STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345255	A. BUILDING: _____ B. WING _____	3/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON STREET CHERRYVILLE, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 159	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS

Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.

The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to provide cognitively intact residents with a personal funds statement for 2 of 2 sampled residents reviewed for personal funds (Resident #61 and # 111).

The findings included:

1. Review of the medical record revealed Resident #61 was admitted on 02/27/13. A quarterly Minimum Data Set dated 02/06/15 noted Resident #61 was cognitively intact.

During an interview on 03/10/15 at 9:42 AM Resident #61 stated the facility did not let her know how much money she had in her personal funds account and did not provide her with a quarterly personal funds statement. Resident #61 further stated she had to go to the office and ask if she wanted to know her account

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balance.

Review of Resident #61's medical record revealed she was her own responsible party and had a family member listed as an emergency contact.

An interview was conducted with the Patient Funds Representative on 03/12/15 at 11:03 AM. The Patient Funds Representative stated she sent out quarterly personal funds account statements to the residents' responsible party listed in the computer which is usually a family member. Resident # 61's quarterly personal funds account statement for January 2015 was reviewed during the interview and revealed the statement had been mailed to the family member listed as her emergency contact. The Patient Funds Representative further stated if a resident wanted a copy of their quarterly personal funds account statement they could come to the office window any time and request one.

An interview with the Administrator on 03/12/15 at 2:53 PM revealed the facility automatically sent the quarterly personal funds account statement to the residents' responsible party. The Administrator confirmed Resident #61 was her own responsible party and was not sure why she did not receive a quarterly personal funds account statement.

2. Review of the medical record revealed Resident #111 was admitted on 01/10/14. A quarterly Minimum Data Set dated 02/06/15 noted Resident #111 was cognitively intact.

During an interview on 03/09/15 at 3:15 PM Resident #111 stated the facility did not let her know how much money she had in her personal funds account and did not provide her with a quarterly personal funds statement. Resident #111 further stated she had to go to the office and ask if she wanted to know her account balance.

Review of Resident #111's medical record revealed she had a family member listed as her responsible party and emergency contact.

An interview was conducted with the Patient Funds Representative on 03/12/15 at 11:03 AM. The Patient Funds Representative stated she sent out quarterly personal funds account statements to the residents' responsible party listed in the computer which is usually a family member. Resident # 111's quarterly personal funds account statement for January 2015 was reviewed during the interview and revealed the statement had been mailed to the family member listed as her responsible party. The Patient Funds Representative further stated if a resident wanted a copy of their quarterly personal funds account statement they could come to the office window any time and request one.

An interview with the Administrator on 03/12/15 at 2:53 PM revealed the facility automatically sent the quarterly personal funds account statement to the residents' responsible party. The Administrator stated if a resident wanted a copy of their quarterly personal funds account statement they could come to the office window any time and request one.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAROLINA CARE CENTER	111 HARRILSON STREET CHERRYVILLE, NC 28021

(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 SS=D	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 and staff interviews the facility failed to label and properly store 2 bedpans lying in the floor and bath tub in a shared resident's bathroom on 1 of 3 halls. The findings included: An observation made on 03/09/15 at 2:53 PM revealed 1 pink bedpan and 1 gray bedpan lying on the bathroom floor beside the commode, shared by room 101 and 103, unlabeled and uncovered. An observation made on 03/10/15 at 8:55 AM revealed 1 pink and 1 gray bedpan lying on the floor of the bathroom beside the commode , shared by room 101 and 103 unlabeled and uncovered. An observation made on 03/11/15 at 8:46 AM revealed 1 pink and 1 gray bedpan lying on the floor of the bathroom beside the commode, shared by room 101 and 103 unlabeled and uncovered. An observation made on 03/12/15 at 11:45 AM revealed 1 pink and 1 gray unlabeled, uncovered bedpan lying in the bath tub shared by room 101 and room 103.	F 253	Carolina Care Center provides housekeeping and maintenance necessary to maintain a sanitary, orderly and comfortable interior. Corrective action for unlabeled bedpans in room 101 and 103 was achieved during survey by removing bedpans from rooms and disposing of the bedpans on 3/12/15. No one in room 101 and 103 was currently using a bedpan. Corrective action for other residents having the potential to be affected by the alleged deficient practice was corrected by other resident rooms and bathrooms being checked during survey for unlabeled bedpans and none were found on 3/12/15. Bedpans will continue to be labeled with resident's name on admission and when new bedpans are issued to residents. 3/12/15 Measures put into place to ensure alleged deficient practice does not recur include the following: -Sign was placed in supply room as reminder for labeling all personal items including bedpans, with resident name,	4/8/15

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

Electronically Signed | 04/02/2015

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F 253	Continued From page 1 An interview was conducted on 03/12/15 at 11:45 AM with Nurse Aide (NA) #1. She stated she did not know why there was 1 pink and 1 gray unlabeled and uncovered bedpan in the bath tub that was shared by room 101 and room 103. She stated all bedpans should be labeled, covered and stored in the resident's closet. NA #1 further stated she had no idea who the bedpans belonged to because 3 of the 4 residents that shared the bathroom took themselves to the bathroom and the 4th resident did not use a bedpan. An interview was conducted on 03/12/15 at 12:10 PM with the Director of Nursing (DON). She stated it was her expectation that all bedpans be labeled with the resident's name, covered and stored in the resident's closet. She stated it was not acceptable for bedpans to be stored unlabeled and uncovered on the resident's bathroom floor or bath tub.	F 253	when issued to resident.3/12/15 - CNA's were instructed to request bedpans from nurses or ward clerks, place in bag and store in resident's closet or bedside table. In-service on proper storing and labeling of bedpans was held on 3/12/15. -Procedure for issuing of bedpans has been revised to allow licensed nurse or ward clerks only to enter medical supply, obtain bedpan and place resident's name on bedpan. 3/30/15 Monitors put into place to ensure proper labeling and storage of bedpans include: Weekly audits of rooms for proper labeling and storage of bedpans are conducted by Assistant Administrator, Director of Nursing, Assistant Director of Nursing, MDS Nurses, Housekeeping Supervisor, Staff Development Coordinator, Activity Staff, Social Workers, Admission Nurses, Restorative Nurses and Ward Clerks. Any unlabeled or inappropriately stored bedpans are reported to weekly tracking committee for any corrective actions needed. The results of the weekly tracking reports are reviewed monthly in the Quality Assurance and Assessment committee to determine the effectiveness or change in procedure or plan. Quality Assurance and Assessment Committee reviews Tracking Reports for a	

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F 253	Continued From page 2	F 253	period of one year.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to correctly code the on the Minimum Data Set (MDS) for 2 of 2 residents	F 278	Carolina Care Center provides an RN assessment nurse to conduct and coordinate accurate completion of MDS	4/8/15

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F 278	Continued From page 3 sampled for PASRR review (Resident #2 and Resident #10) and the facility failed to correctly code the MDS for 1 of 1 resident sampled for hospice review (Resident #160). Findings included: 1. Resident #2 was admitted to the facility on 10/31/00. Diagnoses included an intellectual development disability. A review of Resident #2's medical record revealed the resident had been evaluated by Level II PASRR. A review of the most recent annual MDS dated 10/07/14 indicated the resident had not been evaluated by Level II PASRR to determine if the resident needed specialized services related to mental illness. An interview was conducted with MDS Nurse #1 on 03/11/15 at 11:21 AM. She stated the section of the MDS should have been marked "Yes" because Resident #2 had been evaluated by Level II PASRR. She explained she believed the information was automatically filled out by the computer software the facility used for completing the MDS. An interview was conducted with Assistant Administrator #1 on 03/11/15 at 2:23 PM. She stated her expectation was the MDS was to be completed correctly. She explained the MDS Nurses had been scheduled to attend a class on the MDS soon. She clarified she had spoken with the company that made their computer software and they told her the information was not automatically filled out by the computer software.	F 278	assessments. Corrective action for resident #2 and #10 PASRR coding was achieved by MDS coordinator completing modification and resubmitting MDS to CMS on 3/11/15. Corrective action for resident #106 Hospice coding was accomplished by MDS Coordinator doing a modification and submitting MDS to CMS on 3/12/15. Corrective action for other residents having the potential to be affected by the alleged deficient practice was corrected by MDS coding of other residents with Level II PASRR and Hospice services were reviewed and corrected by MDS Coordinator on 3/13/15. Measures put into place to ensure alleged deficient practice does not recur include: - Admission Coordinator places all PASRR numbers on face sheet in Electronic Health Record. Level II PASRR numbers will be identified on face sheet. Admissions Coordinator will report any changes in stand up meeting. 4/2/15 - MDS staff reviews physician orders for changes in status or services and reports in stand up meeting. 3/17/15 Monitors put into place to ensure MDS is coded accurately includes the following: MDS Coordinator audits with MDS	

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F 278	Continued From page 4 2. Resident #10 was readmitted to the facility on 01/15/15. Diagnoses included schizophrenia. A review of Resident #10's medical record revealed the resident had been evaluated by Level II PASRR. A review of the most recent significant change MDS dated 01/15/15 indicated the resident had not been evaluated by Level II PASRR. An interview was conducted with MDS Nurse #1 on 03/11/15 at 11:21 AM. She stated the section of the MDS should have been marked "Yes" because Resident #10 had been evaluated by Level II PASRR. She explained she believed the information was automatically filled out by the computer software the facility used for completing the MDS. An interview was conducted with Assistant Administrator #1 on 03/11/15 at 2:23 PM. She stated her expectation was for the MDS to be completed correctly. She explained the MDS Nurses had been scheduled to attend a class on the MDS soon. She clarified she had spoken with the company that made their computer software and they told her the information was not automatically filled out by the computer software. 3. Resident #106 was admitted to facility 12/04/14 with diagnoses including dementia, abnormal loss of weight, altered mental status, kidney disease, HTN, and a humerus fracture. The facility's provider wrote an order on 01/27/15 for Resident #106 to receive hospice care.	F 278	process to ensure correct coding of the MDS and reports results at weekly Tracking Meeting weekly. The results of the weekly Tracking Report are reviewed monthly in Quality Assurance and Assessment Committee to determine effectiveness or change in procedure or plan. Quality Assurance and Assessment Committee reviews Tracking Reports for a period of one year.	

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F 278	Continued From page 5 Resident #106's most recent significant change Minimum Data Set (MDS) assessment dated 02/03/15 was performed following Resident #106's admission to hospice but did not indicate the resident was receiving hospice services. Resident #106's Care Area Assessment dated 02/03/15 recorded a significant change related to further decline and admission to hospice care. Resident #106's care plan dated 02/05/15 listed a problem of being under hospice care and support with appropriate goals and approaches documented. An interview was conducted with MDS Nurse #1 on 03/12/2015 at 2:07 PM. She stated that Resident #106 was not coded as receiving hospice care on the most recent significant change MDS. She verbalized that Resident #106 should have been coded as receiving hospice care on the most recent MDS. An interview was conducted on 03/12/2015 at 2:14 PM with MDS Nurse #2. She verbalized that the omission of coding Resident #106 as receiving hospice care on the most recent MDS must have been an oversight. An interview was conducted with Assistant Administrator #1 on 03/11/15 at 2:23 PM. She stated her expectation was for the MDS to be completed correctly. She explained the MDS nurses had been scheduled to attend a class on the MDS soon.	F 278		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		4/8/15

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F 323	Continued From page 6 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility failed to secure loose bed side rails for 8 of 37 sampled residents (Resident #31, #50, #52, #54, #101, #34, #71, #35). The findings included: 1. Review of the medical record revealed Resident #31 was admitted on 01/22/15 with diagnoses including left above the knee amputation and diabetes mellitus. Review of a significant change Minimum Data Set (MDS) dated 02/09/15 revealed Resident #31 was cognitively intact, required extensive assistance with bed mobility, and was totally dependent on staff with transfers. Observations of Resident #31's bilateral 1/2 bed side rails were as follows: - On 03/09/15 at 12:45 PM the right side rail was loose and the top of the rail leaned away from the edge of the mattress approximately 6 inches. The left side rail was not loose and fit properly. - On 03/11/15 at 9:02 AM the right side rail was loose and the top of the rail leaned away from the edge of the mattress approximately 6 inches.	F 323	Carolina Care Center ensures that the resident environment remains free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.No Accidents or Incidents have occurred involving entrapment in side rails. Corrective action for the loose side rails for resident #31,#50,#52,#54,#101#34,#71,#35 identified by surveyor were reviewed by maintenance staff during survey to ensure side rails were secured to bedframes. 3/12/15 Corrective action for other residents having the potential to be affected by the alleged deficient practice was corrected during survey by reviewing side rails to ensure all were secure. No other side rails were found. 3/12/15 Nursing audited bed rails on 3rd shift to ensure initial compliance.3/13/15 & 3/20/15	

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F 323	Continued From page 7 The left side rail was not loose and fit properly. - On 03/12/15 at 9:37 AM the right side rail was loose and the top of the rail leaned away from the edge of the mattress approximately 6 inches. The left side rail was not loose and fit properly. An interview with Nurse Aide (NA) #2 on 03/11/15 at 3:16 PM revealed staff notified maintenance of needed repairs by writing them on the board on the office door, paging maintenance staff or contacting the on call maintenance staff member. NA #2 stated she checked bed side rails while providing care to her residents and when she noticed a loose side rail she tightened it up. NA #2 further stated if she was not able to tighten a loose side rail herself she contacted a maintenance staff member. During an interview on 03/12/15 at 10:16 AM the Maintenance Supervisor stated staff notified him of maintenance issues and needed repairs by overhead paging him or documenting the issue on the board on the maintenance office door. The Maintenance Supervisor further stated the maintenance staff did not conduct routine audits of bed side rails and relied on the NAs to notify them if a bed side rail was loose. The interview further revealed Assistant Administrator #1 and the Housekeeping Supervisor conducted regular room rounds and checked for potential hazards and maintenance issues. An interview was conducted with Assistant Administrator #1 on 03/12/15 10:23 AM. Assistant Administrator #1 stated loose side rails were not acceptable as she wanted the residents to be safe as possible. The interview further revealed she expected the NAs to report loose	F 323	Bed rails were replaced on beds in rooms 103 & 115. Medical Supply Vendor was contacted for possible recommendations for loose bed rails. 3/13/15 Vendor examined rails and recommended a thread locker to be used as needed for loose rails.3/16/15 Thread locker applied to bed rails for additional security.4/1/15 Measure put into place to ensure the alleged deficient practice does not recur include the following: -CNA's and assigned staff have been re in-serviced on proper functioning and fit of side rails. 3/12/15 -CNA's will continue to check side rails each time a resident is transferred. 3/12/15 -In-service included written communication to maintenance department for any side rail repairs, replacements, etc as needed. 3/12/15 Monitors put into place to ensure side rails are secure include the following: Weekly audits assigned and conducted by Assistant Administrator, Director of Nursing, Assistant Director of Nursing, MDS Nurses, Housekeeping Supervisor, Staff Development Coordinator, Activity Staff, Social Workers, Admission Nurses, Restorative Nurse and Ward Clerks to	

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F 323	Continued From page 8 side rails to a maintenance staff member. On 03/12/15 at 10:32 AM the Maintenance Supervisor and Assistant Administrator #1 were accompanied to Resident #31's room and examined the right bed side rail. The Maintenance Supervisor confirmed the side rail was loose and needed to be tightened down. The Maintenance Supervisor stated he thought the NAs might be using the knob to bring the side rail up and down which was actually loosening the side rail. The Maintenance Supervisor further stated he planned to start checking bed side rails himself and make sure they fit properly. 2. Review of the medical record revealed Resident #50 was admitted on 11/07/14 with diagnoses including muscle weakness and lack of coordination. Review of the admission Minimum Data Set (MDS) dated 11/14/14 revealed Resident #50 had short and long-term memory loss and severely impaired cognitive skills for daily decision making. The admission MDS noted Resident #50 required extensive assistance with bed mobility and transfers. Observations of Resident #50's bilateral 1/2 bed side rails were as follows: - On 03/09/15 at 12:05 PM Resident #50 was observed awake in bed. The right side rail loose and the top of the rail leaned away from the edge of the mattress approximately 6 inches. The left side rail was not loose and fit properly. - On 03/10/15 at 9:13 AM Resident #50 was observed awake in bed. The right side rail was loose and the top of the rail leaned away from the	F 323	check all side rails to be secure to bedframe. Any unsecured rail will be reported to maintenance immediately. Weekly audits results will be reported in the weekly Tracking Committee. Weekly audits for preventative maintenance will be conducted by maintenance staff on all side rails and submitted to the weekly tracking committee. The results of the Weekly Tracking reports will be reviewed in the monthly Quality Assurance and Assessment Committee to determine effectiveness or change in procedure or plan. Quality Assurance and Assessment Committee reviews Tracking Reports for a period of one year.	

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F 323	Continued From page 9	F 323		

edge of the mattress approximately 6 inches. The left side rail was not loose and fit properly.

- On 03/11/15 at 9:10 AM Resident #50 was observed awake in bed. The right side rail was loose and the top of the rail leaned away from the edge of the mattress approximately 6 inches. The left side rail was not loose and fit properly.

- On 03/12/15 at 9:32 AM Resident #50 was observed awake in bed. The right side rail was loose and the top of the rail leaned away from the edge of the mattress approximately 6 inches. The left side rail was not loose and fit properly.

An interview with Nurse Aide (NA) #2 on 03/11/15 at 3:16 PM revealed staff notified maintenance of needed repairs by writing them on the board on the office door, paging maintenance staff or contacting the on call maintenance staff member. NA #2 stated she checked bed side rails while providing care to her residents and when she noticed a loose side rail she tightened it up. NA #2 further stated if she was not able to tighten a loose side rail herself she contacted a maintenance staff member.

During an interview on 03/12/15 at 10:16 AM the Maintenance Supervisor stated staff notified him of maintenance issues and needed repairs by overhead paging him or documenting the issue on the board on the maintenance office door. The Maintenance Supervisor further stated the maintenance staff did not conduct routine audits of bed side rails and relied on the NAs to notify them if a bed side rail was loose. The interview further revealed Assistant Administrator #1 and the Housekeeping Supervisor conducted regular room rounds and checked for potential hazards

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and maintenance issues.

An interview was conducted with Assistant Administrator #1 on 03/12/15 10:23 AM. Assistant Administrator #1 stated loose side rails were not acceptable as she wanted the residents to be safe as possible. The interview further revealed she expected the NAs to report loose side rails to a maintenance staff member.

On 03/12/15 at 10:35 AM the Maintenance Supervisor and Assistant Administrator #1 were accompanied to Resident #50's room and examined the right bed side rail. The Maintenance Supervisor confirmed the side rail was loose and needed to be tightened down. The Maintenance Supervisor stated he thought the NAs might be using the knob to bring the side rail up and down which was actually loosening the side rail. The Maintenance Supervisor further stated he planned to start checking bed side rails himself and make sure they fit properly.

3. Review of the medical record revealed Resident #52 was admitted on 12/30/11 with diagnoses including Alzheimer's disease.

Review of a significant change Minimum Data Set (MDS) dated 02/12/15 revealed Resident #52 had short and long-term memory loss and severely impaired cognitive skills for daily decision making. The admission MDS noted Resident #52 required extensive assistance with bed mobility and transfers.

Observations of Resident #52's bilateral 1/2 bed side rails were as follows:
- On 03/10/15 at 10:48 AM the right side rail was loose and the top of the rail leaned away from the

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edge of the mattress approximately 4 inches. The left side rail was not loose and fit properly.

- On 03/11/15 at 9:12 AM the right side rail was loose and the top of the rail leaned away from the edge of the mattress approximately 4 inches. The left side rail was not loose and fit properly.

- On 03/12/15 at 9:34 AM the right side rail was loose and the top of the rail leaned away from the edge of the mattress approximately 4 inches. The left side rail was not loose and fit properly.

An interview with Nurse Aide (NA) #2 on 03/11/15 at 3:16 PM revealed staff notified maintenance of needed repairs by writing them on the board on the office door, paging maintenance staff or contacting the on call maintenance staff member. NA #2 stated she checked bed side rails while providing care to her residents and when she noticed a loose side rail she tightened it up. NA #2 further stated if she was not able to tighten a loose side rail herself she contacted a maintenance staff member.

During an interview on 03/12/15 at 10:16 AM the Maintenance Supervisor stated staff notified him of maintenance issues and needed repairs by overhead paging him or documenting the issue on the board on the maintenance office door. The Maintenance Supervisor further stated the maintenance staff did not conduct routine audits of bed side rails and relied on the NAs to notify them if a bed side rail was loose. The interview further revealed Assistant Administrator #1 and the Housekeeping Supervisor conducted regular room rounds and checked for potential hazards and maintenance issues.

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An interview was conducted with Assistant Administrator #1 on 03/12/15 10:23 AM. Assistant Administrator #1 stated loose side rails were not acceptable as she wanted the residents to be safe as possible. The interview further revealed she expected the NAs to report loose side rails to a maintenance staff member.

On 03/12/15 at 10:36 AM the Maintenance Supervisor and Assistant Administrator #1 were accompanied to Resident #52's room and examined the right bed side rail. The Maintenance Supervisor confirmed the side rail was loose and needed to be tightened down. The Maintenance Supervisor stated he thought the NAs might be using the knob to bring the side rail up and down which was actually loosening the side rail. The Maintenance Supervisor further stated he planned to start checking bed side rails himself and make sure they fit properly.

4. Resident #54 was admitted to the facility on 08/31/09 with diagnoses of hypertension, anxiety and reflux. The quarterly Minimum Data Set (MDS) dated 02/27/15 revealed Resident #54 was cognitively intact and required extensive assistance of two persons for bed mobility and transfers.

Observations of Resident #54's bilateral ½ bed side rails were as follows:

- On 03/09/15 at 2:53 PM the left side rail was loose and leaned away from the bed approximately 3 inches. The right side rail was loose and leaned away from the bed approximately 2 inches.

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- On 03/10/15 at 8:55 AM the left side rail was loose and leaned away from the bed approximately 3 inches. The right side rail was loose and leaned away from the bed approximately 2 inches.

- On 03/11/15 at 8:46 AM the left side rail was loose and leaned away from the bed approximately 3 inches. The right side rail was loose and leaned away from the bed approximately 2 inches.

- On 03/12/15 at 10:20 AM the left side rail was loose and leaned away from the bed approximately 3 inches. The right side rail was loose and leaned away from the bed approximately 2 inches.

An interview with Nurse Aide (NA) #2 on 03/11/15 at 3:16 PM revealed staff notified maintenance of needed repairs by writing them on the board on the office door, paging maintenance staff or contacting the on call maintenance staff member. NA #2 stated she checked bed side rails while providing care to her residents and when she noticed a loose side rail she tightened it up. NA #2 further stated if she was not able to tighten a loose side rail herself she contacted a maintenance staff member.

During an interview on 03/12/15 at 10:16 AM the Maintenance Supervisor stated staff notified him of maintenance issues and needed repairs by overhead paging him or documenting the issue on the board on the maintenance office door. The Maintenance Supervisor further stated the maintenance staff did not conduct routine audits of bed side rails and relied on the NAs to notify

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them if a bed side rail was loose. The interview further revealed Assistant Administrator #1 and the Housekeeping Supervisor conducted regular room rounds and checked for potential hazards and maintenance issues.

On 03/12/15 at 10:20 AM the Maintenance Supervisor and Assistant Administrator #1 were accompanied to Resident #54's room and examined the left and right bed side rail. The Maintenance Supervisor confirmed the side rail was loose and needed to be tightened down. The Maintenance Supervisor stated he thought the NAs might be using the knob to bring the side rail up and down which was actually loosening the side rail. The Maintenance Supervisor further stated he planned to start checking bed side rails himself and make sure they fit properly.

An interview was conducted with Assistant Administrator #1 on 03/12/15 10:23 AM. Assistant Administrator #1 stated loose side rails were not acceptable as she wanted the residents to be safe as possible. The interview further revealed she expected the NAs to report loose side rails to a maintenance staff member.

5. Resident #101 was admitted to the facility on 05/07/13 with diagnoses of hypertension, diabetes, Alzheimer's disease and osteoporosis. The annual Minimum Data Set dated 12/19/14 revealed Resident #101 was severely cognitively impaired and required extensive assistance of 2 persons for bed mobility and transfers.

Observations of Resident #101's bilateral ½ bed

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side rails were as follows:

- On 03/09/15 at 2:55 PM the left side rail was loose and leaned away from the bed approximately 5 inches. The right side rail was loose and leaned away from the bed approximately 3 inches.

- On 03/10/15 at 8:58 AM the left side rail was loose and leaned away from the bed approximately 5 inches. The right side rail was loose and leaned away from the bed approximately 3 inches.

- On 03/11/15 at 8:48 AM the left side rail was loose and leaned away from the bed approximately 5 inches. The right side rail was loose and leaned away from the bed approximately 3 inches.

- On 03/12/15 at 10:22 AM the left side rail was loose and leaned away from the bed approximately 5 inches. The right side rail was loose and leaned away from the bed approximately 3 inches.

An interview with Nurse Aide (NA) #2 on 03/11/15 at 3:16 PM revealed staff notified maintenance of needed repairs by writing them on the board on the office door, paging maintenance staff or contacting the on call maintenance staff member. NA #2 stated she checked bed side rails while providing care to her residents and when she noticed a loose side rail she tightened it up. NA #2 further stated if she was not able to tighten a loose side rail herself she contacted a maintenance staff member.

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During an interview on 03/12/15 at 10:16 AM the Maintenance Supervisor stated staff notified him of maintenance issues and needed repairs by overhead paging him or documenting the issue on the board on the maintenance office door. The Maintenance Supervisor further stated the maintenance staff did not conduct routine audits of bed side rails and relied on the NAs to notify them if a bed side rail was loose. The interview further revealed Assistant Administrator #1 and the Housekeeping Supervisor conducted regular room rounds and checked for potential hazards and maintenance issues.

On 03/12/15 at 10:22 AM the Maintenance Supervisor and Assistant Administrator #1 were accompanied to Resident #101's room and examined the left and right bed side rail. The Maintenance Supervisor confirmed the side rail was loose and needed to be tightened down. The Maintenance Supervisor stated he thought the NAs might be using the knob to bring the side rail up and down which was actually loosening the side rail. The Maintenance Supervisor further stated he planned to start checking bed side rails himself and make sure they fit properly.

An interview was conducted with Assistant Administrator #1 on 03/12/15 10:23 AM. Assistant Administrator #1 stated loose side rails were not acceptable as she wanted the residents to be safe as possible. The interview further revealed she expected the NAs to report loose side rails to a maintenance staff member.

6. Resident #34 was admitted to the facility on

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11/09/10 with diagnoses of anemia, diabetes and hypertension. The annual Minimum Data Set (MDS) dated 12/26/14 revealed Resident #34 was cognitively intact and required extensive assistance with 2 person assist for bed mobility and transfers.

Observations of Resident #34's bilateral ½ bed side rails were as follows:

On 03/09/15 at 3:00 PM the left side rail was loose and leaned away from the bed approximately 3 inches. The right side rail was loose and leaned away from the bed approximately 2 inches.

On 03/10/15 at 9:00 AM the left side rail was loose and leaned away from the bed approximately 3 inches. The right side rail was loose and leaned away from the bed approximately 2 inches.

On 03/11/15 at 8:52 AM the left side rail was loose and leaned away from the bed approximately 3 inches. The right side rail was loose and leaned away from the bed approximately 2 inches.

On 03/12/15 at 10:25 AM the left side rail was loose and leaned away from the bed approximately 3 inches. The right side rail was loose and leaned away from the bed approximately 2 inches.

An interview with Nurse Aide (NA) #2 on 03/11/15 at 3:16 PM revealed staff notified maintenance of needed repairs by writing them on the board on the office door, paging maintenance staff or contacting the on call maintenance staff member.

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NA #2 stated she checked bed side rails while providing care to her residents and when she noticed a loose side rail she tightened it up. NA #2 further stated if she was not able to tighten a loose side rail herself she contacted a maintenance staff member.

During an interview on 03/12/15 at 10:16 AM the Maintenance Supervisor stated staff notified him of maintenance issues and needed repairs by overhead paging him or documenting the issue on the board on the maintenance office door. The Maintenance Supervisor further stated the maintenance staff did not conduct routine audits of bed side rails and relied on the NAs to notify them if a bed side rail was loose. The interview further revealed Assistant Administrator #1 and the Housekeeping Supervisor conducted regular room rounds and checked for potential hazards and maintenance issues.

An interview was conducted with Assistant Administrator #1 on 03/12/15 10:23 AM. Assistant Administrator #1 stated loose side rails were not acceptable as she wanted the residents to be safe as possible. The interview further revealed she expected the NAs to report loose side rails to a maintenance staff member.

On 03/12/15 at 10:25 AM the Maintenance Supervisor and Assistant Administrator #1 were accompanied to Resident #34's room and examined the left and right bed side rail. The Maintenance Supervisor confirmed the side rail was loose and needed to be tightened down. The Maintenance Supervisor stated he thought the

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NAs might be using the knob to bring the side rail up and down which was actually loosening the side rail. The Maintenance Supervisor further stated he planned to start checking bed side rails himself and make sure they fit properly.

7. Resident #71 was admitted to the facility on 02/14/14 with diagnoses of chronic obstructive pulmonary disease, anemia and depression. The quarterly Minimum Data Set (MDS) dated 02/27/15 revealed Resident #71 was cognitively intact and was independent in transfers and needed supervision for bed mobility.

Observations of Resident #71's bilateral ½ bed side rails were as follows:

- On 03/09/15 at 3:05 PM the left side rail was loose and leaned away from the bed approximately 3 inches. The right side rail was loose and leaned away from the bed approximately 3 inches.

- 03/10/15 at 9:05 AM the left side rail was loose and leaned away from the bed approximately 3 inches. The right side rail was loose and leaned away from the bed approximately 3 inches.

- 03/11/15 at 8:55 AM the left side rail was loose and leaned away from the bed approximately 3 inches. The right side rail was loose and leaned away from the bed approximately 3 inches.

- 03/12/15 at 10:35 AM the left side rail was loose and leaned away from the bed approximately 3 inches. The right side rail was loose and leaned away from the bed approximately 3 inches.

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An interview conducted on 03/09/15 at 3:40 PM with Resident #71 revealed she used the ½ bed side rails to help her get out of bed.

An interview with Nurse Aide (NA) #2 on 03/11/15 at 3:16 PM revealed staff notified maintenance of needed repairs by writing them on the board on the office door, paging maintenance staff or contacting the on call maintenance staff member. NA #2 stated she checked bed side rails while providing care to her residents and when she noticed a loose side rail she tightened it up. NA #2 further stated if she was not able to tighten a loose side rail herself she contacted a maintenance staff member.

During an interview on 03/12/15 at 10:16 AM the Maintenance Supervisor stated staff notified him of maintenance issues and needed repairs by overhead paging him or documenting the issue on the board on the maintenance office door. The Maintenance Supervisor further stated the maintenance staff did not conduct routine audits of bed side rails and relied on the NAs to notify them if a bed side rail was loose. The interview further revealed Assistant Administrator #1 and the Housekeeping Supervisor conducted regular room rounds and checked for potential hazards and maintenance issues.

An interview was conducted with Assistant Administrator #1 on 03/12/15 10:23 AM. Assistant Administrator #1 stated loose side rails were not acceptable as she wanted the residents to be safe as possible. The interview further revealed she expected the NAs to report loose side rails to a maintenance staff member.

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On 03/12/15 at 10:35 AM the Maintenance Supervisor and Assistant Administrator #1 were accompanied to Resident #71's room and examined the left and right bed side rail. The Maintenance Supervisor confirmed the side rail was loose and needed to be tightened down. The Maintenance Supervisor stated he thought the NAs might be using the knob to bring the side rail up and down which was actually loosening the side rail. The Maintenance Supervisor further stated he planned to start checking bed side rails himself and make sure they fit properly.

8. Resident #35 was admitted to the facility on 05/01/14 with diagnoses of anemia, heart failure diabetes, cerebrovascular accident and anxiety. The significant change Minimum Data Set dated 02/18/15 revealed Resident 335 was severely cognitively impaired and required extensive assistance with 2 person assist of bed mobility and transfers.

Observations of Resident #35's bilateral ½ bed side rails were as follows:

- On 03/09/15 at 3:10 PM the right side rail was loose and leaned away from the bed approximately 2 inches. The left side rail was loose and leaned away from the bed approximately 2 inches.

- On 03/10/15 at 9:10 AM the right side rail was loose and leaned away from the bed approximately 2 inches. The left side rail was loose and leaned away from the bed approximately 2 inches.

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F 323	Continued From page 22 - On 03/11/15 at 9:00 AM the right side rail was loose and leaned away from the bed approximately 2 inches. The left side rail was loose and leaned away from the bed approximately 2 inches. - On 03/12/15 at 10:40 AM the right side rail was loose and leaned away from the bed approximately 2 inches. The left side rail was loose and leaned away from the bed approximately 2 inches. An interview with Nurse Aide (NA) #2 on 03/11/15 at 3:16 PM revealed staff notified maintenance of needed repairs by writing them on the board on the office door, paging maintenance staff or contacting the on call maintenance staff member. NA #2 stated she checked bed side rails while providing care to her residents and when she noticed a loose side rail she tightened it up. NA #2 further stated if she was not able to tighten a loose side rail herself she contacted a maintenance staff member. During an interview on 03/12/15 at 10:16 AM the Maintenance Supervisor stated staff notified him of maintenance issues and needed repairs by overhead paging him or documenting the issue on the board on the maintenance office door. The Maintenance Supervisor further stated the maintenance staff did not conduct routine audits of bed side rails and relied on the NAs to notify them if a bed side rail was loose. The interview further revealed Assistant Administrator #1 and the Housekeeping Supervisor conducted regular room rounds and checked for potential hazards and maintenance issues.	F 323		

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F 323	Continued From page 23 An interview was conducted with Assistant Administrator #1 on 03/12/15 10:23 AM. Assistant Administrator #1 stated loose side rails were not acceptable as she wanted the residents to be safe as possible. The interview further revealed she expected the NAs to report loose side rails to a maintenance staff member. On 03/12/15 at 10:40 AM the Maintenance Supervisor and Assistant Administrator #1 were accompanied to Resident #35's room and examined the left and right bed side rail. The Maintenance Supervisor confirmed the side rail was loose and needed to be tightened down. The Maintenance Supervisor stated he thought the NAs might be using the knob to bring the side rail up and down which was actually loosening the side rail. The Maintenance Supervisor further stated he planned to start checking bed side rails himself and make sure they fit properly.	F 323		
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,	F 441		4/8/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345255	A. BUILDING _____ B. WING _____	03/12/2015

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F 441	Continued From page 24 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 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 reviews, and staff interviews, the facility failed to correctly implement contact precautions for a resident who had a wound infected with a multi-drug resistant organism (Resident #69). Findings included: 1. A review of the facility's contact precautions section of the infection control policy stated the following: "Implement contact precautions for resident known or suspected to be infected with	F 441	Carolina Care Center has an infection control program that establishes and maintains a safe, sanitary and comfortable environment to help prevent development and transmission of disease and infection. Corrective action was accomplished for Resident#69 by Nurse#2 being in-serviced of facility's policy related to personal protective equipment.	

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F 441	Continued From page 25 microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces" . The policy further instructed staff to wear disposable gowns when entering a contact precautions room. On 02/16/15, the facility received a final report from the laboratory that indicated Resident #69's wound contained a bacteria known as methicillin-resistant staphylococcus aureus (MRSA). During the initial tour of the facility on 03/09/15, Resident #69's room was observed to have an orange sign on the door that informed visitors and staff the resident had been placed on contact precautions. There were gloves and hand sanitizer on the inside of the room and next to the door frame. No other personal protective equipment was observed to be immediately available. An observation was conducted of Resident #69's wound care on 03/12/15 at 7:16 AM. Nurse #2 entered Resident #69's room after knocking, sanitized her hands with a hand sanitizer, and assisted the resident into the proper position for wound care. She then sanitized her hands with hand sanitizer and put on clean gloves. She removed the old dressing from Resident #69's pressure ulcer, cleansed the wound, and replaced the dressing with a new dressing. During the dressing change, Nurse #2's uniform was observed to come into contact with Resident #69's bed sheets several times. The nurse then cleaned the work area and washed her hands with soap and water. An interview was conducted with Nurse #2 on	F 441	Corrective actions for those residents having potential to be affected by the alleged deficient practice included in-service of all licensed nurses and CNA's regarding contact precautions and PPE facility policy.3/30/15 Measures put into place to ensure alleged deficient practice does not recur included: -In-service of all staff regarding contact precautions.3/12/15 -Ensure all necessary PPE is readily accessible and available for residents placed on contact precautions per facility policy. (i.e. gown, gloves, mask, or goggles)3/12/15 PPE is stored outside resident room in cart. Monitors put into place to ensure alleged deficient practice does not recur include: - Staff Development nurse conducts a weekly audit of treatment nurse pertaining to contact precautions during dressing change until contact precautions are discontinued.3/17/15 - Weekly audits are reported to weekly tracking committee for any errors or immediate corrective actions needed. -Tracking committee reports are reviewed in monthly Quality Assurance and Assessment Committee meeting for recommendations or changes needed to plan.	

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F 441	Continued From page 26 03/12/15 at 7:25 AM. She stated she knew Resident #69's wound was tested for MRSA and it was positive. She explained she knew the resident had been placed on contact precautions. Nurse #2 stated she did not know the facility's policy related to personal protective equipment as it related to contact precautions, but she did know she had to wear gloves and clean any used items before placing them back into the treatment cart. She stated Resident #69 had just finished antibiotics, but the facility had not obtained a second culture of the wound. An interview was conducted with the Director of Nursing (DON) on 03/12/15 at 8:02 AM. She stated it was her expectation for staff wear gloves and gowns when entering the room of a resident who has been placed on contact precautions. She stated Nurse #2 should have been wearing a disposable gown during the dressing change for Resident #69. An interview was conducted with the Physician's Assistant (PA) on 03/12/15 at 10:52 AM. She stated she had reviewed the laboratory results that indicated Resident #69's wound contained MRSA. She explained the decision to place a resident on contact precautions was a facility decision. She expected the facility to implement contact precautions according to its policy and follow the guidelines of the infection control policy during each dressing change.	F 441	Quality Assurance and Assessment Committee reviews Tracking Reports for a period of one year.	