CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURV COMPLETED 345281 B. WING 07/23/201		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED	EY	
345281 B. WING 07/23/201)	
01725/20	07/23/2015	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
STANLY MANOR 625 BETHANY CHURCH ROAD BOX 38		
ALBEMARLE, NC 28001		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	5) .ETION TE	
F 322 483.25(g)(2) NG TREATMENT/SERVICES - SS=D F 322 8/19/ Based on the comprehensive assessment of a resident the facility must ensure that F 322	15	
resident, the facility must ensure that (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.		
This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, the facility failed to check the tube placement prior to administering the medications for 1 (Resident #1) of 2 sampled residents with feeding tube. Findings included: Resident #1 was admitted to the facility on 1/29/09 with multiple diagnoses including anoxic brain damage. The annual Minimum Data Set (MDS) assessment dated 5/20/15 indicated that Resident #1 had a feeding tube. The physician's orders for July, 2015 was reviewed. The orders included " check		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DA'	F	

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

08/05/2015

PRINTED: 08/26/2015

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.

Electronically Signed

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 345281 B. WING 07/23/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 625 BETHANY CHURCH ROAD BOX 38 STANLY MANOR ALBEMARLE, NC 28001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 322 Continued From page 1 F 322 gastrostomy (G) tube for placement prior to Medication Administration via the enteral medications, flushes or boluses. " The order was route prior to re-assignment. The written on 6/19/14. in-service was completed 7/30/2015 with On 7/22/15 at 10:30 AM, Resident # 1 was 100% compliance. The Consultant observed during the medication pass. Nurse #1 Pharmacist observed medication was observed to administer the medications via G administration via enteral route with Nurse tube without checking the tube placement. #1 on resident #1 and resident #4 on On 7/22/15 at 10:35 AM, Nurse #1 was 7/30/2015 interviewed. She stated that she should have checked the tube placement prior to All nurses on all shifts full-time/part-time/ administering the medications but she did not. PRN/ will receive in-service education On 7/23/15 at 10:05 AM, administrative staff #1 from the Staff Development was interviewed. She stated that her expectation Coordinator, or Pharmacist on identifying was for the nurse to check the tube placement placement of enteral tube during prior to administering the medications. administration of medication. This education will be provided to ensure residents having the same potential as resident #1 will not be affected. The following measures will be put in place as a systemic change to ensure proper medication administration via the enteral route: All new licensed nursing staff hired after 7/23/2015 will receive education during orientation on proper placement and flushing of enteral tube during medication administration. Licensed Nursing Staff, (Full Time/Part-Time/ PRN) will receive annual education on proper placement and flushing via the enteral route during medication administration. The facility will have the Consultant Pharmacist, Director of Nursing, Assistant Director of Nursing or Staff Development Coordinator complete one enteral medication audit on one resident per

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: NDFK11

Facility ID: 923471

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		AND HUMAN SERVICES			FOR	D: 08/26/2015 M APPROVED D. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED
		345281	B. WING			7/23/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
STANLY	MANOR				25 BETHANY CHURCH ROAD BOX 38 LBEMARLE, NC 28001	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 322 F 332 SS=D	483.25(m)(1) FREI RATES OF 5% OF The facility must en medication error ra	E OF MEDICATION ERROR		322	week x 1 month, and then one enteral medication audit on one resident every 2 weeks x 1 month, then one enteral medication audit monthly on one residen until compliance is sustained x 3 months rotating shifts and days, identifying placement of enteral tube prior to administration of medication to ensure compliance. The reviews will focus on checking for tube placement prior to administering medications. The Director of Nursing or Assistant Director of Nursing will review audits and discuss monthly at Quality Assurance meetings until three months of compliance is sustained. Audits will occu one enteral medication audit on one resident per week x 1 month, and then one enteral medication audit on one resident every 2 weeks x 1 month, then one enteral medication audit monthly on one resident until compliance is sustaine x 3 months rotating shifts and days, identifying placement of enteral tube prio to administration of medication to ensure compliance. The reviews will focus on checking for tube placement prior to administering medications.	r d

Facility ID: 923471

If continuation sheet Page 3 of 21

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	TIPI			0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		345281	B. WING			07/23/2015	
IAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
TANLY	MANOR				25 BETHANY CHURCH ROAD BOX 38 ALBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 332	Continued From pa	ige 3	F 3	32			
	interview, the facilit medication error ra flushing the gastros prior to administerin (Resident #1 & #4) GT. There were 2 error resulting in a findings include: 1. Resident #4 was 12/8/03 with multipl encephalopathy an 8:00 AM, Nurse #1 to administer the m Resident #4 was s medications includi used to treat iron do Nurse #1 started to liquid into the syring flushing the tube fir On 7/22/15 at 8:05 interviewed. She s flushed the tube firs administering the m but she did not. On 7/23/15 at 10:09 was interviewed. St was for the nurse to before and after ea 2. Resident #1 was 1/29/09 with multipl	AM, Nurse #1 was tated that she should have st with water before nedication (Ferrous Sulfate) 5 AM, administrative staff #1 she stated that her expectation o flush the tube with water ch medications. admitted to the facility on le diagnoses including anoxic			For Resident #1 and Resident #4 licensed nursing staff providing medication administration to these residents received in-service educt from the Staff Development Coord or Pharmacist on flushing of entera before and after each medication i administered on 8/5, 8/6,8/10 and 8/11/2015. Nurse #1 was removed from assig with instructions to complete in-ser training with pharmacy consultant of Medication Administration via the er route prior to re-assignment. The Consultant Pharmacist training wa for this nurse on 7/30/2015 with 10 compliance. All licensed nursing staff on all shift Time/Part Time/PRN have receive in-service education from the Staff Development Coordinator, or Phar on flushing the enteral tube before after each medication is administe This education was provided to en residents having the same potentia resident #1 and resident #4 will no affected. In-services held by Consu Pharmacist or Staff Development of 8/5,8/6,8/10, and 8/11/2015.	ation inator, al tube s nment vice on enteral s held 0% its Full d macist and red. sure al as t be ultant on	
	1 was observed to medications for Re- scheduled to receiv Nexium (a drug use	7/22/15 at 10:30 AM, Nurse # prepare and to administer the sident #1. Resident # 1 was ve medications including ed to treat certain stomach and ns) at 10:00 AM. Nurse #1			The following measures will be put place as a systemic change to ens medication administration via the e route: All new licensed nursing sta after 7/23/2015 will receive educat during orientation on proper placer	ure enteral aff hired ion	

Facility ID: 923471

If continuation sheet Page 4 of 21

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 345281 B. WING 07/23/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 625 BETHANY CHURCH ROAD BOX 38 STANLY MANOR ALBEMARLE, NC 28001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 332 Continued From page 4 F 332 started to pour water into the syringe (attached to and flushing of enteral tube during the GT) and immediately followed with the medication administration. powdered Nexium. The nurse was not observed to flush the tube first with water. The medication Licensed Nursing Staff, (Full was stuck at the tip of the syringe and was not Time/Part-Time/ PRN) will receive annual flowing into the tube. Nurse #1 had to pour the education on proper placement and contents of the syringe into a cup and had to flushing via the enteral route during clear the tip of the syringe before she medication administration. administered the medications. On 7/22/15 at 10:35 AM. Nurse #1 was The facility will have the Consultant interviewed. She stated that she should have Pharmacist, Director of Nursing, Assistant flushed the tube first with water before Director of Nursing or Staff Development administering the medication (Nexium) but she Coordinator complete one enteral did not. medication administration audit on one On 7/23/15 at 10:05 AM, administrative staff #1 resident per week x 1 month, and then one enteral medication audit every 2 was interviewed. She stated that her expectation was for the nurse to flush the tube with water weeks on one resident x 1 month, then before and after each medications. one enteral medication audit on one resident monthly until compliance is sustained x 3 months rotating shifts and days, identifying proper flushing of enteral tube prior to administration and during administration of medication to ensure compliance. The reviews will focus on proper flushing of enteral tube before and after each medication is administered. These audits will be monitored by the Director of Nursing or Assistant Director of Nursing and discussed at the facility's Quality Assurance meetings. Audits will occur on one resident per week x 1 month, and then one enteral medication audit every 2 weeks on one resident x 1 month, then one enteral medication audit on one resident monthly until compliance is sustained x 3 months rotating shifts and days, identifying proper flushing of enteral

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 923471

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	LE CONSTRUCTION	(X3) DAT	0938-039
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
		345281	B. WING		07/23/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STANLY	MANOR			25 BETHANY CHURCH ROAD BOX 38 ALBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 332	Continued From pa	age 5	F 332	tube prior to administration and d administration of medication to er compliance. The reviews will focu proper flushing of enteral tube be after each medication is administ	nsure is on fore and	
F 334 SS=D		NZA AND PNEUMOCOCCAL	F 334			8/19/15
	each resident, or the representative receiption immunization; (ii) Each resident is immunization Octobration Octobration annually, unless the contraindicated or the immunized during the (iii) The resident or representative has immunization; and (iv) The resident's in documentation that following: (A) That the resider representative was the benefits and po- immunization; and (B) That the resider influenza immunization of contraindications of the the the influenza immunization of the the contraindications of the the the contraindications of the the the the contraindications of the the the the the contraindications of the the the the the the the contraindications of the	eives education regarding the tial side effects of the soffered an influenza ber 1 through March 31 e immunization is medically the resident has already been this time period; the resident's legal the opportunity to refuse medical record includes t indicates, at a minimum, the ent or resident's legal provided education regarding otential side effects of influenza ent either received the ation or did not receive the ation due to medical r refusal.				

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 345281 B. WING 07/23/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 625 BETHANY CHURCH ROAD BOX 38 STANLY MANOR ALBEMARLE, NC 28001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 334 Continued From page 6 F 334 immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization: and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced bv: Based on record review and staff interview, the For Resident #1 and Resident #11 the residents responsible party's were notified facility failed to document in the resident's medical records that education regarding the and educated on the risk versus benefits, benefits and potential side effects of influenza and side effects of the pneumococcal and

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 345281 B. WING 07/23/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 625 BETHANY CHURCH ROAD BOX 38 STANLY MANOR ALBEMARLE, NC 28001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 334 Continued From page 7 F 334 and pneumococcal immunizations was provided influenza vaccine in September 2014 an to the resident or legal representatives for 2 addendum was placed in the chart (Residents #1 & #11) of 5 sampled residents documenting these conversations. reviewed. Findings include: All current charts were audited to ensure 1. Resident #1 was admitted to the facility on pneumococcal and influenza vaccine was 1/29/09 with multiple diagnoses including anoxic present and documented prior to administration by the Director on Nursing brain damage. The immunization records for Resident #1 was on 8/5/2015. reviewed. The record indicated that Resident #1 has received pneumococcal vaccine on 6/26/15. All licensed nursing staff Full Time/Part There was no documentation in the records that Time/ PRN, have received education from education regarding the benefits and the potential the Staff Development Coordinator or side effects of the pneumococcal immunization Consultant Pharmacist on the following was provided to the legal representative. dates 8/5,8/6,8/10 and 8/11/2015 on the On 7/22/15 at 4:20 PM, administrative staff #1 followina: was interviewed. She stated that if it was not - Before offering the influenza and/or documented it was not done. pneumococcal immunization, each resident, or the resident's legal 2. Resident #11 was admitted to the facility on representative receives education 2/14/14 with multiple diagnoses including regarding the benefits and potential side Congestive Heart failure and Hypertension. effects of the immunization: The immunization records for Resident #11 was - Each resident is offered an influenza reviewed. The record indicated that Resident #11 immunization October 1 through March 31 has received influenza vaccine on 10/2/14. There annually, unless the immunization is medically contraindicated or the resident was no documentation in the records that education regarding the benefits and the potential has already been immunized during this side effects of the influenza immunization was time period; provided to the resident or legal representative. - Each resident is offered a pneumococcal On 7/22/15 at 4:20 PM, administrative staff #1 immunization, unless the immunization is was interviewed. She stated that if it was not medically contraindicated or the resident documented it was not done. has already been immunized; -As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

Event ID: NDFK11

Facility ID: 923471

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		AND HUMAN SERVICES				FORM	08/26/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345281	B. WING	G		07/	23/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP COD		
STANLY	MANOR				25 BETHANY CHURCH ROAD BOX 38 ALBEMARLE, NC 28001	5	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 334	Continued From pa	age 8	F	334	or the resident's legal represer refuses the second immunizat -The resident or the resident's representative has the opportu- refuse immunization; and - The resident's medical record documentation that indicates, a minimum, the following: (A) That the resident or reside representative was provided e regarding the benefits and pote effects of influenza and/or pne immunization; and (B) That the resident either re influenza and/or pneumococca immunization or did not receive influenza immunization due to contraindications or refusal. The following measures will be place as a systemic change to proper documentation of the ir and/or pneumococcal immuniz weekly chart audit will be completed new resident per week X then an audit will be completed admission a month until 3 mor compliance is sustained. The a completed by the Director of N Assistant Director of Nursing o Record Director to ensure corr with the education given.	ion. legal unity to d includes at a ent's legal ducation ential side umococcal ceived the al e the medical e put in ensure offluenza zation: a oleted on 1 month, d on one 1 month, d 1 new oths of audit will be lursing, or Medical opliance	

Event ID: NDFK11

Facility ID: 923471

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		AND HUMAN SERVICES				FORM	08/26/201 APPROVEI 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		345281	B. WING			07/	23/2015
NAME OF	NAME OF PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	••••	
STANLY	MANOR				25 BETHANY CHURCH ROAD BOX 38 LBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334 F 356 SS=C	INFORMATION The facility must por a daily basis: o Facility name. o The current date. o The total number by the following cat unlicensed nursing resident care per sl - Registered nu - Licensed pract vocational nurses (- Certified nurses o Resident census. The facility must por specified above on of each shift. Data o Clear and readab	O NURSE STAFFING ost the following information on and the actual hours worked egories of licensed and staff directly responsible for nift: rses. tical nurses or licensed as defined under State law). e aides. ost the nurse staffing data a daily basis at the beginning must be posted as follows: le format. ace readily accessible to	F 3		facility's Quality Assurance meetings three months of compliance is susta for all audited chart reviews. The audits will include the following: chart audit will be completed on one resident per week X 1 month, then a audit will be completed on one new resident every 2 weeks x 1 month, t an audit will be completed 1 new admission a month until 3 months o compliance is sustained. The audit of focus on the above criteria of documentation needed above for the pneumonia and influenza vaccine.	ained a new an hen f will	8/18/15

		AND HUMAN SERVICES & MEDICAID SERVICES			FOI	ED: 08/26/2015 RM APPROVED IO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2)			DATE SURVEY OMPLETED
		345281	B. WING			7/23/2015
NAME OF I	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
STANLY MANOR					25 BETHANY CHURCH ROAD BOX 38 LBEMARLE, NC 28001	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 356	The facility must, up make nurse staffing for review at a cost standard. The facility must ma staffing data for a m required by State la This REQUIREMEN by: Based on observat facility failed to post was accurate. The On 7/21/15 at 8:53 was conducted. Th central nursing stati The census include and assisted living for On 7/22/2015 at 8:00 information was obse documented as 92. nursing residents at On 7/22/2015 at 8:00 information was obse documented as 91. nursing residents at On 7/22/15 at 8:01 stated the ward seco and posted the staff information. On 7/22/15 at 8:05 she filled out the staff in the computer tha residents that were said that census that posting sheet was t	oon oral or written request, data available to the public not to exceed the community aintain the posted daily nurse hinimum of 18 months, or as w, whichever is greater. AT is not met as evidenced ion and staff interview, the daily staffing information that findings included: AM, an initial tour of the facility e staff posting located at the ion stated the census was 92. d skilled nursing residents residents. D1 AM, staff posting served and the census was The census included skilled assisted living residents.	F3	356	No residents were noted to be affected having the total census reported on the daily posting of staffing information. The daily posting was corrected to show the census for skilled nursing and the censu for home of the aged during the DSHR survey. No potential residents were noted to be affected by having the total census reported on the daily posting. The daily posting of staffing information was corrected to show the census for skilled nursing and the census for home of the aged. The systematic change put in place was the modification of the daily posting of staffing information form to include a break out of census for the skilled level care census and home for the aged census. The ward secretary, ward clerk or charg nurse will complete on each shift and each day including weekends the Daily Posting of staffing.	of

Facility ID: 923471

	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT		<u>NO. 0938-039</u> DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED
		345281	B. WING _		07/23/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
STANLY	MANOR			625 BETHANY CHURCH ROAD BOX 38 ALBEMARLE, NC 28001	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL 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 356	Continued From pa	age 11	F 35	56	
	ward secretary sta previous ward seconumber (residents	dents (ALF) in the facility. The ted she was directed by the retary to put the total census in the building at midnight the staff posting sheet.		In-service education will be provided by the Staff Development Coordinator or Director of Nursing to the charge nurse ward clerk and ward secretary on how properly complete the Daily Staffing Posting for all days, all shifts, including weekends. In-services will be complete by 8/18/2015.	S, to
				The Director of Nursing, Administrator Assistant Director of Nursing will audit posting per week x one month, then wi audit one posting every two weeks x or month and then audit once posting monthly per month until compliance is sustained. The focus will be for accura of census being broken out between th skilled level of care and home for the aged.	one I Ie
				These audits will be reviewed and discussed at the facility's QA meetings the Director of Nursing or Assistant Director of Nursing until three months of compliance is sustained to ensure the correct census is reflected. The audit schedule will be as follows: Audit one posting per week x one month, then wi audit one posting every two weeks x or month and then audit once posting monthly per month until compliance is sustained. The focus will be for accurat of census being broken out between th skilled level of care and home for the aged.	of I Ie Cy e
F 371 SS=E	483.35(i) FOOD P STORE/PREPARE	ROCURE, E/SERVE - SANITARY	F 37		8/19/15

Facility ID: 923471

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		AND HUMAN SERVICES & MEDICAID SERVICES			FC	TED: 08/26/2015 ORM APPROVED NO. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3)	(X3) DATE SURVEY COMPLETED	
		345281	B. WING			07/23/2015	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STANLY MANOR					25 BETHANY CHURCH ROAD BOX 38 LBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From pa	ge 12	F3	371			
	considered satisfac authorities; and	om sources approved or tory by Federal, State or local distribute and serve food litions					
	by: Based on record re observations, the fa temperatures in two refrigerators (200-5 facility failed to main temperature betwee Fahrenheit for one refrigerators (600 h The findings include 1. An observation of nourishment freeze PM. No thermomete 200-500 hall nouris ounce containers of containing three Klo the 200-500 hall no An observation of th freezer was made of ounce containers of	all). ed: f the 200-500 hall r was made on 7/22/15 at 3:03 er was observed in the hment freezer. Sixteen 4 f ice cream, two boxes each dike bars and one box ondike bars were observed in			The facility immediately placed thermometer in freezer in the nourishm refrigerator and discarded the 600 hall college size refrigerator during the DHS survey. Maintenance Director checked the refrigerator in nourishment room and found it to be working properly. The following measures will be put in place as a systemic change to ensure proper temperature is maintained in nourishment refrigerators/freezer and accurate recordings are taken: The Dietary Manager on 7/30/2015 provider education to the housekeeping staff or how to read a thermometer and the acceptable temperature ranges. The Dietary Manager also gave instructions promptly contacting maintenance with a concerns regarding the temperatures of the nourishment refrigerator/freezer. A new daily temperature sheet was creat	ed on any of	

Facility ID: 923471

DEPARTMENT OF HEALTH AND HUMAN SE CENTERS FOR MEDICARE & MEDICAID SE				FORM	08/26/2015 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPP AND PLAN OF CORRECTION IDENTIFICATION	LIER/CLIA (X2) MU		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
34528	1 B. WING	G		07/2	23/2015
NAME OF PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		6	25 BETHANY CHURCH ROAD BOX 38		
STANLY MANOR		A	LBEMARLE, NC 28001		
(X4) ID SUMMARY STATEMENT OF DEFICIENT PREFIX (EACH DEFICIENCY MUST BE PRECEDED TAG REGULATORY OR LSC IDENTIFYING INFOR	BY FULL PREF	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
 F 371 Continued From page 13 A review of the Refrigerator/Freezer T Record Log for the 200-500 hall and 0 nourishment refrigerators revealed th temperatures were not monitored. An interview was conducted with Hou on 7/22/15 at 3:31 PM. She stated the housekeeping staff was responsible f monitoring the temperatures in the nour freigerators. She stated she was not monitor the temperatures in the nour freezers. The Housekeeper stated sh been monitoring the temperatures in nourishment freezers. She also stated observe a thermometer in the 200-50 nourishment freezer. An interview was conducted with Adm Staff # 3 on 7/22/15 at 4:10 PM. She housekeeping staff were not expected the temperatures in the nourishment An interview was conducted with Hou on 7/22/15 at 4:24 PM. She stated sh instructed to monitor the temperature nourishment freezers. 2. A review of the Refrigerator/Freezer Temperature Record Log dated 6/3/1 for the 600 hall nourishment refrigera conducted. The acceptable temperature the nourishment refrigerator/Freezer Temperature reading equal to 3 Fahrenheit was documented on 6/3/1 temperature reading equal to 50 degr Fahrenheit was documented on 6/3/1 temperature reading equal to 30 degr 	Temperature 500 hall e freezer sekeeper #1 e or burishment instructed to shment e had not the d she did not 0 hall hinistrative stated the d to monitor refrigerators. sekeeper #2 he was not s in the er 5 to 7/22/15 tor was ure range for referenced sure Record 50 degrees 5. A ees 15. A	371	freezer temperatures. The facility will have the Dietary Ma or Assistant Dietary Manager to con a weekly audit of nourishment refrigerator/freezer temperature log one month, then audit every two we 1 month, then audit once a month u three months of compliance is susta This audit will be reviewed and disc at the Quality Assurance Committee meeting by the Dietary Manager or Assistant Dietary Manager. The rev will focus on proper temperature documentation. Audits will be reviewed and discuss the Dietary Manager or Assistant Di Manager at the Quality Assurance Committee Meetings until three mon compliance is sustained for 3 month reviews. Audit schedule will be as for Complete a weekly audit of nourishing refrigerator/freezer temperature log one month, then audit every two we 1 month, then audit once a month u three months of compliance is susta This audit will be reviewed and disc at the Quality Assurance Committee meeting by the Dietary Manager or Assistant Dietary Manager. The rev will focus on proper temperature documentation.	nplete s for eks X intil ained. ussed e iews ed by etary nths of nly blows: ment s for eks X intil ained. ussed e	

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 345281 B. WING 07/23/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 625 BETHANY CHURCH ROAD BOX 38 STANLY MANOR ALBEMARLE, NC 28001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 371 Continued From page 14 F 371 Fahrenheit was documented on 6/21/15. A temperature reading equal to 30 degrees Fahrenheit was documented on 6/29/15. A temperature reading equal to 32 degrees Fahrenheit was documented on 6/30/15. A temperature reading equal to 30 degrees Fahrenheit was documented on 7/2/15. A temperature reading equal to 32 degrees Fahrenheit was documented on 7/3/15. A temperature reading equal to 30 degrees Fahrenheit was documented on 7/4/15. A temperature reading equal to 30 degrees Fahrenheit was documented on 7/5/15. A temperature reading equal to 26 degrees Fahrenheit was documented on 7/7/15. A temperature reading equal to 28 degrees Fahrenheit was documented on 7/8/15. A temperature reading equal to 28 degrees Fahrenheit was documented on 7/9/15. A temperature reading equal to 30 degrees Fahrenheit was documented on 7/10/15. A temperature reading equal to 28 degrees Fahrenheit was documented on 7/12/15. A temperature reading equal to 26 degrees Fahrenheit was documented on 7/13/15. A temperature reading equal to 20 degrees Fahrenheit was documented on 7/14/15. A temperature reading equal to 20 degrees Fahrenheit was documented on 7/16/15. A temperature reading equal to 24 degrees Fahrenheit was documented on 7/17/15. A temperature reading equal to 52 degrees Fahrenheit was documented on 7/20/15. A temperature reading equal to 50 degrees Fahrenheit was documented on 7/21/15. An observation of the 600 hall nourishment refrigerator on 7/22/15 at 2:51 PM revealed the refrigerator contained three pasteurized raw

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 345281 B. WING 07/23/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 625 BETHANY CHURCH ROAD BOX 38 STANLY MANOR ALBEMARLE, NC 28001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 371 Continued From page 15 F 371 eggs, containers of thick it, containers of juice and cans of soda. An interview was conducted with Housekeeper #1 on 7/22/15 at 3:31 PM. She stated the housekeeping staff was responsible for monitoring the temperatures in the nourishment refrigerators. She stated she was unaware of the acceptable temperature range for the nourishment refrigerators. She stated she verbally informed Administrative Staff #2 on 7/22/15 of the recent elevated temperature readings for the 600 hall nourishment refrigerator. An interview was conducted with Administrative Staff # 3 on 7/22/15 at 4:10 PM. She stated the housekeeping staff were expected to monitor the temperature of the nourishment refrigerators daily. She stated the nourishment refrigerators were expected to be maintained at 50 degrees Fahrenheit or below. She stated she was not made aware that the 600 hall nourishment refrigerator temperature was equal to 52 degrees Fahrenheit on 7/20/15 and equal to 50 degrees Fahrenheit on 7/21/15. She stated the housekeeping staff were expected to inform her of all abnormal temperature readings. She would then inform the maintenance director of the abnormal temperature reading. An interview was conducted with Housekeeper #2 on 7/22/15 at 4:24 PM. She stated the housekeeping staff were expected to monitor the temperature of the nourishment refrigerators daily. She stated the nourishment refrigerators were expected to be maintained between 32 to 34 degrees Fahrenheit. She stated she verbally informed Administrative Staff #1 and Administrative Staff #2 on 7/21/15 of the elevated

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/26/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345281	B. WING		07/2	23/2015
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	•	
STANLY	MANOR			25 BETHANY CHURCH ROAD BOX 38 ALBEMARLE, NC 28001		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371 F 431 SS=D	Staff #2 on 7/22/15 told of the elevated 600 hall nourishmer stated he was not n refrigerator had rea months of June and temperature of the to the high number the refrigerator. Adr 600 hall nourishmer on 7/22/15 and a la placed on the 600 h 483.60(b), (d), (e) D LABEL/STORE DR The facility must en a licensed pharmac of records of receip controlled drugs in a accurate reconciliat records are in order controlled drugs is n reconciled. Drugs and biological labeled in accordan professional princip appropriate access instructions, and the applicable. In accordance with	gs for the 600 hall rator. onducted with Administrative at 5:13 PM. He stated he was temperature reading in the nt refrigerator on 7/20/15. He nade aware that the ched low temperatures in the d July. He stated the refrigerator was elevated due of foods items placed within ministrative Staff #2 stated the nt refrigerator was removed rger refrigerator would be nall. DRUG RECORDS, UGS & BIOLOGICALS ploy or obtain the services of ist who establishes a system t and disposition of all sufficient detail to enable an ion; and determines that drug and that an account of all maintained and periodically als used in the facility must be ce with currently accepted les, and include the	F 371			8/19/15
		its under proper temperature				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 08/26/2015 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY DMPLETED
		345281	B. WING			7/23/2015
NAME OF F	PROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
STANLY	MANOR				25 BETHANY CHURCH ROAD BOX 38 LBEMARLE, NC 28001	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	have access to the The facility must pro- permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distril	t only authorized personnel to keys. Divide separately locked, I compartments for storage of ed in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can	F4	431		
	by: Based on record reinterview, the facility medications and to on 3 of 5 medication observed. Findings Facility's policy on M dated 10/14 was rein in part " all multi do opened. The multi do opened. The multi do opened. The multi do append. The multi do opened. The multi do opene	Medication Expiration Dates viewed. The policy indicated ose vials must be dated when dose vial should be discarded ate the vial is opened. " :00 PM, the medication cart served. There was an opened supplement to prevent UTI) ning. The instruction on the dicated " discard three ng. "			The medications that were noted expire or did not have open dates listed on vials from medication carts on 400/500/600 cart were removed from the cart and returned to the pharmacy on 7/22/2015. All carts were checked to ensure no out date medication or open undated vials were present by the Director of Nursing of 7/23/2015. All licensed nursing staff, Full Time/ Part Time/PRN, have received in-service education from the Staff Development Coordinator, or Consultant Pharmacist of proper labeling of multi dose vials when opened and discarding of expired medications on 8/5, 8/6, and 8/10/2015 The following measures will be put in place as a systemic change to ensure proper discarding and labeling of open	5 of on

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 345281 B. WING 07/23/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 625 BETHANY CHURCH ROAD BOX 38 STANLY MANOR ALBEMARLE, NC 28001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PRÉFIX** PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 431 Continued From page 18 F 431 was for the nurse to write the date on the vials on medication carts: The facility will have the Consultant Pharmacist, Director bottle/vial when it was first open. of Nursing, Assistant Director of Nursing 1b. On 7/22/15 at 200 PM, the medication cart on or Staff Development Coordinator 400 hall was observed. There was an opened complete 1 cart audit a week X one bottle of Regular insulin with date of opening of month, then one cart audit every 2 weeks 6/8/15. x one month, then one cart audit monthly On 7/22/15 at 2:20 PM, Nurse #2 was interviewed until three months of compliance is sustained. The audit will occur on different and stated that Regular insulin was good for 28 days after opening and acknowledged that the days of the week, including weekends. opened bottle of Regular insulin was already The Director of Nursing, Assistant expired. On 7/23/15 at 10:05 AM, administrative staff #1 Director of Nursing or Consultant was interviewed. She stated that her expectation Pharmacist will review and discuss the was for the nurse to check the expiration date on audits at Quality Assurance meetings until three months of compliance is sustained the vial before administering the insulin. She for all audited medication cart reviews. acknowledged that Regular insulin was good for 28 days after opening. The audit schedule will be as follows: The facility will have the Consultant 2a. On 7/22/15 at 2:30 PM, the 500 hall Pharmacist, Director of Nursing, Assistant medication cart was observed. There was an Director of Nursing or Staff Development opened bottle of UTI stat with no date of opening. Coordinator complete 1 cart audit a week The instruction on the bottle of the UTI stat read X one month, then one cart audit every 2 " discard three months after opening. " The weeks x one month, then one cart audit pharmacy sticker on the bottle indicated that it monthly until three months of compliance is sustained. The audit will occur on was dispensed from the pharmacy on 2/4/15. On 7/22/15 at 2:45 PM, Nurse #1 was different days of the week, including interviewed. She stated that the UTI stat should weekends. have been dated when opened but it was not. On 7/23/15 at 10:05 AM, administrative staff #1 was interviewed. She stated that her expectation was for the nurse to write the date on the bottle/vial when it was first open. 2b. On 7/22/15 at 2:30 PM, the 500 hall medication cart was observed. There were 2 opened bottles of lidocaine HCL (local anesthetic) injection with no date of opening. The sticker instruction on the bottle read " discard 28 days

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 345281 B. WING 07/23/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 625 BETHANY CHURCH ROAD BOX 38 STANLY MANOR ALBEMARLE, NC 28001 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 431 Continued From page 19 F 431 after opening. " There was also 1 opened bottle of lidocaine HCL injection in a small plastic bag with no date of opening. The bag indicated that the lidocaine was dispensed from the pharmacy on 5/25/15. On 7/22/15 at 2:45 AM. Nurse #1 was interviewed. Nurse #1 stated that the lidocaine should have been dated when opened and they were good for 28 days after opening. On 7/23/15 at 10:05 AM, administrative staff #1 was interviewed. She stated that her expectation was for the nurse to write the date on the bottle/vial when it was first open. 3a. On 7/22/15 at 3:04 PM, an observation of the 600 hall medication cart was conducted. An opened package of Budesonide (breathing medication) 0.25 milligrams (mg)/ two milliliters (ml) was observed in the medication cart. The label on the package stated to discard 14 days after opening. The date opened was documented as 7/5/15. On 7/22/15 at 3:04 PM. Nurse #1 stated she should have discarded the medication. On 7/22/15 at 3:37 PM, the pharmacy consultant stated the medication should have been discarded 14 days after opening the package on 7/5/15. 3b. On 7/22/15 at 3:04 PM, an observation of the 600 hall medication cart was conducted. An opened one ml vial of promethazine (nausea medication) 25mg/ ml was observed in the medication cart. This was a single dose vial. The date opened on the vial stated 9/16/14. On 7/22/15 at 3:04 PM, Nurse #1 stated she did not know the vial was in the medication cart. On 7/22/15 at 3:37 PM, the pharmacy consultant stated the promethazine was a single dose vial and any medication left in the vial after

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
	345281	B. WING				07/23/2015	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CC					
STANLY MANOR		625 BETHANY CHURCH ROAD BOX 38 ALBEMARLE, NC 28001					
PREFIX (EACH DEFICIENC)	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL				N SHOULD	BE	(X5) COMPLETION DATE
-	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 administration should be have been discarded		PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE			HOULD BE COMPLÉTION	

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