STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 09/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AYDEN COURT NURSING AND REHABILITATION CENTER	128 SNOW HILL RD AYDEN, NC 28513

(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 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, staff interview and physician interview, the facility failed to obtain daily weights as ordered by the physician for one of one sampled residents (Resident #54). Findings included: Resident #54 was originally admitted to the facility 7/19/11. Diagnoses included: CHF (Congestive heart Failure), Chronic kidney disease and Diabetes. Admission MDS assessment dated 7/26/11 documented weight at 154 lbs. A review of resident #54's care plan dated 7/27/11 revealed a potential for or actual fluid volume excess due to CHF and edema of lower extremities, therapeutic diet NAS. Interventions included assessment for signs and symptoms of fluid excess, acute weight gain and weights per facility protocol. Physician orders were reviewed. On 7/19/2011, Resident #54's physician ordered daily weights with the physician to be notified of the weight was	F 309	Britthaven of Ayden acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Britthaven of Ayden's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Britthaven of Ayden reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. Resident #54 no longer has an active order for daily weights beginning on 8/09/2011. A 100% chart audit was completed on 9/21/2011 by the DON to ensure residents having weight orders to include daily were being done with no potential issues identified. On the day of admission, the admitting nurse will fill out the Weight Alert form and forward to the Restorative Aide. The Weight Alert form will communicate to the Restorative Aide how often weights are ordered to be done on resident (daily or weekly). The Weight Alert form will also be used to communicate any new weight orders to Restorative Aide. The Restorative Aide will be responsible to make sure the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathy D Sheppard, NHA — TITLE: Administrator — (X6) DATE: 9-28-11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345490	A. BUILDING _____ B. WING _____	C 09/16/2011

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F 309	Continued From page 1 greater than five(5) pounds. Medications for resident #54 included Zaroxolyn (diuretic) 2.5 mg. (milligrams) qam. (daily) and Lasix (diuretic) 20 mg.daily. The weight summary record was reviewed with the following weights recorded: Weight 7/19/11--153.5, 7/27/11-- 172.0, 8/1/11--172.0, 8/10/11 174.0. MD progress note dated 7/27/11 indicated Resident #54 displayed signs of CHF with some excess fluid. Daily weights were to be continued. On 9/14/11, at 4:17 PM., the Director of Nursing (DON) stated she expected nursing staff to record the weights in the computer (weight/ vital sign section). On 9/14/11, at 4:28 PM., RN #1, when asked regarding the order for daily weights, stated daily weights were done by the restorative aide and the weight information would be given to the day nursing supervisor. On 9/15/11, at 9:26 AM., RN #2 stated she had never seen the order for daily weights for Resident #54. She further indicated the nurse that signed the order off would have notified the weight person (restorative aide). On 9/15/11, at 10:16 AM., the Director of Nursing indicated she could not find any documentation that Resident #54 had received daily weights. She stated she expected the nurse who noted the order to communicate that information to the restorative aide and the daily weight order was	F 309	daily weight is obtained and documented in the computer. The Restorative Aide will also communicate the daily weight to the hall nurse to be documented on the MAR. The hall nurse will be responsible to contact the doctor if the weight exceeds the limit set forth in the doctor's order. In-servicing on the Weight Alert procedure and daily weight documentation responsiblities conducted by the DON or SDC began on 09/22/2011 with completion on 10/14/2011 with all nurses and restorative aides. Weight Alert forms will be forwarded to the DON, by the Restorative Aide, for her review within 24 hours of receipt by the Restorative Aide with follow up taken for any potential issues upon identification. The daily weights will be monitored weekly by the weekly Weight & Wound Committee with follow up taken for any potential issues upon identification. The results of the audits will be forwarded monthly x 3 then quarterly to the Executive QI Committee for the identified trends, development of action plans as appropriate and to determine the need and/or frequency for continuing QI monitoring as deemed necessary.	10/14/11

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F 309	Continued From page 2 not communicated to the restorative aide. The charge nurse on the floor would be responsible to ensure the daily weights had been obtained. On 9/15/11, at 10:52 AM., the restorative aide stated she did not receive any communication that Resident #54 needed daily weights until August 2011. On 9/15/11, at 11:26 AM., LPN #1 stated the order for daily weights would be documented on the Medication Administration Record (MAR). She reviewed the July and August MAR and said the order for daily weights was not recorded on either MAR. On 9/15/11, at 1:15 PM.,Resident #54's physician, per telephone interview, stated she had ordered daily weights due to Resident #54's diagnosis of CHF and history of renal failure. She further indicated Resident #54 had displayed problems with fluid balance and would develop renal failure if given too much Lasix and heart failure if not given enough Lasix.	F 309		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	1.Dented can was discarded on 9/12/2011 by the Dietary Manager. Storage area checked for other dented cans on 9/12/2011 by the Dietary Manager and none found. Dietary staff were inserviced beginning 9/13/2011 and completed 9/23/2011 regarding discarding dented cans by staff upon identification. First and Second shift cooks are assigned to ensure there are no dented cans in the storage area and	

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F 371	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to dispose of one dented can and failed to label and date opened food items. Findings included: 1. During initial tour, on 9/12/2011, at 10:20 AM., with the Dietary Manager, one 50 ounce can of cream of mushroom soup was noted in the dry storage area with dents noted to the bottom, top and side of the can. The Dietary Manager stated "When the cans are dented, I throw them away. I just missed it when I put up the stock." On 9/20/2011 at 10:50 AM., the Dietary Manager stated he put up the stock items every Wednesday. He also stated he checked the stock every Tuesday for reorder and checked cans at that time, also. 2. During the initial tour, on 9/12/2011 at 10:25 AM., with the Dietary Manager, twenty-two containers of no sugar added applesauce were noted in the walk-in cooler with an expiration date of Aug. 24 2011. In the freezer room, the following opened items were unlabeled and undated: one opened brown bag of potato tots, one bag of frozen green beans and ten frozen pancakes in a plastic bag. In the refrigerator, an opened package of sliced yellow cheese was unlabeled and undated. The Dietary Manager stated he expected expired items to be discarded and items that have been opened to be labeled and dated. He said the dietary aide on the morning shift should go through all items in the cooler/ refrigerator/freezer and discard items daily. The Dietary Manager further stated he	F 371	document completion on Daily Cleaning Assignment each day with follow up occurring for any potential issues upon identification. Wednesday stock person is assigned to check all inventory for dented cans and document completion on the Daily Cleaning Assignment sheet each day with follow up occuring for any potential issues upon identification. Dietary Manager is assigned to review daily log weekly for documentation and check storage areas weekly for dented cans and follow up on any potential issues upon identification. The results of the audits will be forwarded monthly x 3 then quarterly to the Executive QI Committee for the identified trends, development of action plans as appropriate and to determine the need and/or frequency for continuing QI monitoring as deemed necessary. 2. All undated or expired food items were thrown away immediately on 9/12/2011 by the Dietary Manager. In-servicing on undated and expired foods conducted by the Dietary Manager began on 09/13/11 with completion on 09/23/11 with all dietary staff.	

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F 371	Continued From page 4 checked the cooler/ refrigerator and freezer areas at least once weekly--usually on Tuesday. On 9/12/2011 at 10:35AM, the morning dietary aide stated the refrigerator, walk-in cooler and walk-in freezer was checked for expired items at the beginning of the morning shift. She stated she had not checked the refrigerator, walk-in cooler and freezer on 9/12/2011.	F 371	First and second shift cooks and second shift dietary aides are assigned daily to ensure all food products are stored properly with open dates utilizing the Daily Cleaning Assignment with follow up taken for any potential issues upon identification. Dietary Manager is assigned to review daily log weekly and check all storage areas to verify all food items are stored and dated properly with follow up taken for any potential issues upon identification. The results of the audits will be forwarded monthly x 3 then quarterly to the Executive QI Committee for the identified trends, development of action plans as appropriate and to determine the need and/or frequency for continuing QI monitoring as deemed necessary.	10/14/2011

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	345490	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/05/2011

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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 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: 42 CFR 483.70(a) By observation on 10/5/11 at approximately noon the hazardous area was non-compliant, specific findings include door to Kitchen dry storage wedged open during survey.		Ayden Court Nursing & Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Ayden Court Nursing & Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Ayden Court Nursing & Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding. K 029 Dietary Manager was informed by the Maintenance Supervisor on 10/5/2011 that doors cannot be propped open. All staff will be in-serviced by the SDC or department head regarding not propping open doors. In-servicing will be completed by 11/19/2011. Administrator will complete audit tool confirming that no doors are being propped open weekly x 4 weeks and then monthly. Department heads will be notified at the time of the audit if doors are found to be propped open in their departments. The Administrator will review completed audits weekly x 4 weeks and then monthly for any identified concerns and will take appropriate follow up action as indicated. The results of these audits will then be forwarded quarterly to the Executive QI Committee for the identified trends, development of action plans as appropriate and to determine the need and/or frequency for continuing QI monitoring as deemed necessary.	11/19/11
K 072 SS=D	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 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 10/5/11 at approximately noon the means of egress was non-compliant, specific			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathy D Sheppard, NHA | TITLE: Administrator | (X6) DATE: 10/20/11

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DRS

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	345490	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/05/2011

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K 072	Continued From page 1 findings include three lifts recharging in the corridor near room 500, mechanical room near kitchen, and outside of kitchen.	K 072	Lifts were removed from the corridors on 10/5/2011 by administrative nurses. Staff will be in-serviced by the SDC or department head regarding lifts not being left on the halls during non-use times as to not block exit corridors. Administrator will complete audit tool confirming that items are not being stored in exit corridors weekly x 4 weeks and then monthly. Department heads will be notified at the time of the audit if items are being stored in the hallway by their staff. The Administrator will review completed audit tools weekly x 4 weeks and then monthly for any identified concerns and will take appropriate follow up action as indicated. The results of these audits will then be forwarded quarterly to the Executive QI Committee for the identified trends, development of action plans as appropriate and to determine the need and/or frequency for continuing QI monitoring as deemed necessary.	11/19/11
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 10/5/11 at approximately noon the generator was non-compliant, specific findings include the generator did not crank during survey.	K 144	Maintenance Supervisor attempted to crank generator following life safety survey on 10/5/2011 and generator cranked. Generator repairman came on 10/11/2011 to repair generator. Generator cranked appropriately following his repairs. Generator will be placed under a full load test daily x 1 week then weekly x 4 weeks and audit tool completed. Any issues identified will be addressed at the time of the load test and a repairman will be contacted. Generator will then be placed back on a monthly schedule for generator load tests. The Administrator will review completed audit tools weekly x 4 weeks and then monthly for any identified concerns and will take appropriate follow up action as indicated. The results of these audits will then be forwarded quarterly to the Executive QI Committee for the identified trends, development of action plans as appropriate and to determine the need and/or frequency for continuing QI monitoring as deemed necessary.	11/19/2011