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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____ OCT 28 2011	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interview, the facility failed to provide privacy during a bed bath for 1 of 3 sampled dependent residents (Resident #11) whose care was observed. Findings include:	F 164	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1. Nursing Assistant providing care for resident #11 on 9/22/2011 (NA #2) was provided 1:1 education on providing privacy during bathing. 2. Dependent residents and residents requiring assistance with bathing and/or personal care have the potential to be affected. Nursing assistants and licensed nurses were in-serviced by the Staff Development Coordinator (SDC) on providing privacy during bathing and personal care. In-service education for nursing assistants and licensed nurses regarding resident rights and dignity was provided by Therapeutic Alternatives on 10/20/2011 and on 10/26/2011. 3. DNS, SDC, and/or Nursing Supervisor will observe nursing assistants providing bathing or personal care 10 x per week x 2 weeks, 3 x week x 2 weeks, weekly x 4 weeks, then monthly x 1 month to validate privacy is maintained during care. 4. Result of these observations will be reported to the facility's Performance Improvement Committee monthly x 3 months for further recommendation.	F 164 10/31/2011

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

Executive Director 26 OCT 11

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

T.T. N.B.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 164	Continued From page 1 Resident #11 was admitted to the facility on 12/08/06. Cumulative diagnoses included peripheral vascular disease, diabetes mellitus, depression and cerebrovascular accident. According to the most recent Annual Minimum Data Set (MDS) assessment of 08/24/11, Resident #11 had a score of 5 out of 15 for cognition. He needed total care from staff for dressing, toilet use, hygiene and bathing. On 09/22/11 at 9:45 AM, Nurse Aide #2 (NA#2) was observed preparing to provide a bed bath for Resident #11. As she was preparing her basin of water, a family member came in to visit with his roommate. The roommate was positioned in a reclined gerichair horizontally between the two beds. It was noted that the privacy curtain between the two beds was drawn approximately three quarters between the beds with the bottom half of the roommate's body in view. NA#2 closed the door to the room and placed her supplies on the overbed table. She began providing the bed bath to Resident #11. She did not pull the privacy curtains around his bed to provide privacy. The family member was moving about on the roommate's side of the room during the time care was being provided. As she provided the bath, she used a towel to cover his upper body while washing the perineal area leaving his entire lower body exposed. He was in plain view of the visitor. NA#2 never pulled his privacy curtain. NA#2 was interviewed immediately following the observation. On 09/22/11 at 10:30 AM, she stated she did not pull the privacy curtains around	F 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 164	Continued From page 2 Resident #11's bed because the curtain gets caught in her hair making it difficult to provide care. She added that it was also hot with the curtain pulled. After discussion, NA#2 agreed that pulling the privacy curtain would have been appropriate. Resident #11 was interviewed on 09/23/11 at 10:00 AM. When asked if he liked being bathed without his privacy curtains pulled, he shook his head that he did not. He also indicated that the aide would sometimes pull the privacy curtain but not always. During an interview with the Director of Nursing Services (DNS) on 09/23/11 at 3:00 PM, she stated it was the expectation that all staff provide total privacy when providing personal care. She stated the privacy curtain should be pulled around the resident's bed to totally enclose the resident's bed any time personal care was being provided.	F 164	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, staff/resident and family interviews and record review, the facility failed to promote the dignity of 1 of 14 sampled residents (Residents # 11) by allowing the to sit in soiled undergarments for an extended length of time. Findings include:	F 241	1. Nursing Supervisor identified as working the 7a-7p shift on 9/17/2011 was provided in-service education and counseling regarding the facility's expectations for prompt call bell response and meeting residents' needs. 2. Residents using the call bell to request assistance have the potential to be affected. Nursing assistants, licensed nurses, and general facility staff were provided in-service education by the Staff Development Coordinator (SDC) regarding the facility's expectations for prompt call bell response and meeting residents' needs. In-service education for nursing assistants, licensed nurses, and general facility staff regarding resident rights and dignity was provided by Therapeutic Alternatives on 10/20/2011 with additional in-servicing by the Ombudsman on 10/26/2011. 3. Department Managers will monitor call bell response during Angel Care Rounds 3 x week x 2 weeks, weekly x 6 weeks, then monthly x 1 month. Alert and oriented residents will be interviewed during the Angel Care Rounds to determine satisfaction with call bell response. Call bell testing to judge response time will monitor non-interviewable residents.	F 241 10/31/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 241	Continued From page 3 1. Resident # 11 was re-admitted on 05/10/11 with cumulative diagnoses of Parkinson's disease, chronic obstructive pulmonary disease, depression and mild dementia. The resident's care plan, dated 01/13/10, indicated Resident # 1 was incontinent of bowel and bladder. The goal of keeping him clean, dry and free of skin breakdown would be accomplished by giving perineal care in the morning,evening and after each incontinent episode. A Quarterly Minimum Data Set (MDS), dated 08/05/11, indicated Resident # 11 was able to be understood and was able to understand others. The resident was coded as cognitively intact. There were no behaviors or rejection of care coded on the MDS for Resident # 1. Resident # 1 was coded as requiring total assistance of staff for bed mobility, transfer, toilet use and personal hygiene. On 09/20/11 at 4:15 PM Resident # 11 was interviewed in the presence of his Responsible Party (RP) . The resident shook his head no when asked if the staff treated him with dignity and respect. The RP interjected and stated the previous Saturday, (09/17/11) during the 7:00 AM to 7:00 PM weekend supervisor's shift, Resident # 11 used his call bell to request assistance with toilet use. When the supervisor entered the room, he asked what was needed and turned the call bell off. He stated he would find the Nursing Assistant (NA). The resident and his RP stated the Nursing Supervisor did not offer to assist with the resident's toileting needs. Resident # 11	F 241	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 4. Result of these Angel Care Rounds and call bell testing will be reported to the facility's Performance Improvement Committee monthly x 3 months for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 241	Continued From page 4 stated when the NA came to the room, she stated no one had paged her or told her he needed assistance. By that time, the resident and the RP stated the resident had voided on himself and had sat in the soiled undergarment for approximately 30 minutes according to her watch. Resident # 11 stated he was very angry and humiliated over soiling himself. The Director of Nursing (DON) was interviewed on 09/23/11 at 10:15 AM. The DON stated the expectation was for all staff to answer the light and attend to the immediate need when possible. If the staff member could not attend to the need, a time frame was expected to be given to the resident of when the need would be met. The DON added if the NA could not be found, the expectation was for the nursing supervisor to assist with the resident's needs. On 09/25/11 at 12:36 PM, a telephone interview was held with the Nursing Supervisor. He stated he had answered a call bell for Resident # 11 on 09/17/11. The resident stated he needed assistance with toileting. The supervisor stated he told the resident he would get the NA. On the way out, he passed the hall nurse. The supervisor stated he instructed the hall nurse to notify the NA of the resident's need. He added he had not offered to assist Resident # 11 with his toileting needs. The supervisor added had he known it was an immediate need, he would have assisted. On Sunday (09/18/11), the RP again came to him for assistance with Resident # 11. At that time, the nursing supervisor stated he found out about the resident sitting for a long period of time in a soiled undergarment on 09/17/11. The nursing supervisor stated he did	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 241	Continued From page 5 not report the incident to the DON. Attempts were made to interview the NA. The phone was no longer in service. A message was left with the nursing staff for the NA to return the call. No call was returned.	F 241	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 253 SS=B	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record reviews, the facility failed to keep furniture in good working order, failed to keep air conditioning units free of rust, failed to keep walls in good repair and failed to repair a sink in a timely manner on 4 of 4 halls (100 hall, 200 hall, 300 hall and 400 hall) that were observed. Findings include: During the initial tour of the building on 09/19/11 at 2:20 PM, the following was observed: On the 300 hall wallpaper was missing by the bath on the 300 hall, the air conditioner (ac) in room 325 was rusty and the top was not fitted properly exposing sharp edges, in room 327 the bottom of the nightstand was badly damaged with the finish off exposing the bare board. The top screen of the ac was not fitting properly leaving exposed edges. Dust and debris were seen inside the opened control box on the ac in room 327. In the day room on the 300 hall, there was dirt and debris seen in the opened control box on the ac. The	F 253	October 10, 2011. Wallpaper in room 216 was repaired on October 4, 2011. Toilet tank lid was replaced in room 206 on September 23, 2011. Bathroom floor in room 207 was stripped and re-waxed on September 27, 2011. The 200 Hall central bath was cleaned on September 27, 2011. Wallpaper on 300 Hall by bath was replaced on October 6, 2011. 2. Residents residing in the facility have the potential to be affected. Maintenance staff were in-serviced on October 13, 2011 on making required daily rounds, submission of work orders, management of work orders. Housekeeping staff were in-serviced on cleaning procedures and the submission of work orders on October 14, 2011. Angel Care staff members were in-serviced on October 13, 2011 on how to complete work orders during the routine rounds they make three times per week. Resident rooms and common areas were inspected and required repairs or replacements were completed during the period of September 23, 2011- October 31, 2011.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 6 front of the ac had dried fluid and dust present. The baseboard by the day room door was torn. On the 200 hall, in room 207, the edge was off the wardrobe leaving a jagged, sharp edge. The floor in the bathroom of room 207 was soiled with brown spots and the towel bar was rusty for the length of the bar. In room 208, the door was missing from the cabinet over the wardrobe. In room 209, dead flies were laying on top of the ac. The shower room on the 200 hall had odor. The 400 hall was then observed. The night stand in room 408 had rough edges with part of the finish missing, a geriatric chair placed in the hallway had white dried material covering the left side panel. In room 414 the wardrobe was found with rough,jagged edges with splintery material exposed. In rooms 413 and 415, dressers were seen in poor repair with missing drawer knobs. An additional tour was made on 09/20/11 starting at 4:00 PM. On the 200 hall, in room 216, the baseboard was loose for approximately 18 inches in the bathroom. Wallpaper was found loose on the left side of the door. In room 216, a towel was placed under the ac. The resident in the room stated the towel had been placed because the ac was leaking. Rough edges were evident on the ac in room 212 exposing sharp edges. The door was missing from the cabinet over the wardrobe in room 208. During observations of the 100 hall, dried materials were seen on the wheelchair in room 103. The resident and his Responsible Party (RP) stated the wheelchair had not been cleaned since his admission on 05/10/11. In room 107,	F 253	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 3. Maintenance Director or Maintenance Assistant will continue to make daily rounds but will also complete an audit on ten rooms per day, 5 days per week for 4 weeks, then two times per week for 4 weeks, then once per week for 4 weeks to ensure repairs are effected timely. The administrator, or his designee, will also complete an audit sheet on 8 rooms (2 rooms per hallway) once per week for 12 weeks. 4. Results of these audits will be reported to the facility's Performance Improvement Committee monthly for three months, for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 7 the ac top was not fitting properly exposing sharp edges. The over bed table was worn with sharp edges. The night stand had several worn rounded edges with the finish removed exposing the wood underneath. In room 113, the wardrobe was damaged with pieces of the finish missing exposing the base wood. In room 302, floor tiles were missing by the wall. The toilet paper holder in the bathroom 302 was rusty. A black substance was seen in the corner of the room with the wall covering buckled. In room 306, knobs were missing from the dresser. The door was missing from the cabinet over the wardrobe in room 306. In room 319, the over bed table was rusty with the finish missing from the edges. The ac was rusty and the top panel was not fitted properly exposing sharp edges. On 09/21/11 at 1:20 PM, an interview was held with the Maintenance Director (MD). He stated nurses, nursing assistants, residents and family members could request repairs. Requests were received either on a work order form or verbally. Those requests submitted on a work order were signed when the job was completed. Forms were kept for a period of approximately a year. The MD stated he made rounds in the building daily but did not have a check sheet to document routine assessments of individual rooms. This past summer, he stated halls 100 and 200 received new paint in every room and anything that needed to be repaired had been repaired. On halls 300 and 400, the MD stated the floors had been stripped and the halls painted. The painting should be completed by the end of November 2011. The MD stated he was responsible for the furniture maintenance and added he looked at furniture daily on his rounds.	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 8 He added he was not aware what the regulation indicated about what condition resident furniture should be. The MD added it was logical to replace the furniture when it was no longer good. Floor tiles were replaced by a contract company. The MD added he knew there were tiles that needed to be replaced on the south hall (300 hall), but no plans were in place to replace the tiles. The MD stated ac's were checked daily. The MD and the Housekeeping supervisor accompanied the surveyor on rounds of the building that started on 09/21/11 at 3:10 PM. He stated he was unaware of the baseboard being loose in room 216. The MD stated the loose baseboard presented a hazard since pests could harbor behind the baseboard and water could collect. In room 208, the MD stated he was unaware the door was down. In room 206, he stated he was unaware of the rough edge on the furniture. The MD added a resident could easily get a splinter in their finger. He acknowledged he did not know the back of the toilet tank was chipped presenting the risk of a resident cutting themselves. He added the towel bar was rusty and needed to be replaced, but added he was unaware of the rust on the towel bar. In room 209, the MD observed the dead flies that remained in the ac (same flies as observed on Monday). He stated that could have been easily cleaned. In room 107, the MD stated he was unaware of the over bed table damage and added the table needed to be replaced. He added the ac tops needed to be sanded to remove the rust and repainted. In room 306, the MD stated he was unaware knobs were missing from the dresser. He added the ac grate was in a dangerous position and could injure residents on	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 9 the sharp edges. In room 307, the MD stated he was not aware of the wall damage and the missing furniture knobs. In room 327, the MD stated he was unaware of the knobs missing leaving exposed screw ends that could easily cause damage to a resident. In room 302, the MD stated the wall damage had been caused by leaking during the recent rain. He was unaware of what the black substance on the ceiling could be. On 09/21/11 at 3:50 PM, the Housekeeping Supervisor was interviewed. The supervisor stated his expectations were for the housekeeping staff to wipe the ac's off daily. He added while the housekeeping staff did not have access to a vacuum cleaner, there was no reason the flies had been on the ac for 3 days, since the flies could have easily been wiped off. The supervisor stated he expected his staff to report any items in a resident's room that needed repair. He added of all the things he had observed, he found the screws sticking out of the wardrobe as the most dangerous. On 09/21/11 at 4:10 PM, Resident # 11 reported the drain pipe under his sink was taped. He stated the pipe was clogged about 2 weeks ago. The resident added the MD came in to fix the clog. After declogging the sink, the sink still leaked so the MD taped the pipe. Resident # 11 stated he did not think that was a way to fix the sink, adding he was sure that was not the way anyone would want it done in their home. He stated it would have taken the MD maybe 10 minutes and about $2.00 to fix the leak. The resident thought the sink should have been fixed promptly and not still be taped 2 weeks later. An	F 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 10 observation was made of Resident # 11's sink at 4:30 PM. The sink pipe was wrapped with black tape. On 09/22/11 at 8:20 AM, the MD was interviewed about Resident # 11's taped sink. He stated his assistant had placed the tape until parts could be bought. The MD stated the tape had been on the sink at least 2 weeks. He added it was a job that would have taken 5 to 10 minutes and described the sink repair as a "cheap repair". He stated the repair just slipped his mind. The MD stated the facility was the resident's home and most would not tolerate that type of work in their home. An interview was held with the Administrator on 09/23/11 at 1:30 PM. He stated he did not expect knobs on furniture to be missing, doors missing or broken and Resident # 11's sink should have been fixed in 2 to 3 days. He stated the mold on the ceiling should have been removed. The Administrator stated he expected any staff to report any needed repairs promptly. At the end of July 2011, the Administrator stated he started making daily rounds of the building with the MD and the Housekeeping Supervisor. The rounds focused on the hallways.	F 253		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 11 by: Based on observation, record review and staff interviews, the facility failed to provide grooming services for 1 of 1 sampled dependent residents (Resident #9) who was in need of shaving. Findings include: Resident # 9 was admitted on 05/11/11 with cumulative diagnoses of hypertension, chronic obstructive pulmonary disease and contractures. Resident # 9's care plan, dated 05/23/11 identified he had a problem with self care related to hygiene. The goal indicated he would be clean, neat and odor free through the next review. Approaches included shaving daily and as needed and provision of morning and evening care per facility policy and protocol. The Quarterly Minimum Data Set (MDS), dated 07/30/11, indicated Resident # 9 was cognitively intact. He was identified as requiring total assistance of staff for transfer, dressing, bathing and personal hygiene. Resident # 9 was not coded as rejecting care. Nurse's notes were reviewed for Resident # 1 from 09/01/11 through 09/20/11. There was no documentation he rejected care. On 09/19/11 at 3:00 PM, during the initial tour of the facility, Resident # 9 was observed with a growth of facial hair. He stated he liked to get up early, but had a hard time getting the 11 to 7 shift to do things for him. On 09/20/11 at 9:30 AM, Resident # 9 was dressed and sitting in his wheelchair at the	F 312	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1. Resident #9 was shaved 9/23/11. Nursing assistants #2 and #4 were provided in-service education by the Staff Development Coordinator (SDC) on the facility's policy for AM care, including shaving. 2. Dependent residents and residents requiring assistance for shaving have the potential to be affected. Nursing assistants and licensed nurses were provided in-service education by the SDC on the facility's policy for providing AM care, including shaving. Alert and oriented residents were interviewed to determine individual preference for shaving frequency. Individual preferences were added to the Resident Care Cards. 3. Department Managers will observe residents for facial hair during Angel Care Rounds 3 x week x 2 weeks, weekly x 6 weeks, then monthly x 1 month. Residents in need of shaving will be identified and the DNS or ADNS notified. The DNS or ADNS will notify the assigned nursing assistant and validate shaving is completed. 4. Result of these Angel Care Rounds will be reported to the facility's Performance Improvement Committee monthly x 3 months for further	F 312 10/31/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 12 nurse's station. He was unshaven. Resident # 9 was interviewed on 09/21/11 at 10:10 AM. He stated his last shave occurred on Sunday (09/18/11). Since then, no one had offered to shave him. The resident acknowledged he needed to have a shave. Nursing Assistant (NA) # 2 was interviewed on 09/22/11 at 9:00 AM. She stated she worked with Resident # 9 on the 7 to 3 shift. The NA stated in addition to a bath, morning care included oral care, nail care and shaving the men every other day. She stated she had never seen a care plan for Resident # 9. The NA added Resident # 9 did not refuse care and identified him as alert and oriented. NA # 2 stated the resident liked to get up early. She added if he needed a shave and the 11 to 7 shift did not shave him, then she was responsible. NA # 2 stated she had worked with the resident on 09/20/11 and admitted she had not shaved him. The only reason the NA gave as to why she did not shave him that day was he got up late and after rising, rolled himself around the facility in his wheelchair. Nurse # 4 was interviewed on 09/22/11 at 3:15 PM. She worked with Resident # 9 on the 7 to 3 shift. She stated he was alert and oriented. Nurse # 4 stated she had not noticed the resident needed a shave. The Director of Nursing (DON) was interviewed on 09/23/11 at 10:15 AM. The expectation was for morning care to include a bath, oral care, nail care and a shave as needed. She stated if the resident arose early then shave him before he left the room. The DON added if a resident rolled	F 312	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 13 around the facility, he eventually returned to his room and shaving could be completed then.	F 312	*This Plan of Correction is the center's credible allegation of compliance.*	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff and resident interviews and record reviews, the facility failed to provide the ordered treatment on a pressure ulcer and/or failed to report the reassessment of a pressure ulcer for 1 of 2 sampled residents (Resident # 9) whose pressure ulcer was reviewed. Findings include: Resident # 9 was admitted on 05/11/11 with cumulative diagnoses of pneumonia, chronic obstructive pulmonary disease, hypertension, paraplegia, and anemia. Nursing Admission Assessments, dated 05/11/11, indicated Resident # 9 had pressure ulcers on his sacrum and his left hip area. The Weekly Pressure Ulcer Condition Report, dated 05/12/11, indicated a left trochanter pressure ulcer that measured 2 centimeters by 1	F 314	*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1. Resident #9 left trocanter pressure ulcer was reassessed by the wound nurse and treatment order implemented on 9/20/2011. 2. Residents with pressure ulcer treatments have the potential to be affected. Licensed nurses were provided in-service education by the Staff Development Coordinator (SDC) on the facility's policy for assessing and treating pressure ulcers. Residents with physician orders for pressure ulcer treatments were reviewed to validate the physician's orders and pressure ulcer assessments were current and appropriate. The initial on-site visit by the representative from The Carolinas Center for Medical Excellence (CCME) occurred on 10/14/2011 for review and recommendation in the development of this plan of correction. 3. DNS or ADNS will audit Treatment Administration Records daily (Monday-Friday) to ensure pressure ulcer treatments are completed as ordered and treatment orders are current and appropriate. The Wound Nurse will assess pressure ulcers weekly and contact the physician if treatment order changes are required. The DNS or ADNS will monitor the weekly pressure	F 314 10/31/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 314	Continued From page 14 centimeter. The treatment nurse indicated the ulcer was a healing Stage IV. Undermining was documented as 0.5 centimeters. Necrotic tissue covered less than 25% of the wound bed. The care plan for Resident # 9, with an onset date of 05/23/11, indicated impairment of his skin integrity. Approaches to prevent new skin breakdown included turning and positioning often, use of positioning and pressure relieving devices and skin checks weekly. Review of the May 2011 Treatment Record indicated Resident # 9 received pressure ulcer treatments to both his sacrum and his left trochanter. There was an entry for weekly skin checks that directed the nurses to document positive findings with a plus mark (+) and negative findings with a dash (-). Positive findings were to be reported to the treatment nurse and documented in the nurse's notes. There was no indication of assessment on the treatment sheet for weekly skin checks. Pressure ulcer dressings were undocumented for 1 day from Resident # 9's 05/11/11 to 05/31/11. No explanation for the lack of initials was documented. The Treatment Record for June 2011 indicated a weekly skin check for Resident # 9 had been completed only once for the month. Pressure ulcer treatments to his sacrum and/or his left trochanter had been undocumented twice. No explanation was given on the treatment sheet or in the nurse's notes for the lack of documentation. The 07/12/11 Weekly Pressure Ulcer Condition	F 314	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* ulcer assessments and treatment orders weekly during the Standards of Care meeting to validate weekly assessments are completed and treatment orders remain current. Follow-up conference calls with the representative from CCME have been scheduled for 2 and 4 weeks post initial on-site visit for further review and recommendation. 4. Weekly Standards of Care minutes will be reviewed by the facility's Performance Improvement Committee monthly x 3 months for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 314	Continued From page 15 Report indicated the wound had been debrided the week before. Measurements were listed as 2.5 centimeters by 1.5 centimeters with 4.5 centimeters of tunneling in the 3:00 PM position. Resident # 9's Quarterly Minimum Data Set (MDS), dated 07/30/11, coded the resident as cognitively intact. The MDS also indicated Resident # 9 was dependent on staff for transfer, personal hygiene, dressing and toilet use and required extensive assistance for bed mobility. The MDS did not indicate Resident # 9 rejected care. The assessment was coded to reflect 2 - Stage IV pressure ulcers with the largest measuring 4 centimeters (cm) by 4 cm by 4 cm with slough present. Skin and ulcer treatments included nutrition or hydration intervention, ulcer care, application of non-surgical dressings and applications of ointments and medications. The July 2011 Treatment Record indicated the sacral treatment was ordered every 3 days. Review of the record indicated the treatment was completed on 07/12/11 and then not documented as done again until 07/18/11. On 07/24/11, the sacral treatment was not documented as completed. The treatment nurse documented the reason for not completing the pressure ulcer treatment as "already up in motorized wheelchair." The treatment to the left trochanter was not documented as completed on 07/09/11 and 07/22/11 with no reason given. The treatment was not documented as completed to the left trochanter on 07/24/11 because the resident was not in bed. Weekly skin checks were not entered on the treatment sheet for the month of July.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 314	Continued From page 16 Physician orders received on 08/15/11 indicated Resident # 9's left trochanter pressure ulcer should be dressed daily and as needed for leakage and dislodgement using a wet to dry dressing. Orders indicated this treatment order was good for 30 days, then reassessment would be completed. The physician's order was signed as received by the Treatment Nurse. The discontinuation date was listed on the treatment sheet as 09/15/11. Review of the August 2011 Treatment Record indicated weekly skin checks were completed as ordered. The Treatment Record indicated the sacral pressure ulcer healed on 08/01/11. Daily care was provided to the left trochanter pressure ulcer. A plastic surgery consult, dated 09/01/11, indicated the left hip (trochanter) pressure ulcer presented with a small amount of yellow drainage, The consult also indicated while there was no odor and a decrease in size, the tunneling remained unchanged. The consult also indicated the dressing should continue and a wound vacuum should be considered. There was no corresponding nurse's note or order that indicated this information was relayed to Resident # 9's attending physician. Physician's orders, dated 09/07/11, indicated Resident # 9 received Vancomycin (an antibiotic) 1 gram every 24 hours for 6 weeks for an infection in his left trochanter pressure ulcer. A Physician's Progress Note, dated 09/10/11 indicated Resident # 9 was assessed The physician documented Resident # 9 received	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 314	Continued From page 17 Vancomycin for his left trochanter osteomyelitis. There was no mention of continuing the treatment to the left trochanter. On 09/13/11, the Treatment Nurse measured the left trochanter wound as 4 cm x 2.5 cm with 5 cm tunneling. Necrotic tissue was documented as not visible. Drainage was described as bloody. On the back of the form where the treatment nurse wrote a narrative was written, "cleansed with NS (normal saline, wet to dry dressing reapplied. Daily drsg (dressing) (symbol for change)." There was no mention of physician notification or receiving new orders. Review of the September 2011 Treatment Sheet for Resident # 9 indicated the entry for the left trochanter pressure ulcer care. The order ended with 09/15/11 with the remainder of the month X'd out. The last day documented as the treatment being completed was 09/14/11. Review of nurse's notes from 09/13/11 through 09/20/11 did not indicate the assessment of Resident # 9's left trochanter pressure ulcer was reported to the physician. Notes did not indicate new orders had been received for the continued treatment of the wound. Notes for 09/16/11 and 09/19/11 did indicate a nurse other than the treatment nurse, had contacted the resident's physician's regarding another medical problem. No mention was made and no order received for the continued treatment of the left trochanter pressure ulcer. On 09/20/11, an order was written that indicated the dressing to Resident # 9's left trochanter was to continue as previously ordered. Above the	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 314	Continued From page 18	F 314		

order, was written, late entry for 09/15/11. Initial observation of the order, on 09/20/11 prior to the dressing change did not indicate the late entry notation.

An observation was made on 09/20/11 at 11:15 AM of Resident # 9 receiving left trochanter pressure ulcer treatment from Nurse # 4. Nurse # 4 removed the soiled dressing with a date of 09/18/11 and the initials of the nurse that had changed the dressing. The wound bed had approximately 10 % slough at the top edge with approximately 90 % of the wound bed appearing beefy red. The wound had a 5 cm tunnel in the 3:00 PM position. The wound was cleansed around the circumference then Nurse # 4 was observed to clean the middle. After cleansing the wound, Nurse # 4 removed the soiled gloves. Normal saline moistened gauze was placed in the tunnel using a cotton swab to pack the area. The wound was covered with a larger gauze and secured with tape.

Nurse # 4 was interviewed on 09/20/11 at 3:30 PM. She stated she did not complete the left trochanter pressure ulcer dressing for Resident # 9 on 09/18/11 because he refused to go back to bed to have the dressing changed.

Resident # 9 was interviewed on 09/21/11 at 10:10 AM. He stated the dressing to his left trochanter wound had not been changed on Monday, 09/19/11. He stated the staff told him there was not enough help that day to get the dressing change completed. He did not identify which staff member had relayed this information. Resident # 9 stated he did not refuse to go back to bed and no staff person had offered to change

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 314	Continued From page 19 his dressing. Review of the nurse's notes from 09/01/11 through 09/20/11 did not indicate Resident # 9 had refused care including pressure ulcer care. On 09/22/11 at 3:15 PM, Nurse # 4 indicated she did not change Resident # 9's dressing on 09/19/11 because she thought the order had been discontinued or the area had healed.. She added she had not checked with the Treatment Nurse to see if the wound on the resident's left trochanter had been reassessed and she did not check for a new order. She added the dressing change on 09/18/11 must have been completed without a valid order. Nurse # 4 added on 09/20/11 prior to the observed dressing change, the Treatment Nurse passed her a current order for the left trochanter pressure ulcer. Nurse # 4 added Resident # 9 did not refuse to go back to bed on 09/19/11 as she previously reported. A telephone interview was held with Nurse # 5 on 09/25/11 at 6:25 PM. She stated she had changed the dressing on Sunday, 09/18/11 for Resident # 9. She was unsure if she had changed the dressing on 09/17/11 and stated she needed to review the treatment book. On review of the treatment book, Nurse # 5 acknowledged there was no documentation the treatment was done on 09/17/11. She stated the order had expired on 09/15/11. Nurse # 5 stated she knew to change Resident # 9's left trochanter dressing because it was "routine" adding she had not checked the treatment book prior to changing the dressing. The nurse stated she had not called the physician for new orders because that was the responsibility of the treatment nurse that	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 314	Continued From page 20 worked during the week. Nurse # 5 stated she was unaware the treatment for Resident # 9 had expired. She stated Resident # 9 being out of bed was not a reason not to do his treatment. The nurse added the resident liked to get up early, but no one had mentioned either doing the treatment before he got up or after he went back to bed. On 09/23/11 at 10:15 AM, an interview was held with the Director of Nursing (DON). The expectation was for the Treatment Nurse to reassess and receive a new treatment order prior to the expiration of the previous treatment. She added that treatments were noted as completed by the initials by the treatment book entry . If a blank was on the treatment sheet, that meant the treatment had been skipped. The DON reviewed the treatment record for Resident # 9 and acknowledged he had treatments missing, weekly skin checks by hall nurses had not been completed and orders had not been received for continuing the left trochanter treatment prior to expiration of the previous treatment. The DON stated not doing a treatment because the resident was out of bed was not an acceptable excuse, adding it could be done prior to rising or after returning to bed. Telephone calls and messages with a return number were left for the Treatment Nurse on 09/30/11 and 10/05/11. No call back was received. Calls were placed to the resident's physician on 10/05/11 with no return call received.	F 314		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 325	Continued From page 21 Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to implement physician ordered interventions for weight loss prevention for 1 of 1 sampled resident (Resident # 1) reviewed for weight loss. Findings include: Resident # 1 was admitted on 05/19/11 with cumulative diagnoses of left knee replacement and anorexia. The Admission Nursing Assessment listed Resident # 1's weight as 238 pounds on 05/19/11. An Admission Minimum Data Set (MDS), dated 05/25/11, indicated the resident had clear speech and was understood and able to understand. He was assessed as cognitively intact. Resident # 1 had no behaviors or rejection of care noted. The MDS indicated Resident # 1 was independent with eating. His weight was recorded as 238 pounds.	F 325	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 1. Resident #1 tray card was updated to include double portions for all meals. 2. Residents with physician's orders or dietary recommendations for diet changes have the potential to be affected. Nursing assistants and licensed nurses were provided in-service education by the Staff Development Coordinator (SDC) regarding the facility's policy for documenting meal intake, implementing diet changes, notification of the dietary department of diet changes, and use of the Nutrition/Nursing Communication forms for kitchen notification. Nutritional Services Manager completed resident tray card and diet order comparison to validate accuracy for current residents. 3. The DNS or ADNS will identify new diet orders or diet order changes daily (Monday-Friday) during clinical rounds and validate the kitchen was notified using the Nutrition/Nursing Communication form (carbon copy remains in communication book). Nutritional Services Manager will audit 10 meal trays weekly x 4 weeks, then monthly x 2 months to validate food provided on the tray is appropriate per the tray card.	F 325 10/31/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 325	Continued From page 22 Weights recorded on the Weight History Sheet indicated Resident # 1 weighed 229.40 pounds on 06/03/11, 227 pounds on 07/11/11, 221.5 on 08/02/11 and 219.8 pounds on 08/08/11. On the Quarterly MDS, dated 08/06/11, Resident # 1 was coded as cognitively intact and independent with eating. His weight was recorded as 229 pounds with no significant weight loss identified. Review of the August 2011 Individual Resident Meal Intake Record indicated the resident normally consumed 100% of his meals and snacks. Nutritional progress notes, dated 08/30/11 indicated Resident # 1's weight was 215 pounds. The Registered Dietician (RD) further documented the resident had experienced a gradual weight loss over the previous 3 weeks, however, the ADL (Activities of Daily Living) flow sheet showed good intake of 75% to 100%. The RD indicated she recommended double portions. A physician's order was received for double portions of all meals. Resident # 1's care plan with a revision date of 08/31/11, identified he had a nutritional problem. The third goal was to maintain his current weight of 214 pounds +/- 5 pounds for the next 90 days. Approaches to reach that goal included notifying the physician and RD of significant weight changes, monitor weights, provide the diet as ordered and on 08/31/11, double portions was added. An observation was made on 09/20/11 at 12:50	F 325	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 4. The Nutrition/Nursing Communication book and meal tray audits will be reviewed by the facility's Performance Improvement Committee monthly x 3 months for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 325	Continued From page 23 PM. Resident # 1 received 1 pork chop on his lunch tray. The tray card indicated he received standard portions. The breakfast observation, made on 09/21/11 at 8:30 AM, indicated Resident # 1 received eggs, 1 slice of bacon, grits, toast and jelly. Portion size was standard according to the tray card. The resident was interviewed at 11:40 AM. He stated he ate the slice of bacon and about half of his eggs. Resident # 1 stated he left food on his plate most meals. Nurse # 2 was interviewed at 11:50 AM. She stated Resident # 1 was alert and oriented. She added if he were confused it was infrequent. An observation was made of Resident # 1's lunch on 09/21/11 at 12:50 PM. He received a salad consisting of lettuce, cucumbers, and approximately 12 strips of shredded carrots with 4 strips of chicken on top. The tray card indicated this was a standard portion. The resident was observed spitting out the cucumbers indicating the cucumbers were too tough to chew. At 5:45 PM on 09/21/11, the dinner tray card indicated standard portions. For dinner, Resident # 1 received standard portions of cabbage, potatoes, 2 sausages, ice-cream, chocolate milk shake. During this observation, Resident # 1 stated he could not eat the sausage because they were too tough. He added he did not eat all of his lunch. On 09/22/11 at 8:45 AM the resident received grits, hash browns and 1 strip of bacon. The tray card indicated he received standard portions.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 325	Continued From page 24 On 09/22/11 at 8:53 AM, the Dietary Manager (DM) was interviewed. The DM stated when a resident received orders for a diet change, the process included nursing sending a communication slip to the dietary department with the change in diet listed. Anyone that received double portions would have that information written on their meal tray card. The DM reviewed the tray card for Resident # 1 and stated he did not receive double portions. The DM added resident intake was determined by the information nursing assistants entered on the meal intake record. She reviewed the 08/30/11 RD note and the physician's order and acknowledged she was unaware Resident # 1 was to get double portions of all meals. The DM stated if Resident # 1 continued to receive standard portions instead of the ordered large portions, he may continue to have weight loss. Review of the communication book did not reveal a copy of an order for Resident # 1's large portions. An interview was held with Nursing Assistant (NA) #1 on 09/22/11 at 10:05 AM. NA #1 stated she had worked with Resident # 1 on the 7 to 3 shift since he was admitted. She added that most of the time, Resident # 1 was alert and oriented. The NA stated the resident's intake was variable. She stated if he ate 100% of his breakfast he rarely ate 100% of his lunch. She added that some days, Resident # 1 barely touched any of his foods. The NA stated Resident # 1 never ate 100% of both breakfast and lunch. When asked, NA # 1 identified Resident # 1 as receiving double portions. She stated she knew this because it was listed on his tray card. The NA reviewed the tray card for Resident # 1 and acknowledged the information for a double portion was not on the	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 325	Continued From page 25 card. She then stated the nurse on the hall had told her. NA # 1 stated the resident had not received double portions for his breakfast or lunch on 09/21/11. The NA added she had not questioned the standard portions. After review of the Meal Intake Record for August 2011, NA # 1 stated the documented percentage of meal intake was inaccurate. The NA stated at times she just did not have the time to find the resident's tray to see how much food he had consumed, so therefore, she just wrote something on the meal intake record. On 09/22/11 at 2:25 PM, Nurse # 2 was interviewed. Nurse # 2 received the 08/30/11 physician's order for double portions of all meals. The nurse stated when a dietary order was received, the green copy of the order was hand delivered to the dietary department. Nurse # 2 identified Resident # 1 as a resident on her hall that received double portions. She added the information about double portions should be listed on the tray card. The nurse stated she had not realized Resident # 1 had not received his double portions adding the NA had not reported this to her. Nurse # 2 added that Resident # 1 usually consumed between 50% to 75% of each meal. The Director of Nursing (DON) was interviewed on 09/23/11 at 10:15 AM. She stated when a diet change order was received, the expectation was for that order to be communicated with the dietary department by either using a communication sheet or forwarding the green copy of the order. The DON stated the NA would know about a resident's diet by looking on the tray slip. The DON stated she had spoken with Nurse # 2 who assured her the 08/30/11 order for	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 325	Continued From page 26 Resident # 1 had been forwarded to the dietary department. She had no explanation why Resident # 1 had not received the diet. The DON added she was disappointed the intake record did not match the resident's actual intake.	F 325	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interview, the facility failed to provide timely podiatry services for 1 of 1 sampled dependent residents (Resident #11) who was in need of toenail care. Findings include: The rationale for the facility's procedure for the care of nails (finger and toe), last revised on 10/31/10, was to provide cleanliness, prevent the spread of infection and prevent skin problems. In the procedure section of the procedure, a basin of clean water was to be used to soak the resident's feet. Once soaked, the nails were to be scrubbed gently with a brush. The feet were to be removed from the basin and placed on a	F 328	1. Resident # 11 was seen by the podiatrist on 9/26/2011 and toenails were trimmed. 2. Dependent residents and residents requiring assistance with toenail care have the potential to be affected. Current residents were assessed by the Wound Nurse and the ADNS to identify residents needing toenail care. These identified residents received toenail care, as appropriate according to their medical diagnoses. The toenails were either trimmed by the nurses and nursing assistants or arrangements made for the residents to be seen by the podiatrist. Nursing assistants and licensed nurses were provided in-service education by the Staff on the facility's policy for toenail care. Nursing assistants will provide nail care daily during bathing services. Nurses will assess toenails weekly during the weekly skin assessments and provide nail care or initiate podiatry consult as appropriate. 3. The Wound Nurse will assess 10 residents' toenails weekly x 8 weeks, then monthly x 1 month to validate toenail care is provided as appropriate. 4. Results of these assessments will be reviewed by the facility's Performance	F 328 10/31/201

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 328	Continued From page 27 towel. The nails were to be trimmed and cleaned then filed smoothly. A note indicated if the resident was diabetic, the nurse or podiatrist would cut the toenails. Resident #11 was admitted to the facility on 12/08/06. Cumulative diagnoses included peripheral vascular disease, diabetes mellitus, schizophrenia, depression and cerebrovascular accident. A podiatry visit note of 09/01/10 was found in Resident #11's chart indicating he had been seen for painful mycotic toenails. There were no other notes to indicate he had been seen since that time. According to the most recent Annual Minimum Data Set (MDS) assessment of 08/24/11, Resident #11 had a score of 5 out of 15 for cognition. He needed total care from staff for dressing, toilet use, hygiene and bathing. He was always incontinent of bowel and bladder. The Care Area Assessment (CAA) summary for this assessment indicated he triggered in 9 areas which included activities of daily living (ADL). The ADL CAA indicated he needed assistance with his care and was carried to care plan. Resident #11's care plan, last reviewed on 09/08/11, identified problems with self care deficit in regards to hygiene and bathing/showers. Approaches included in both of these care plans were to clean and check toenails. During an observation of a bed bath, on 09/22/11 at 9:45 AM, Nurse Aide #2 (NA#2) removed the covers from his body and it was noted that the	F 328	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Improvement Committee monthly x 3 months for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 328	Continued From page 28 great toenail on his right foot was very discolored and curled down over the tip of his great toe. The other toenails on his right foot were noted to be very long and thick as well as discolored. The great toenail on the left foot was noted to be very thick and discolored. NA#2 completed his bath but did not provide nail care to his toenails. NA#2 was interviewed on 09/22/11 at 10:30 AM. She stated it was the responsibility of the aide to clip fingernails and toenails as long as the resident was not diabetic. She stated if the resident was diabetic, the hall nurse would cut them. She stated this was usually done during the bath. When questioned if she had noticed Resident #11's toenails, she stated they needed to be cut but he was diabetic so she would have to ask the nurse to cut them. NA#2 stated she had not reported the long toenails to the hall nurse. Resident #11 was interviewed about his toenails on 09/23/11 at 8:30 AM. He stated staff never cut his toenails. When questioned as to why, he responded he did not know why. He denied any pain associated with the curled great toenail. During an interview with Nurse #3, on 09/23/11 at 9:00 AM, she stated if a resident needed to be seen by the podiatrist the nurse could fill out a form and give it to staff person #1 as she was responsible for overseeing podiatry visits. Nurse #3 added that if a resident needed to be seen before the scheduled podiatry visit, all one needed to do was to call and schedule an appointment as the facility would transport them to the podiatrist's office.	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 328	Continued From page 29 Nurse #4 indicated during an interview on 09/23/11 at 9:05 AM that Resident #11 did not resist care and was alert and oriented to time, person and place. She stated if he needed podiatry care she would complete a form and give it to staff person #1. During an interview with the Assistant Director of Nursing Services (ADNS) and staff person #1, on 09/23/11 at 9:15 AM, the ADNS stated the podiatrist visited the facility every 90 days. She stated it was the responsibility of the nurse aides on the hall to report any resident who was in need of podiatry services to the hall nurse so that resident could be placed on the list. Staff person #1 stated a list was faxed to the podiatrist's office of the resident's who had been seen the last time the podiatrist visited the facility. The ADNS stated staff person #1 was responsible for advising the nurses as to which residents were on the list and the nurse could add anyone they felt needed to be seen. The Assistant Director of Nursing Services (ADNS) indicated during an interview on 09/23/11 at 11:00 AM that Resident #11 had been placed on the podiatry list two weeks ago. She stated she had looked at his toenails today and his toenails should have been addressed at that time rather than placing him on the list to be seen. The ADNS stated his toenails were in need of care and she had scheduled an appointment for him to go out to the podiatrist on 09/26/11 at 9:00 AM. She also reported that she had conducted an inservice for staff on his hall. She added that she had tried to cut them today but they were too thick. The ADNS also stated she would check to see if Resident #11 had been seen the last time	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 328	Continued From page 30 the podiatrist had visited in June 2011. At 2:00 PM on 09/23/11 the ADNS provided a list of residents who had been seen by podiatry on 06/09/11. It was noted that Resident #11's name was not on the list. The Director of Nursing Services (DNS) was interviewed on 09/23/11 at 3:00 PM. She stated the nurse aides were responsible for cutting nails. She stated if the resident was diabetic, the hall nurse was responsible for cutting them. The DNS added that some residents had nails too thick to cut and were usually seen by the podiatrist. She stated Resident #11's long toenails should have been addressed two weeks ago when they were discovered to be in need of care instead of placing his name on the list.	F 328	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	F 441	1. Nursing assistant #2 was provided in-service education by the Staff Development Coordinator (SDC) regarding the facility's policy on linen handling to prevent the spread of infection. Resident #11 over-bed table was cleaned and disinfected. 2. Residents requiring the removal of soiled linen by facility staff have the potential to be affected. Nursing assistants and licensed nurses were provided in-service education by the SDC regarding the facility's policy on linen handling to prevent the spread of infection. The initial on-site visit by the representative from The Carolinas Center for Medical Excellence (CCME) occurred on 10/14/2011 for review and recommendation in the development of this plan of correction. 3. The SDC will observe nursing assistants handling soiled and clean linen during facility rounds daily x 2 weeks, 2 x week x 2 weeks, weekly x 1 month, then monthly x 1 month to ensure linen is handled per facility policy to prevent the spread of infection. Follow-up conference calls with the representative from CCME have been scheduled for 2 and 4 weeks post initial on-site visit for further review and recommendation.	F 441 10/31/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 441	Continued From page 31 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure that staff were following their policies and procedures for prevention of transmitting infections as evidenced by placing soiled linens on a resident's overbed table during incontinent care for 1 of 3 sampled residents (Resident #11) whose care was observed. Findings include: According to the facility's policy for the Infection Control and Prevention Program, last revised 10/31/09, an infection control and prevention program was designed to "identify and reduce the risk of acquiring and transmitting infections among residents, staff, volunteers, students, and visitors. It is maintained to provide a safe, sanitary, and comfortable environment and	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 4. Results of these observations will be reviewed by the facility's Performance Improvement Committee monthly x 3 months for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 441	Continued From page 32	F 441		

involves each department." In the Compliance Guidelines section, it was noted that policies and procedures were implemented to prevent the spread of infections that included promoting consistent adherence to Standard Precautions and other infection control practices. Included in these guidelines was staff training to identify most common symptoms of infection and protocols to prevent the spread of infections. Education and training was to be provided upon hire and as needed to ensure these polices and procedures were practiced and included sanitation procedures and transmission based precaution techniques.

The facility's "Work Practices: Laundry" policy, last revised 10/31/10, indicated that "Linen and laundry are handled in a manner to reduce the likelihood of recontamination." In the Compliance Guidelines section, it was noted that used articles of linen were to be bagged or placed in containers. The used articles of linen were either enclosed in containers or bagged to "prevent inadvertent exposures to residents, personnel and visitors and to prevent contamination of the environment."

Resident #11 was observed eating breakfast on 09/22/11 at 9:00 AM. His breakfast tray was sitting on the overbed table. A green activities calendar was noted on the table along with his water pitcher. When interviewed, he stated he usually ate breakfast in his room while he waited for staff to bathe him so he could get out to smoke.

On 09/22/11 at 9:45 AM, Nurse Aide #2 was observed preparing to provide a bed bath for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 441	Continued From page 33 Resident #11. NA#2 prepared a basin of water and placed it on the overbed table. It was noted that his water pitcher was sitting on the overbed table along with a green activities calendar. She obtained a bottle of liquid shampoo and placed it on top of the green activities calendar on the overbed table as well. She proceeded to provide a bed bath to Resident #11. As NA#2 was providing incontinent care to remove stool, she used disposable wipes. After she removed the stool with several wipes, she placed each of them on the green activities calendar as well as on the surface of the overbed table along side the bottle of liquid shampoo. NA#2 proceeded to wash away the balance of the stool with a wash cloth. She placed the stool soiled wash cloth on the overbed table as well. She continued with the bath. Once the bath was completed, she picked up the soiled wash cloth and wipes from the overbed table and placed them into a plastic bag. She discarded the soiled linens in the dirty utility room just down the hall from Resident #11's room. NA#2 went to the clean linen cart which was positioned in the hallway and obtained clean linens to change his bed linens. She came into Resident #11's room, placed the clean linens on top of the overbed table in the same place as the soiled wipes and washcloth had been. She proceeded to make his bed. Once she was finished, she bagged the linens and took them to the dirty utility room. NA#2 did not wear gloves while transporting them. She came back into his room and washed her hands. She placed the basin back into his closet and the shampoo back into the drawer where she had obtained it originally. She never cleaned the overbed table in any manner. NA#2 left the activities calendar on the table as well.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 441	Continued From page 34 NA#2 was interviewed immediately following the observation. On 09/22/11 at 10:30 AM, she stated she was to wear gloves while transporting bagged soiled linens. She stated to prevent the spread of infection she had been taught to practice good hand washing and bag soiled linens. When questioned about placing the stool soiled wipes and wash cloth on the overbed table, she stated she did not have a plastic bag to bag them so she placed them on the table. NA#2 added that in hindsight she should have had extra plastic bags. She stated that placing clean linens directly atop the green calendar and on the contaminated surface of the overbed table without cleaning it was probably not a good idea. NA#2 added that she did not have any extra wash cloths to clean the table with so she didn't clean it. She stated she would ask housekeeping to clean his overbed table. During an interview with the Director of Nursing Services (DNS) on 09/23/11 at 3:00 PM, she stated it was the expectation that all staff practice good handwashing techniques and standard precautions. She stated all residents and items were treated as if were infectious. The DNS stated she had instructed personal care staff to take the barrels with them when they were doing incontinent rounds so it was easy for them to discard soiled items. She stated staff should not be placing soiled items on the floors. The DNS stated staff should be bagging soiled linens/items and if they didn't use the barrels, to wear gloves while transporting them to the dirty utility room. She stated they should be washing their hands afterwards. The DNS indicated she would not expect staff to place stool soiled disposable wipes	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 441	Continued From page 35 or stool soiled wash cloths on any surface especially the overbed table. She stated some type of barrier should be used if staff were using overbed tables for care to prevent contaminating the surface of the tables. The DNS stated that NA#2 should have cleaned the overbed table surface before leaving the room as the resident used that table when he ate his meals.	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure that resident's clinical records were accurate and complete as evidenced by 1 of 11 sampled residents (Resident #5) who had missing occupational therapy progress notes and for 1 of 11 sampled residents (Resident #1) who had inaccurate meal intake records. Findings include: 1. Resident #5 was admitted to the facility on	F 514	1. Nursing assistant #1 was provided in-service education by the Staff Development Coordinator (SDC) on the facility policy for documenting meal intake. Unable to correct for resident #5 as missing therapy documentation has not been located. 2. Residents receiving meals or therapy services in the facility have the potential to be affected. Nursing assistants and licensed nurses were in-serviced by the SDC on accurate completion of the meal intake record. Rehab staff and medical records staff in-serviced by the ED on the importance of timely filing of information in medical records, process for filing therapy documentation, and use of documentation checklist to validate therapy documentation is present in the medical record at the time of discharge. 3. DNS or ADNS will audit meal intake records 3 x week x 2 weeks, weekly x 6 weeks, then monthly x 1 month to validate accuracy. Meal intake documentation will be compared to the actual remnants on the meal tray to validate accuracy. Rehab technicians will file therapy documentation daily in residents' medical records. The Rehab Manager will audit 8 medical records	F 514 10/31/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 514	Continued From page 36 01/17/11 and expired on 06/27/11. Cumulative diagnoses included diabetes mellitus, hypertension, atrial fibrillation and bipolar disease. A signed OT recertification request to the physician was noted for the time period of 01/18/11 through 04/12/11. A physician's order of 06/06/11 indicated to discontinue physical therapy (PT), occupational therapy (OT) and speech therapy (ST) skilled services. An OT discharge summary of 06/06/11 indicated Resident #5 had received skilled occupation therapy services from 01/18/11 through 06/06/11. The summary indicated she had been discharged due to hospice services. There were no OT progress notes for the time frame of 01/18/11 through 04/12/11 found in the closed record. During an interview with the rehabilitation manager, on 09/23/11 at 9:30 AM , the missing OT notes were requested. Upon exit from the facility at 4:00 PM, the OT notes were still missing. 2. Resident # 1 was admitted on 05/19/11 with cumulative diagnoses that included a left knee replacement, severe osteoarthritis, a dysfunction with activities of daily living (ADL), anorexia and difficulty walking. On admission, the resident's weight was 238 pounds.	F 514	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* per week x 4 weeks, then monthly x 2 months of residents on therapy caseload to validate therapy documentation is filed timely and is present in the medical record. Upon discharge, the medical records clerk and a Rehab representative will use the therapy documentation checklist to audit the medical records to ensure therapy documentation has been filed timely and is present in the medical record. Both the medical records clerk and the Rehab representative will sign the documentation checklist once the information has been validated. The Rehab manager will maintain the documentation checklists for verification the audit has been completed. 4. Results of these audits will be reviewed by the facility's Performance Improvement Committee monthly x 3 months for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 514	Continued From page 37 On 08/30/11, the Registered Dietician (RD) recommended double portions at all meals for Resident # 1 related to weight loss. The RD documented the resident continued to lose weight despite the Individual Resident Meal Intake Record reflecting an intake of 75 % to 100 % of all meals. The RD recorded the resident's weight as 215 pounds. Review of the resident's Individual Meal Intake Records from admission through August 2011, indicated he had consumed 100% of each meal offered. There were only 4 meals for the month of August that indicated Resident # 1 consumed less than 100%. Observations were made of Resident # 1's meals on 09/20/11 at 12:50 PM, 09/21/11 at 8:30 AM, 09/21/11 at 12:50 PM , 09/21/11 at 5:45 PM and 09/22/11 at 8:45 AM. The resident left at least 50% of his meals. Review of the Individual Resident Meal Intake Record for September 2011 indicated the resident had consumed 100% of his meals through 09/20/11. An interview was held with Nursing Assistant (NA) # 1 on 09/22/11 at 10:05 AM. NA # 1 stated she had worked the 7 to 3 shift with the resident since his admission. The NA described the resident's intake as usually 100% for breakfast, adding that if he ate 100% for breakfast, he rarely ate much lunch. She added this had been his normal and usual pattern since admission. The NA reviewed the Individual Meal Intake Records and stated the records were not accurate. NA # 1 stated she was not always the one that picked up trays after meals. Instead of finding the person that took the tray and verifying Resident # 1's intake, she	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345260	A. BUILDING _____ B. WING _____	C 09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUARDIAN CARE OF ROCKY MOUNT	160 WINSTEAD AVE ROCKY MOUNT, NC 27804

(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 514	Continued From page 38 would just write something down. The NA acknowledged that the documentation of inaccurate information could affect the resident's nutritional status.	F 514		