review to the Speech Language Pathology Screen dated 3/2/11 revealed Resident #58 received a pureed diet assisted by staff. The resident continued to have an open mouth posture with no significant changes in her condition. Speech Therapy was not indicated as this time. Review of the most recent quarterly Minimum Data Set (MDS) dated 3/24/11 indicated Resident #58 had short and long term memory problems with severely impaired decision-making skills. The MDS revealed the resident was totally dependent on staff for eating; and had chewing and swallowing problems. In reviewing the Nursing Notes, documentation indicated that Resident #58 had difficulty chewing and swallowing food. The records revealed the resident was unable to close her mouth resulting in a noted loss of liquids from mouth when eating or drinking. The review of the Speech Therapy Plan of Treatment dated 4/15/11 indicated Resident #58 was to receive treatment for swallowing dysfunction and/or oral function for feeding; and was to be evaluated for swallowing function at her bedside. The Goal of the therapy was: Caregivers/staff to demonstrate appropriate caregiver/training of aspiration precautions, compensatory feeding strategies, positioning and oral care methods to increase the resident's safety with by mouth intake. There was no evidence that a Care Plan was developed by the facility to address Resident #58's aspiration risk due to her chewing and	F 279		

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F 279	Continued From page 12 swallowing difficulties. A Physician's Order dated 4/21/11 documented as a late entry for 4/14/11, a Speech Therapy Clarification order: Resident #58 was to receive speech therapy services 5 times per week for 1 week for dysphagia with focus on diet/liquid receiving, safe feeding strategies, aspiration precautions, oral care methods and discharge planning. On 6/6/11 at 4:44pm, Resident #58 was observed asleep in bed lying on her right side in a fetal position. The resident was making a continuous chewing motion with her mouth. During an interview on 6/8/11 at 3:25pm, Nursing Assistant #1 (NA#1) revealed that Resident #58 had always made a chewing motion with her mouth when awake and her mouth would hang open when she was asleep. NA#1 stated that the resident required assistance with feeding of pureed food; alternating between food and liquids to avoid choking and the food/liquid spilling from the resident's mouth. During an interview on 6/9/11 at 5:10pm, the MDS Coordinator stated that after reviewing Resident #58's closed records, she was unable to locate a Care Plan for the resident's risk of aspiration after the resident received treatment from Speech Therapy. During an interview on 6/9/11 at 5:11pm, the Director of Nursing revealed that the Speech Therapist had conducted and in-service with the nursing assistants on first shift concerning feeding Resident #58 to avoid aspiration risk.	F 279		

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F 279	Continued From page 13 During a dining observation on 6/10/11 at 12:50pm, Resident #58 was observed sitting up in bed being fed, by a nursing assistant, a meal of pureed food items and thin liquids. NA#1 was also in the resident's room, giving verbal guidance to the nursing assistant during the meal service. There was no observation of the resident coughing or choking during the meal.	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and staff interviews, the facility failed to handle medication in a safe sanitary way for 1 of 2 medication administration observations. (Resident #24 & #45) Findings include: A review of the facility policy titled ' Administration of Oral (PO) Medication ', Number 38.1 with a date of issue 7/03 and Reviewed/Revised: 7/04, 10/04, 10/05, 10/06, 10/07, 10/08, 11/08, 11/09 was completed. Included in the administration of oral medication policy was " Medications should never be returned to the package or bottle once they have been removed. The dose should be properly destroyed and if a controlled substance follow proper procedure for disposal. Nurse should wash her hands and don gloves prior to direct	F 281	**F281 Meet Professional Standards-Medications** Nurse #2 received on-the-spot counseling and education on the facility's policy and procedure regarding medication administration, by the Director of Nursing. The medication for this resident was immediately removed from the medication cart by the Director of Nursing and replaced by the pharmacy. Nurse #2 received on-the-spot counseling and education regarding the facility policy and procedure for medication administration, by the Director of Nursing. Licensed Nurses have been observed during medication administration and any deficient practice observed was corrected immediately with on-the-spot counseling and education.	7/8/2011

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F 281	Continued From page 14 contact with medications. " 1. On 6/8/11 at 9:30am Nurse #2 was observed dropping a pink pill (Plavix) onto the top of the medication cart. The nurse picked up the pill with out any type of barrier on her fingers and placed the pill into the medication cup filled with other pills. The top of the medication cart had spilled water near were the pill was dropped. During the observation of preparing medication for administration the nurse did not clean the top of the medication cart off. The dropped pill along with other medication was observed on 6/8/11 at 9:30am being given to Resident #24. On 6/9/11 at 11:30am an interview with Nurse #2 revealed that she had dropped the Plavix on the top of the medication cart but felt it was a clean area and that it was all right to give it to the resident. 2. On 6/8/11 at 9:58am Nurse #2 was observed picking up a medication (Lopressor) and placing it into a pill cutter with her hands and removing the pill with her fingers after it was cut with out any type of protective barrier on her hands and fingers. The nurse placed one half of the pill (Lopressor) into the medication cup and the other half of the pill was returned to the bottle of pills (Lopressor) it had been removed from. On 6/9/11 at 11:30am a telephone interview with Nurse #2 revealed that she was trained to throw out the other half of a medication when it is broken in half. "I guess I was just nervous." Further discussion revealed that she felt if her hands were clean she could handle medication with out a protective barrier on her hands/fingers.	F 281	Continued from page 14 The Medication Administration Policy and Procedure has been reviewed with the Licensed Nurses who have been re-educated on this Policy and Procedure including appropriate Infection Control practices when administering medication. Each nurse has been given a copy of the Policy. Pharmacists and Nurse Managers will conduct random medication passes weekly over the next three months utilizing the Quality Assessment and Assurance tool that has been created to insure that nurses are following the correct policy and procedure. Five nurses, at a minimum will be observed weekly. Any deficient practices observed during the medication pass will be corrected immediately, followed by the nurse receiving on-the-spot counseling. The facility will follow progressive disciplinary policy up to and including termination for any nurse who consistently fails to adhere to the policy. The results of these medication pass observations will be shared with the Director of Nursing weekly and with the facility Quality Assessment and Assurance Committee monthly. After three months of sustained compliance,	

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F 281	Continued From page 15 3. On 6/8/11 at 10:30am Nurse #2 was observed tearing a package containing a pill (Flagyl) which placed the pill into the bare hands of the nurse. The nurse stated "my hands are clean." Nurse #2 was observed placing sanitizer on her hands with out any time for the sanitizer to dry before tearing the packing placing the pill on to the palm of her hand. She then dropped the pill into a medication cup along with other pills and gave it to Resident #24. On 6/8/11 at 11:10am a discussion with the DON (Director of Nursing) regarding returning the broken half of the Lopressor back to the original bottle. At 2:25pm on 6/8/11 the DON stated the bottle of Lopressor had been discarded due to the return of pills into the bottle. 6/9/11 at 11:30am interview with Nurse #2 revealed that she felt if her hands were clean it was all right to handle a pill without any protective barrier on her hands/fingers.	F 281	Continued from page 15 this tool will become a permanent part of the facility Quality Assessment and Assurance Program.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff	F 318	F318 Resident #58 has been re-evaluated by the Physical Therapist and recommendations have been made. Responsible party refuses to have resident participate in a therapy or a nursing restorative program as they have chosen for staff to provide comfort measures only. The Attending Physician has been notified and this response has been documented in the medical record. Resident #96 has been re-evaluated	7/8/2011

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F 318	Continued From page 16 interviews, the facility failed to provide the restorative services for range of motion exercises as recommended by the rehabilitation department to 2 of 3 sampled residents with contractures. (Residents #58 and #96). Findings included: 1. Resident #58 was admitted on 5/16/06 with diagnoses which included: multiple cerebrovascular accidents; hypertension; paraplegia; spastic contracture; dementia with agitated features; diabetes mellitus and, congestive heart failure. Review of the Occupational Therapy and the Physical Therapy Screens dated 3/3/11 concluded therapy evaluations were not indicated due to no change in Resident #58's functional status; the resident's bilateral knee contractures were at baseline. The documentation indicated that the resident began the Restorative Nursing Program on 3/3/11. The Review of the "Therapy to Nursing Communication" form indicated a Restorative Nursing Assistant (RNA) completed a caregiver training program by the Physical Therapist on providing Resident #58 gentle passive knee range of motion (knee straightening) on both knees then how to position her legs straight with pillows. The RNA completed the training and signed the form on 3/7/11. Review of the most recent quarterly Minimum Data Set (MDS) dated 3/24/11 indicated Resident #58 had short and long term memory problems	F 318	Continued from page 16 by the Physical Therapist and has been treated by therapy for two weeks at which time they transitioned to Restorative Nursing. Resident #96 is now receiving Restorative Nursing. Residents with referrals to Restorative Nursing in the past 12 months have been reviewed to insure that appropriate Restorative Nursing Programs have been implemented. The Nursing Administration Team and Therapy have been educated by the Director of Nursing regarding the revised referral process which includes timely and appropriate communication and follow through on recommendations for Restorative Programs. Therapy referrals to Restorative Nursing will be audited by the Nurse Manager on a weekly basis to insure that recommendations are followed and appropriate Restorative Programs are implemented. Results of this monitoring will be shared with the Director of Nursing weekly and with the facility Quality Assessment and Assurance Committee monthly.	

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F 318	Continued From page 17 with severely impaired decision-making skills. The MDS revealed the resident was totally dependent on staff for all Activities of Daily Living and had range of motion impairments in both upper and both lower extremities. The resident was not receiving any therapy or restorative services. Review of the Care Plan dated 3/30/11 and updated 5/2/11 revealed Resident #58 had impaired mobility and was at an increased risk of further contracture development secondary to a decreased range of motion. Approaches to this problem included: active range of motion or passive range of motion to left wrist 15 minutes for 6-7 days each week; gentle passive range of motion to both knees repeating 5 times for 6-7 days each week; if decline noted, refer to therapy for screen; and apply a hand roll to left hand checking every shift for proper placement. Restorative Nursing was to be responsible for these approaches. There was no documentation available indicating Resident #58 received Restorative Nursing from 3/3/11 through 5/4/11. The resident was put on comfort care on 5/4/11. The monthly Physician's Orders records (April 2011 and May 2011) for Resident #58 included: "may evaluate and place in Restorative Nursing Program(s) as appropriate". The Treatment Administration Records (April 2011, May 2011, and June 2011) included as treatment for Resident #58: "Hand roll in left hand check every shift for placement".	F 318		

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F 318	Continued From page 18 During an observation on 6/6/11 at 4:42pm, Resident #58 was observed asleep in bed with both arms bent towards chest, left hand tightly fisted, and both legs bent towards chest. There were no splint devices noted. On 6/8/11 at 8:53am, Resident #58 was asleep in a reclined geri-chair in her room. The resident's hands were in tight fists against her chest; and her legs were bent/drawn upward in a fetal position and elevated on a pillow. The Treatment Nurse placed rolled cloths in both of the resident's hands. During an interview on 6/8/11 at 9:00am, the Treatment Nurse revealed Resident #58 should have the handrolls on at all times, and whenever noticed not in hands, the nursing assistants or nurses should have replaced them. She also stated that when she did treatment rounds every morning, she would check the resident to ensure the handrolls were in place. During an interview on 6/8/11 at 3:07pm, Nursing Assistant #1 (NA#1) revealed that Resident #58 received range of motion exercises during morning care due to contractures of her left hand and both legs at the knees. NA#1 stated that rolled wash cloths were placed in the resident's hands every morning by a nursing assistant or a restorative nursing assistant and remain on the resident for 8 hours then removed. NA#1 later revealed that she was not sure how long handrolls were to remain in the resident's hands. During an interview on 6/8/11 at 4:29pm, the Restorative Nurse stated that Resident #58 was not in the Restorative Nursing Program and had	F 318		

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F 318	Continued From page 19 not been in Restorative for 2-3 years. During an interview on 6/9/11 at 5:05pm, the Director of Nursing revealed that one of the Restorative Nursing Assistants informed her that Resident #58 last received restorative range of motion for upper and lower extremities in December 2010. During an interview on 6/10/11 at 12:38pm, the facility's Rehabilitation Manager described the process for referrals to Restorative Nursing as: a week before a resident is discharged from therapy; the restorative nursing assistant would be trained on the therapy/restorative program. Upon completion of this caregiver/aide training, a written referral with the restorative nursing assistant's signature would be sent to the nurse in charge of the Restorative Program. 2. Resident #96 was admitted to the facility on 10/26/10 with diagnoses which included: late effects cerebrovascular accident; seizure episode; diabetes mellitus; pseudobulbar syndrome; and, dementia. Review of the Occupational Therapy (OT) Discharge Summary dated 1/25/11 indicated Resident #96's increased passive range of motion in both upper extremities has decreased her risk of further contraction. The Review of the "Therapy to Nursing Communication" form indicated a Restorative Nursing Assistant (RNA) completed a caregiver training program by the Occupational Therapist Assistant on providing Resident #96 with passive	F 318		

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F 318	Continued From page 20 range of motion/stretch to both upper extremities to prevent contracture development. The RNA completed the training and signed the form on 1/26/11. The review of the quarterly OT Screen dated 4/7/11 indicated Resident #96 was on a Restorative Range of Motion Program for the prevention of contracture management and OT evaluation was not indicated. Review of the quarterly Minimum Data Set (MDS) dated 4/7/11 indicated Resident #96 had short and long term memory problems with severely impaired decision-making skills. The MDS revealed the resident was totally dependent on staff for all activities of daily living; and had range of motion limitations on one side of her upper extremity and both sides of her lower extremities. There was no care plan completed for the resident's range of motion limitations. The monthly Physician's Orders records (May 2011 and June 2011) for Resident #96 included: "may evaluate and place in Restorative Nursing Program(s) as appropriate". During an observation on 6/7/11 at 9:43am, Resident #96 was observed in bed. The resident's right hand was tightly fisted. There were no splinting devices. During an interview on 6/8/11 at 4:15pm, the Treatment Nurse revealed Resident #96 had contractures in both of her hands. She also stated that the resident was not in Restorative Nursing. During an interview on 6/8/11 at 4:31pm, the	F 318		

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F 318	Continued From page 21 Restorative Nurse stated that Resident #96 was not and had never been in the Restorative Nursing Program. During an interview on 6/10/11 at 10:14am, Nursing Assistant #1 (NA#1) revealed Resident #96 was semi-contracted in both arms and would stiffen arms when touched. NA#1 stated that the resident was not receiving therapy; but did receive range of motion when she was turned and positioned every 2 hours. On 6/10/11 at 10:20am, Resident #96 was observed in her bed with both arms crossed over and held to her chest. During an interview on 6/10/11 at 12:14pm, the facility's Rehabilitation Manager revealed Resident #96 was not contracted, but received OT earlier this year for range of motion for shoulders, elbows, wrists and hands to prevent the risk of contracture development. She stated that when the resident's quarterly screen was completed in April, she did not double-check to ensure Restorative was providing the treatment requested by the Rehabilitative Department. The Rehabilitation Manager described the process for referrals to Restorative Nursing as: a week before a resident is discharged from therapy, the restorative nursing assistant would be trained on the therapy/restorative program. Upon completion of this caregiver/aide training, a written referral with the restorative nursing assistant's signature would be sent to the nurse in charge of the Restorative Program.	F 318		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431	F431 Drug Records, Label, Store Drugs, and Biological Nurse #2 received on-the-spot counseling and education regarding the proper	7/8/2011

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F 431	Continued From page 22 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to have medications stored in a	F 431	Continued from page 22 storage of medications. Nurse #3 received on-the-spot counseling and education regarding the proper labeling of medication. The Novolin insulin was immediately discarded and replaced. Medication carts have been inspected to insure that all multi-dose vials and other medication requiring a "dating when opened" to insure timely discard are appropriately labeled with "date opened" and a "date expires". The Medication Administration Policy and Procedure has been reviewed with the Licensed Nurses who have been re-educated on this Policy and Procedure, including proper storage and labeling. Each nurse has been given a copy of the Policy. The 7p-7a Nurses will conduct a weekly medication cart inspection using the monitoring tool that has been created and implemented. This tool assures that all multi-dose vials have a "date opened" and "date expires" on them and that no out of date medications are present in the medication cart. The Hospital Pharmacist will review medications for appropriate labeling and storage as well as compliance with other aspects of the Medication	

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F 431	Continued From page 23 locked area and failed to date an opened vial of insulin for 2 of 4 medication carts. (medication cart for small nursing station and for substation) Findings include: 1. On 6/8/11 at 9:58am Nurse 2 was observed preparing medication for Resident # 24. The nurse placed the medication in a medication cup on top of the medication cart. The nurse pushed the cart down the hall looking for the resident. The nurse placed her medication cart against a bank of windows in front of the activity area and left the cart unattended with the medication on top of the cart. There were residents and staff walking by the medication cart where the medication for Resident #24 were left unattended. The medication were left unattended from 10:02am until 10:09am when Nurse #3 returned picked up the medication and gave them to Resident #24. On 6/9/11 at 11:30am an interview with Nurse #3 revealed that she was trained to never leave medication unlocked. Further discussion revealed she did not remember leaving the medication on top of the medication cart. "I was nervous." 2. The manufacturer's package insert instructions for Novolin 70/30 insulin dated 5/2010 included the following information regarding the storage of Novolin 70/30 insulin. The insert indicated that vials should be discarded 28 days after opening whether refrigerated (36-46 degrees Fahrenheit) or at room temperature (less than 86 degrees Fahrenheit). On 6/10/11 at 11:30 am observation with Nurse #3 of medication storage on the Medication Cart	F 431	Continued from page 23 Policy and Procedure, during weekly medication cassette exchanges. Any discrepancies will be discarded and reported to a Nurse Manager. The appropriate storage and labeling of medication will be monitored by the Pharmacist and the Nursing Administration Team during the weekly medication pass observations. Results of this monitoring will be reported to the Director of Nursing weekly and will be shared with the facility Quality Assessment and Assurance Committee monthly.	

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F 431	Continued From page 24 for the Substation found a multidose vial of Novolin 70/30 insulin open and undated. Nurse #3 stated that she labeled all insulin with the date opened when she opened them. She indicated that insulin should be labeled with the open date to know how long you could use it. On 6/10/11 at 12:08 pm the Director of Nurses (DON) stated in an interview that nurses should know where and how to store medications as that was discussed during orientation. The DON also indicated that new nurses oriented with a seasoned nurse until familiar with all routines. If not sure where and how to store medications she revealed that a nurse was told to check with the nurse manager or call the pharmacist.	F 431		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345051	A. BUILDING 02 - ANSON CO HOSPITAL B. WING	07/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ANSON COMMUNITY HOSPITAL SNF	500 MORVEN RD WADESBORO, NC 28170

RECEIVED AUG 0 2 2011 CONSTRUCTION SECTION

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K 018 SS=D	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: A. Based on observation on 07/07/2011 the following doors failed to latch when closed, #30, #23 and #18.	K 018	K 018 – The identified doors were adjusted to latch on July 8, 2011. Doors throughout the facility were checked for similar conditions and adjusted where necessary on 7/8/11. Positive latching of doors will be added to our semi-annual safety survey for all patient care areas for future periods. Results of semi-annual surveys will result in maintenance work orders to adjust, repair or replace non-latching doors or door hardware where doors are found not positively latching. The next survey is scheduled for December, 2011.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or	K 029	K 029 – Door closers were ordered and installed on the three doors identified during the survey with work completed on July 29, 2011. All other doors to one hour rated compartments were checked for the need for door closers and one additional door was equipped with a closer as a result. This condition will also be monitored during semi-annual safety surveys.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Fred G. Thompson PhD
TITLE: President
(X6) DATE: 08/01/2011

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.

CD

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	345051	A. BUILDING 02 - ANSON CO HOSPITAL B. WING ______	07/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 029	Continued From page 1 field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 07/07/2011 the door to the laundry did not close and latch. B. The door to the storage room at the nurses sub-station failed to close and latch. C. The soiled utility room near room 18 is used for soiled linen also failed to close and latch.	K 029	K 047 – Two Exit signs for each courtyard not so equipped have been ordered and will be installed on emergency power by August 9, 2011. The facility has been reviewed and egress lighting will be replaced in the older courtyards to provide two sources of egress lighting at each exit provided with an exit sign by 8/9/11. Maintenance of these lights has been added to the building maintenance program and will be inspected accordingly. These lights are also included on our semi-annual safety surveys.	
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: A. Based on observation on 07/07/2011 the facility has three (3) large court yards that do not have illuminated exit signs to direct a person exiting the court yards.	K 047	K 056 – A high/low pressure switch has been added to the older dry sprinkler system. It was connected to the fire alarm system and tested for operation on July 28, 2011. It has been added to our sprinkler system maintenance program and our fire alarm system testing and inspection program for regular testing. All testing is documented.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of	K 056		

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K 056	Continued From page 2 Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: A. Based on observation on 07/07/2011 the dry sprinkler system for the older section of the building did not have a supervised high and low air pressure switch. 42 CFR 483.70 (a)	K 056	K 062 - Ceiling spray on identified sprinkler head was removed on July 15, 2011. Sprinkler heads throughout facility were inspected for similar condition and those found were also cleaned. This inspection will also be added to the semi-annual safety surveys. The next semi-annual survey is scheduled for December 2011.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: A. Based on observation on 07/07/2011 the corridor sprinkler head near room 31 had been painted (head must be replaced).	K 062	K 072 – The identified door was equipped with a UL Listed door closer on July 29, 2011. The facility was surveyed for any similar deficiencies and none were found. Operation of closers and positive latching hardware will be monitored during semi-annual safety surveys. The next scheduled semi-annual safety survey is scheduled for December 2011.	
K 072	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072		

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K 072	Continued From page 3 This STANDARD is not met as evidenced by: A. Based on observation on 07/07/2011 the door to Janitors closet #51 opened into the corridor but not 180 degrees,thus reducing the width of the corridor. This door must be equipped with a listed closer.	K 072		
K 147 SS=D	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: A. The soiled linen room near room 51 had exposed bulbs in the light fixtures. B. The med. refrigerator in the storage room near room 20 was not connected to an emergency circuit. C. The facility is to verify that some of the court yard light fixtures are on emergency power. 42 CFR 483.70 (a)	K 147	K 147 -- Protective lamp sleeves were installed on the identified light fixtures on July 8, 2011. The facility was inspected to identify any additional occurrences, and where found, this condition was also corrected. This item will be added to the semi-annual safety surveys. The next semi-annual survey is scheduled for December 2011.	