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

acepted

PRINTED: 10/09/2012 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING c/R B. WING 345410 10/05/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1287 NEWSOME STREET** CENTRAL CONTINUING CARE MOUNT AIRY, NC 27030 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Filing the Plan of Correction does not F 000 **INITIAL COMMENTS** F 000 constitute an admission that the deficiencies alleged, did, in fact, exist. This Plan of Correction is filed as No deficiencies were cited as a result of the Complaint Investigation of 10/01/12 - 10/05/12. evidence of the facility's desire to comply Event ID #KOAL11. with the requirements and to continue to 483.25(m)(1) FREE OF MEDICATION ERROR F 332 F 332 provide high quality resident care. RATES OF 5% OR MORE SS=D The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced 11/2/12 1) The Director of Nursing will in-service by: Nurse #1 on following physician orders Based on observation, record review and staff and facility policy and procedure with an interview, the facility failed to ensure the emphasis on medication administration. medication error rate was 5% or below by not The Director of Nursing, or her designee, following the physician's orders. There were four will notify the attending physician for errors out of 50 opportunities resulting in an 8% error rate affecting two (Residents # 19 & # 75) of resident #19 and #75 of the medication ten residents observed for medication administration. 2) The Director of Nursing, or the Staff Development Coordinator will conduct Findings include: individual medication pass observation with the current licensed staff and provide 1. Resident # 19 was readmitted on 7/20/12 with corrective action for non-compliance with diagnoses, dementia with behaviors and facility policies and procedures related to gastroesophageal reflux disorder (reflux of medication administration. stomach acid into the esophagus). 3) The Director of Nursing or Staff Development Coordinator will in-service Review of the physician's orders dated 10/2/12 the licensed staff on following physician indicated an order for Miralax (bulk laxative) 17 orders and the facility policy and Grams (Gms) in 8 ounces water and take by procedures for medication administration. mouth daily. The Staff Development Coordinator will Observation of medication administration on include information on following 10/4/12 at 8:30 AM revealed Nurse # 1 mixed 17 physician orders and the facility policy and Grams of Miralax in water. The nurse stated there procedures for medication administration,

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.

(X6) DATE

10/17/2012

TITLE

Facility ID: 943085

ADMINISTRATOR

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	THOUSE PERSONAL CONTRACTOR OF THE PERSON OF		(X3) DATE SUI COMPLET	
	345410	B. WING	.		5/2012
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	12	EET ADDRESS, CITY, STATE, ZIP CODE 187 NEWSOME STREET OUNT AIRY, NC 27030 PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	(X5) COMPLETION DATE
TAG REGULATORY OR I	SO DENTI TROOTS OF STREET	1,70	DEFICIENCY)		
diabetes and macular 2 a. Review of the ph 10/2/12 revealed order of chest pain) ER (ex milligrams (mg) one to (do not crush). At 8:50 AM on 10/4/1 crush the isosorbide with other medication resident's room and so from the medication of them to the resident. not administer the medication of the hallway. An interview with nurshe should not have She discarded the correspoured the medicate ER intact. 2 b. Review of the ph 10/2/12 revealed and stimulant) 15 milliliter Observation of medication of medi	diagnoses of dementia, r degeneration. ysician's orders dated ers for isosorbide (for control tended release) 60 ablet by mouth once daily 2 nurse #1 was observed to ER and mix it in applesauce as. She entered the espooned the medications cup and started to administer. Upon request Nurse #1 did edications and stepped into se #1 at that time revealed crushed the isosorbide ER. ushed medications and ations, leaving the isosorbide ensemble order for Eldertonic (appetite ris (ml) before meals. cation administration on evealed nurse #1 nic to resident #75. The ne resident had finished	F 332	in the orientation of new lic The Director of Nursing, or and/or the Staff Developme will conduct random medica observations with licensed s at least weekly for three modest monthly and provide in and/or counseling as indicate of the review process. 4) The Director of Nursing, designee, will monitor through the service of the review and Pharmace report review, at least monte months, then at least quarte medications are administered physician orders and facility procedure. Monitors will be scheduled QA Meetings. The Administrator is responsible compliance.	her designee, nt Coordinator ation pass staff members on the then at in-servicing ted as a result or her aigh diministration by Consultant hly for three rly, to assure ed according to y policy and e reviewed at the	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDI	A. BUILDING		С	
		345410	B. WING_]	5/2012	
NAME OF PROVIDER OR SUPPLIER CENTRAL CONTINUING CARE			S	REET ADDRESS, CITY, STATE, ZIP CODE 1287 NEWSOME STREET MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 332	AM ". When questione Eldertonic she reveale who don't eat well bed appetite. 2 c. Review of the phy 10/2/12 revealed an of (SR) (multivitamin with mouth daily. Observation of medicarevealed nurse #1 add with minerals tablet to on 10/4/12. At 3:30 PM the labels	to residents before 7:30 ed about the purpose of the ed it is given to residents cause it stimulates the visician's orders dated order for Cerovite Senior in minerals) one tablet by ation administration ministered a multivitamin oresident # 75 at 8:55 AM on the bottles of orals and Cerovite senior SR ourse #1. The labels	F 33	2			
F 333 SS=D	A telephone interview 10/5/12 at 10:45 AM in ordered the senior tab stated that Cerovite Sileyes that are not contwith minerals. 483.25(m)(2) RESIDE SIGNIFICANT MED ETHE facility must ensurany significant medical This REQUIREMENT by:	s should be given. He R contains vitamins for ained in the multivitamins NTS FREE OF RRORS re that residents are free of	F 333	1) Nurse #1 gave Resident #75 the form of medication on 10/2/2012. Director of Nursing will in-servic #1 on passing medications in according with physician orders with an emple do not crush medications. 2) The Director of Nursing, or her designee, has reviewed current resident Medication Administration Recording assure do not crush medications with the service was a service with the service wi	The e Nurse ordance phasis on sident ds to	11 2 12	

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

STATEMENT OF DEFICIENCIES (X1)		(VA) PROMOCRATION		WALLET TO A CONTROL OF THE			OMB NO. 0938-0391	
AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		i	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345410	B. WIN	ig_		1	C 05/2012	
NAME OF P	ROVIDER OR SUPPLIER			CT.	DEET ADDRESS OFFICE TO CORE	1 10/0	/3/2012	
CENTRAL	. CONTINUING CARE			1	REET ADDRESS, CITY, STATE, ZIP CODE 1287 NEWSOME STREET MOUNT AIRY, NC 27030			
(X4) ID	SHMMADY ST	TATEMENT OF DEFICIENCIES						
PREFIX TAG	(EACH DEFICIENC	DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 333	Continued From pag			333	identified The Director of Name	:ma au 41. a		
	interview the facility t	failed to prevent a significant			identified. The Director of Nurs Staff Development Coordinator	ing, or the		
		one (Resident #75) of ten			conduct individual medication p	WH		
		or medication administration			observation with the current lice	ass		
	by crushing isosorbid	le ER not in accordance with			and provide corrective action for			
	the physician's order.	•			compliance with facility policies			
	. .,				procedures related to medication			
	Findings include:				administration.	ı		
	Resident # 75 had di	agnoses of dementia,			3) The Director of Nursing or St	aff		
	diabetes and macula	agnoses of dementia, r degeneration			Development Coordinator will in-service			
	anabotoo ana madala	r degeneration.			the licensed staff on following p	hvsician		
	Review of the physici	ian's orders dated 10/2/12			orders and the facility policy and	1		
	revealed orders for is	sosorbide (for control of			procedures for medication admin			
	chest pain) ER (exter	nded release-slowly			The Staff Development Coordin			
	absorbed over 24 hor	urs) 60 milligrams (mg) one			include information on following			
	tablet by mouth once	daily (do not crush).			physician orders and the facility			
	A4 0-50 A14 4014/4	• • • • • • • • • • • • • • • • • • • •			procedures for medication admir			
	At 8:50 AM on 10/4/1	2, during a medication			in the orientation of new licensed	d staff.		
	iecearbide ED and mi	ration, nurse #1 crushed ixed it in applesauce with			The Director of Nursing, or her	designee,		
		ne entered the resident's			and/or the Staff Development Co	ordinator		
	room, spooned the m				will conduct random medication	pass		
	medication cup and b	egan to administer them to			observations with licensed staff	members		
		quest nurse # 1 did not			at least weekly for three months	then at		
		ations and stepped into the			least monthly and provide in-ser	vicing		
	hallway.	••			and/or counseling as indicated as	a result		
					of the review process.			
	An interview with nurs	se #1 at that time revealed			The Director of Nursing, or he	er	I	
		crushed the isosorbide ER.			designee, will monitor through			
		ished medications and			observation, Medication Admini		l	
	re-poured the medical ER intact.	tions, leaving the isosorbide			Record review and Pharmacy Co	nsultant	ŀ	
	LIX IIIIaGi.				Report review, at least monthly f	or three		
	On 10/4/12 at 9:45 AM	of the Medication			months, then at least quarterly, to	assure		
		d (MAR) was reviewed. The		medications are administered according				
	isosorbide ER listing	was consistent with the			physician's orders. Monitors wil	l be		
	physician's order and	included instructions not to			reviewed at scheduled QA Meeti			
	crush the medication.	In the front of the MAR			Administrator is responsible for compliance.	overall		

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 A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345410	B. WING		400	C 10/05/2012	
NAME OF PROVIDER OR SUPPLIER CENTRAL CONTINUING CARE			1287	T ADDRESS, CITY, STATE, ZIP CODE NEWSOME STREET JNT AIRY, NC 27030		U5/2U12	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	OULD BE COMPLETION	
F 333	there was a list of me and included isosorbi indicated it is a time n	dications not to be crushed de ER. The list further elease formula. se #1 on 10/4/12 at 3:30 PM otify the physician for an dent has difficulty	F 333				

PRINTED: 11/05/2012 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION 01 - MAIN BUILDING 01 A. BUILDING 10/30/2012 345410 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1287 NEWSOME STREET MOUNT AIRY, NO 27030/STRUCTION SECTION CENTRAL CONTINUING CARE (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) Filing the Plan of Correction does not K 000 constitute an admission that the deficiencies INITIAL COMMENTS K 000 l alleged, did, in fact, exist. This Plan of Correction is filed as evidence of the This Life Safety Code(LSC) survey was facility's desire to comply with the conducted as per The Code of Federal Register requirements and to continue to provide high at 42CFR 483.70(a); using the Existing Health quality resident care. Care section of the LSC and its referenced publications. This building is Type III(211) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows: 1) The Maintenance Director, or his 12/14/12 K 012 NFPA 101 LIFE SAFETY CODE STANDARD K 012 designee, shall assure the holes in the sheet SS=F rock in the attic are repaired. Building construction type and height meets one 2) The Maintenance Director, or his of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, designee, will conduct environmental rounds 19.3.5.1 to identify other holes in the sheet rock in the attic and make repairs to areas identified through the inspection process. 3) The Maintenance Director, or his designee, will conduct at least quarterly This STANDARD is not met as evidenced by: inspections to assure there are no holes in Based on observation on Tuesday 10/30/12 the sheet rock in the attic. between 9:30 AM and 1:30 PM the following was 4) The Maintenance Director, or his noted: designee, will monitor through observation

K 029 NFPA 101 L SS=D

42 CFR 483.70(a)
NFPA 101 LIFE SAFETY CODE STANDARD

maintained. The sheet rock in the attic that is part

of the one hour fire rated corridor has holes that

1) The one hour rated corridor was not

were not repaired in order to maintain the

required rating of the ceiling.

One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system

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

.

Facility ID: 943085

compliance.

K 029

(X6) DATE

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

at least quarterly, to assure there are no

holes in the sheet rock in the attic. Monitors

will be reviewed at scheduled QA meetings.

The Administrator is responsible for overall

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

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES				OND NO.	0938-0391
STATEMENT OF DEFICIENCIES (X1) PRO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SI COMPLE	URVEY ETED
		345410	B. WII	NG_		10/3	0/2012
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
CENTRA	L CONTINUING CAR	E			287 NEWSOME STREET IOUNT AIRY, NC 27030		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 029	option is used, the other spaces by sn doors. Doors are s field-applied protect	areas are separated from noke resisting partitions and self-closing and non-rated or stive plates that do not exceed bottom of the door are	K	029	1) The Maintenance Director rep dry storage room door located ner exit door of the kitchen to assure latching 2) The Maintenance Director, or designee, will conduct environme to identify other doors for positive and make repairs to areas identified the inspection process. 3) The Maintenance Director, or designee, will conduct at least mo inspections to assure doors maintenance.	at to the positive his ntal rounds e latching ed through his	12/14/12
	This STANDARD is not met as evidenced by: Based on observation on Tuesday 10/30/12 between 9:30 AM and 1:30 PM the following was noted: 1) The dry storage room for the kitchen located next to the exit door did not have positive latching.				latching. 4) The Maintenance Director, or designee, will monitor through obmonthly for three months, then at quarterly, to assure doors maintail latching. Monitors will be review scheduled QA meetings. The Adi is responsible for overall compliants.	his servation least n positive ed at ninistrator	
K 054 SS=D	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3		К	054	smoke duct detectors located in the unit in the telephone room. 2) The Maintenance Director, or designee, will conduct environme to identify other smoke duct detect located in the HVAC units and cleidentified through the inspection part of the Maintenance Director, or large transport of the maintenance Director of the maintenance Direc	his ntal rounds tors ean areas process.	121:4/12
	Based on observation between 9:30 AM a noted: 1) The smoke duction units were not main	The smoke duct detectors located in the HVAC units were not maintained clean and in good operating condition. Location - HVAC unit in the elephone room.			designee, will conduct at least quainspections of smoke duct detecto in the HVAC units and clean them necessary. 4) The Maintenance Director, or lesignee, will monitor through ob at least quarterly, to assure smoke detectors are clean and in good op condition. Monitors will be review scheduled QA meetings. The Adr	rs located n as nis servation duct erating wed at	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
	PROVIDER OR SUPPLIER	345410	B. Wil	STF	REET ADDRESS, CITY, STATE, ZIP CODE 287 NEWSOME STREET	10/3	30/2012	
CENTRA	CE CONTINUING CAR			λ	MOUNT AIRY, NC 27030			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 076 \$S=D	Medical gas storage protected in accord Standards for Healt (a) Oxygen storage 3,000 cu.ft. are enc separation. (b) Locations for su 3,000 cu.ft. are ven 4.3.1.1.2, 19.3.2.4 This STANDARD is Based on observat between 9:30 AM a noted: 1) Oxygen cylinders together in the oxyg 2) Oxygen storage v findings include; full were stored togethe enclosure, empty cy and designated (with Empty cylinders sha confusion and delay	locations of greater than losed by a one-hour pply systems of greater than ted to the outside. NFPA 99 one of the outside.	K		,	d assured ly used to ator will used s ude n the The ee, will of the gen gulation. rvation ast s are uitors ueetings.	12114/12	