STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345166	A. BUILDING _____ B. WING _____	05/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STOKES COUNTY NURSING HOME	1570 NC 8 AND 89 HWY DANBURY, NC 27016

(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 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE 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 interviews with staff and record review the facility staff failed to follow-up for 7 days on the dietary recommendations for a liquid nutritional supplement and protein supplement to address a low albumin and low total protein levels. This was evident in 1 of 3 residents in the sample reviewed for nutrition. (#18) Findings included: Resident #18 was readmitted to the facility on 2/4/13 after a hospitalization for pneumonia. Review of the May 2013 physician orders revealed a no added salt mechanical diet. Review of the Careplan dated 2/20/13 revealed in part problems associated with an increased risk for inadequate nutrition and hydration. One of the interventions included an initial and when every necessary dietary assessment and recommendations.	F 325	**F325 – 483.25(I) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE** **Corrective action to be accomplished for those residents found to have been affected by the deficient practice:** • Affected Resident #18 was on the ordered supplement at the time of the survey and maintaining a stable weight. Resident #18 had an initial weight loss since admission, which resulted from fluid hydration during hospitalization 01/24/13 through 02/04/13. Resident #18 has continued to have weekly weights obtained since the survey, with findings as noted: 05/03/13 of 120.2 pounds, 05/10/13 of 122.4 pounds, 05/17/13 of 122.6 pounds. • An additional Nutritional Assessment was completed on 05/08/13 to include recommendation of the following: 15ml of Eldertonic 30 minutes before meals. The recommendation was faxed to Dr. Samuel Newsome on 05/08/13 at 1630 by Dawn Mabe, RN, SNF DON. Dr. Samuel Newsome was contacted by Christy Handy, LPN on 05/10/13. An order was written by Christy Handy, LPN for the recommendation on 05/10/13 at 1400. The recommendation was signed by Dr. Samuel Newsome on 05/10/13.	5-28-2013

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

Pamela P. Tillman | Assistant Administrator | 5-28-2013

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F 325	Continued From page 1 Interview on 5/9/13 at 1 PM with nursing assistant #1 (NA) revealed resident ' s food and fluid intakes varies. Review of the blood work dated 2/8/13 revealed a level of Total protein level of 5.9 grams per deciliters (g/dl). The reference range was 6.3-8.2 g/dl. The albumin level was 2.6 milligrams per deciliters (mg/dl). The reference range was 3.5-5 mg/dl. Review of the dietitian ' s progress note dated 2/27/2013 revealed the part Resident#18 was at risk for skin breakdown. The dietary recommendations on 2/27/13 included Ensure (liquid nutritional supplement with protein) between meals bid (twice a day) and 60 cc (cubic centimeters) Prostat (protein supplement) every day. Review of the medical record revealed no evidence that the dietary recommendations have been addressed until 3/6/13. Review of the physician orders dated 3/6/13 revealed the nurse practitioner ordered Ensure 240 cc 240 cc between meals twice a day and Prostat 60 cc daily. Review of the Medication Record revealed Ensure was started on 3/6/13 Prostat 60 cc was transcribed on the Medication record with an error drawn to 3/6/13. There was a blank space for 3/6/13 and circled initials for 3/7/13 and 3/8/13. The comment documented was Prostat was not available. However on 3/12/13 Healthy Shots (a liquid protein supplement) 12 grams (gms) daily was documented as given.	F 325	• The care plan was updated for Resident #18 on 05/10/13 to include the ordered dietary recommendation. • Additional nutritional actions were added to Resident #18's care plan on 05/15/13 by Veronda Pruitt, MDS Coordinator as follows: Provide large breakfast daily and talk with resident to see why supper intake is not good. **Corrective action to be accomplished for residents having potential to be affected by the same deficient practice:** • A policy was written to reflect the handling of a dietary referral on 05/09/13 by Melody Bowman, RN, CNO and Dawn Mabe RN, SNF DON. • The new policy was reviewed with the staff working on 05/09/13. The new policy was also posted at the nurse's station for all nurses to review and initial from 05/09/13 to present. • All dietary referrals will be reviewed with the physician within 48 hours of receipt from the dietician. • A list of all dietary supplements available in the facility was given to the physicians at the medical staff meeting on 05/28/13. • A Memorandum concerning the dietary recommendations and a list of dietary supplements available in the facility was given to the dietician on May 28, 2013.	5-28-2013

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F 325	Continued From page 2 Interview on 5/9/13 at 4:39 PM via the phone with the dietitian revealed he was worried about the resident's low albumin level when he recommended the Ensure and Prostat. I " I do not remember who I gave the recommendations to. I know I gave it to someone usually the nurse on duty. " Interview on 5/10/13 at 1:56 PM with the director of nurses (DON) revealed the facility did not have a written protocol but the dietitian usually gives the recommendations to the nurse who in turn would fax to the physician. According to the DON Sherry Kahn (no longer works for the facility) Nurse#1, Nurse#2 and Nurse#3 were on duty on 2/27/13. The DON indicated Nurse#2 and Nurse#3 does not remember the dietitian providing the recommendations to them. Continued interview revealed Nurse#1 no longer worked at the facility. The DON indicated that Prostat was not used in the facility and that Healthy Shots were used interchangeable. Nurse#4 joined the interview and indicated she was not provided the dietary recommendations. Interview on 5/9/13 at 1:20 PM with the food service manager revealed no explanation of why the 2/27/13 recommendations had not been follow through until 3/6/13. Interview on 5/10/13 at 12:20 PM with Chief Nursing Officer, infection control coordinator and the MDS coordinator was held. The Chief Nursing Officer indicated that the dietary recommendations should have been implemented within 48 hours.	F 325	• Resident care plans will be updated to reflect dietary recommendations as ordered. **Measures to be put into place or systemic changes made to ensure that the deficient practice will not occur:** • A policy was written to reflect the handling of a dietary referral on 05/09/13 by Melody Bowman, RN, CNO and Dawn Mabe RN, SNF DON. • The new policy was reviewed with the staff working on 05/09/13. The new policy was also posted at the nurse's station for all nurses to review and initial from 05/09/13 to present. • All dietary referrals will be reviewed with the physician within 48 hours of receipt from the dietician. • A list of all dietary supplements available in the facility was given to the physicians at the medical staff meeting on 05/28/13. • A Memorandum concerning the dietary recommendations and a list of dietary supplements available in the facility was given to the dietician on May 28, 2013. • Resident care plans will be updated to reflect dietary recommendations as ordered.	5-28-2013

We will monitor our performance to make sure that solutions are sustained.

- Dawn Mabe, RN, SNF DON or her designee will monitor for completion of dietary referrals on a weekly basis.
- The monitoring will be tallied monthly and reported quarterly at the Quality of Life meeting and Housewide Quality Improvement Committee.
- Noncompliance with dietary recommendation policy will be addressed one on one with the staff member involved.

Date of Completion

Date of Completion: May 28, 2013

5-28-2013

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
	345166	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	JUN 1 8 2013 05/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type I (222) construction, two story's. Skilled nursing floor is not sprinkled. The deficiencies determined during the survey are as follows:	K 000	**K000** Stokes County Nursing Home is in the process of installing a Sprinkler System. Reference Project No. HL-9540-DWS. FID No.943474 **K051 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD** **Corrective action to be accomplished by facility to correct the deficient practice:** • Maintenance Director appropriately labeled the fire alarm breaker on 5/31/13. • First floor annunciator was serviced on 6/6/13 by Johnson Control Company and is operational. **How will other life safety issues having potential to affect residents by the same deficient practice be identified:** • Testing the audible alarm at the annunciator will continue to be performed during quarterly fire alarm testing and documented. • Electrical control panels were checked to ensure that all other breakers were appropriately labeled. **Measures to be put in place or systemic changes made to ensure that the deficient practice will not occur:** • Testing the audible alarm at the annunciator will continue to be performed during quarterly fire alarm testing and documented. **How we will monitor our performance to make sure that solutions are sustained:** • Testing the audible alarm at the annunciator will continue to be performed during quarterly fire alarm testing and documented.	
K 051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Pamela P. Dillman — TITLE: Assistant Administrator — (X6) DATE: 06/14/2013

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 051	Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: 1. staff could not located breaker for fire alarm panel for test of loss of power(panel location missed labeled). 2. fire alarm control panel did not have a audible signal on loss of power(nurse station 1st floor). 42 CFR 483.70(a)	K 051	• Quarterly fire alarm testing documentation will be submitted to the Safety and Quality Improvement Committee by the Maintenance Director. **Date of Completion: 6/6/13**	6/6/13
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: 1. deep fat fryer was not equipment with splash guard's on both sides. 2. no documentation that hood had been cleaned every 6 months. 42 CFR 483.70(a)	K 069	**K069 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD** **Corrective action to be accomplished by facility to correct the deficient practice:** • Stainless steel splash guards, measuring eight inches in height (per requirement), were ordered for the deep fat fryer. Expected delivery and installation will be completed by 6/21/13. • The exhaust hood is scheduled to be cleaned on 6/19/13. The exhaust hood will be cleaned every 6 months. **How will other life safety issues having potential to affect residents by the same deficient practice be identified:** • Risk management surveys are completed weekly in each department to identify safety concerns and are reported to the Safety Officer. **Measures to be put in place or systemic changes made to ensure that the deficient practice will not occur:**	
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant	K 072	• Risk management surveys are completed weekly in each department to identify safety concerns and are reported to the Safety Officer.	

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K 072	Continued From page 2 use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: floor fan, walker and lift blocking hand rail going into day room. Also lift stored by room 213 reducing corridor width. 42 CFR 483.70(a)	K 072	**How we will monitor our performance to make sure that solutions are sustained:** • Documentation that monitoring and hood cleaning has been performed at the required intervals, will be reported by the Dietary Manager to Quality Improvement Committee every 6 months . • Visible documentation of hood cleanings will be posted on external hood for verification. • Risk management surveys will be completed weekly in each department to identify safety concerns and reported to the Safety Officer. **Date of Completion: Schedule Date of Completion on 6/21/13** **K072 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD** **Corrective action to be accomplished for those residents found to have been affected by the deficient practice:** • One lift and walker were being utilized for toileting residents in the hallway bathroom. The other lift was awaiting utilization to transfer a resident after their bath. The lifts were moved to proper storage on 5/30/13. • The walker was folded and stored on 5/30/13. • The fan remained in use, but was placed to one side of the hallway on 5/30/13.	Scheduled 6/21/13

Continued from Page 3

K072

Corrective action to be accomplished for residents having potential to be affected by the same deficient practice:

- During toileting rounds the lift, walker and residents will all be positioned on the same side of the hallway, allowing for a clear egress.
- During toileting rounds, the fan will be removed from the hallway to allow for a clear egress.
- No items will be stored in the hallway which would block handrails.

Measures to be put into place or systemic changes made to ensure that the deficient practice will not occur:

- An in-service was developed to review life safety practices related to this issue on 06/12/13 by Melody Bowman, RN, CNO and Veronda Pruitt, RN, MDS Coordinator.
- The in-service was presented to nursing, dietary and housekeeping staff for review on 06/12/13.

We will monitor our performance to make sure that solutions are sustained:

- Complete weekly safety/risk audits as scheduled by the Safety Officer, Keith Lawson.
- Non-compliance issues will be documented on the audit and reported to the SNF DON or her designee, immediately related to this issue. Immediate interventions for noncompliance will be implemented.
- Random visual inspections will be made by the SNF DON and the MDS Coordinator with immediate interventions for noncompliance.

Continued from Page 4

K072

- Documentation of monitoring activities and corrective actions will be reported to Safety and Quality Improvement Committee quarterly by the SNF DON.

Date of Completion: 6/14/13

completed 6/14/13