

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

PRINTED: 04/20/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345242	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/16/2016
NAME OF PROVIDER OR SUPPLIER THE FOUNTAINS AT THE ALBEMARLE			STREET ADDRESS, CITY, STATE, ZIP CODE 200 TRADE STREET TARBORO, NC 27886	
(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation conducted on 3/16/16. Event ID # UGIO11. Intake # NC00114618	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to cover the urinary collection bag for 1 of 2 residents, (resident # 30) observed with indwelling urinary catheters. The findings included: Resident #30 was re-admitted to the facility on 10/29/2015, with diagnoses to include neuromuscular dysfunction of the bladder and retention of urine. Her Minimum Data Set (MDS) assessment dated 1/1/2016 revealed her cognitive status was severely impaired, and she had an indwelling catheter. An observation was conducted on 3/14/2016 at 1:58 PM, in the resident's room. The resident was lying in bed with the urine collection bag hanging from the side of her bed with no cover, and visible upon entering the room. An observation was conducted on 3/15/2016 at 8:51 AM. The resident's urine collection bag was not covered, and was hanging on the side of her bed, visible upon entering her room. On 3/15/2016 at 3:21 PM, an interview was	F 241	F241 Corrective Action for Affected Resident: 1. Resident #30 urinary collection bag was immediately covered at the time of survey on 03/16/2016. Procedure for Identifying Potentially Affected Residents: 2. Currently two residents have indwelling urinary catheter, one with diagnosis of Neurogenic Bladder and the other with diagnosis of Comfort/Palliative Care. The Nurses and CNAs assigned to residents with urinary collection bags are required to check and ensure the residents' bags are covered at all times. 03/16/2016. 3. To serve as a reminder for the Nurses, "Keep Foley Bag Covered" is documented on the residents' MARs. As a reminder for the CNAs, the same alert was added to the resident's Kardex in the electronic health record, Point of Care. 04/06/2016 Measures Adopted for Systemic Change: 4. The Nurses and CNAs were	4/13/16

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

TITLE

(X6) DATE

Electronically Signed

04/06/2016

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.

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F 241	Continued From page 1 conducted with the resident, who was sitting up in a recliner chair in her room facing the hallway. The resident's urine collection bag was not covered, and was hanging towards the front of the chair, visible from the hallway. The resident stated she liked being up in her chair, and she had had her catheter for years. On 3/16/2016 at 10:37 AM, a dressing change was observed on Resident #30 with nurse #1. The resident's urine collection bag, with no cover, was hanging on the side of the bed, visible upon entering the room. On 3/16/2016 at 11:20 AM, an interview was conducted with the resident's nursing assistant, NA #1. The NA stated she covered the urine collection bag when the resident was in her wheelchair and out of her room. She did not use a cover for the bag when the resident was in her room. On 3/16/2016 at 11:22 AM, an interview was conducted with nurse #1, who stated they only covered the urine collection bag when the resident left the room On 3/16/2016 at 12:21 PM, an interview was conducted with the Director of Nursing, DON, who stated she expected the urine collection bag to be covered when the resident was out of her room, in a public area. The DON stated she had not noticed the urine collection bag was visible from the hallway when the resident was up in her recliner.	F 241	re-educated on how to ensure and maintain all residents' DIGNITY with emphasis on always covering the urinary collection bags, ostomy bags and the like. 03/16/2016, 03/18/2016 DIGNITY training will be reinforced at next nursing staff meeting. 04/13/2016 5 DON, ADON and/or NHA will conduct purposeful rounds at random times during the week to ensure residents with urinary collection bags are always covered and that staff delivers personalized care to our residents in an environment that maintains or enhances each resident's dignity in respect to his or her individuality. Starting 04/01/2016. Monitoring of Corrective Action and Quality Assurance: 6. The DON, ADON and/or NHA will present findings of their daily rounds and any corrective actions taken to the Quality Assurance (QA) Committee monthly. Starting 04/21/2016 next scheduled QA Committee meeting.		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371		4/13/16	

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F 371	<p>Continued From page 2</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to 1) discard 1 container of pimento cheese and 1 container of pumpkin by the use-by date in 1 of 1 walk-in refrigerator, 2) failed to store 1 container of fish in the walk-in freezer with a lid and 3) failed to wear hair restraints for 1 of 3 food service employees who did not wear a hair net or hat and did not wear a beard cover while working in the kitchen. The findings included: 1) On 3/14/16 beginning at 7:00 AM an observation of the walk-in refrigerator revealed a container of pimento cheese with a label dated 2/28/16 and a container of pureed pumpkin filling dated 2/19/16. On 3/14/16 at 7:10 AM Cook #1 stated the date on the label was the date the items were made or put into the refrigerator. On 3/14/16 at 9:35 AM the Dietary Director stated the containers of pimento cheese and pumpkin should be "acceptable for 3-4 days" from the date on the label. She stated the items should have been discarded. 2) On 3/14/16 at 7:11 AM an observation of the walk-in freezer revealed a clear plastic container of fish. The container was broken along the top edge on 2 sides with sharp pointed edges observed. There was no lid on the container. The fish was observed to have ice crystals on the exposed top area and the thin edges of the fish had a freezer burned white appearance.</p>	F 371	<p>F371 All containers found with expired food were discarded immediately on day of survey. 03/14/2016</p> <p>1. 1. All dining services staff with food preparation and/or food storage responsibilities will be in-serviced and re-educated on proper storage of all food products, both acceptable length of storage and appropriate containers. In-service will occur on 4/7/2016. Chef or his designee will monitor all refrigerators and freezers daily, for 60 days, to verify compliance with proper handling and storage procedures. If no violations are encountered, random inspections will continue ongoing. Audit results will be reported to the QI Committee monthly for three months beginning 4/21/2016.</p> <p>2. All dining services staff with food preparation and/or food storage responsibilities will be in-serviced and re-educated on proper storage of all food products, both acceptable length of storage and appropriate containers. In-service will occur on 4/7/2016. Chef or his designee will monitor all refrigerators and freezers daily, for 60 days, to verify compliance with proper handling and</p>		

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F 371	Continued From page 3 On 3/14/16 at 7:13 AM Cook #1 stated he thought the fish was for a function scheduled for that same night. He stated he did not know why the container was broken or why it was replaced on the shelf without a lid on it. He did not know where the lid was located. On 3/14/16 at 9:35 AM the Dietary Manager stated the container of frozen fish should have been discarded and the lid may have been swept out when the staff swept the inside of the freezer. She stated once the container was broken it should have been discarded. 3) On 3/14/16 beginning at 7:05 AM Dietary worker #1 was observed working in the dish room area of the kitchen. He was not be wearing a hair restraint or beard cover. On 3/14/15 at 7:18 AM he was observed carrying 3 cutting boards from the dish room into the cooking area of the kitchen and place them on a counter top. He was not wearing a hair restraint or beard cover. On 3/14/16 at 7:20 AM an interview was conducted with Dietary Worker #1. He stated he usually wore a hat while working in the kitchen if he was running the dish machine but may not wear one while he was putting away clean food service ware. During the interview he was observed to have a mustache and beard. On 3/14/16 at 9:35 AM the Dietary Manager stated Dietary Worker #1 should have had a hair restraint on because he was obviously working in the kitchen.	F 371	storage procedures. If no violations are encountered, random inspections will continue ongoing. Audit results will be reported to the QI Committee monthly for three months beginning 4/21/2016. 3. All dining services associates will be in-serviced and re-educated on proper uniform policy for kitchen tasks, including head covers and beard covers. Beard covers were ordered immediately following survey exit, and in-service will occur on 4/7/2016. Kitchen Manager or his designee will monitor all associates, first and second shift, for proper uniform including approved head covers, facial hair covers and gloves for 60 days to verify compliance. If no violations are encountered, random inspections will continue ongoing. Audit results will be reported to the QI Committee monthly for three months beginning 4/21/2016.		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431		4/13/16	

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F 431	<p>Continued From page 4</p> <p>controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, and staff interviews the facility failed to secure 1 of 2 medication carts, (the west hall cart), when left unattended. The findings included: An initial tour of the facility was conducted on 3/14/2016 at 6:11 AM. One of the 2 medication</p>	F 431	<p>F431 Corrective Action for Affected Resident: 1. No Affected Resident was Identified. Procedure for Identifying Potentially Affected Residents: 2. All residents have the potential to be</p>		

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F 431	Continued From page 5 carts in the main hallway was unlocked. Various boxes were on top of the cart, as well as the medication administration record book. 3 residents were present in the main hallway, near the medication carts. 1 resident was sitting in a wheelchair and 2 residents were standing with their walkers. A couple of minutes later the nurse came out into the hallway, from several rooms away and walked to the cart. An interview was immediately conducted with the nurse, Nurse #2. The nurse stated she didn't usually leave the cart unlocked, she just left to do a blood sugar check. On 3/15/2016 at 3:38 PM, an interview was conducted with the Director of Nursing (DON). The DON stated she expected the nurses to lock the medication cart every time they left it unattended.	F 431	affected by the deficient practice of not securing the medication cart. Measures Adopted for Systemic Change: 3. Nurse #2 responsible for failing to lock the medication cart while unattended was given an oral documented counseling by the DON on 03/18/2016. 4. Licensed staff (Nurses and CMA) were re-educated regarding policy Skilled Nursing Medication Pass (WRC-SNF-P098) with focus on locking medication carts when unattended and safe medication storage by Nurse #2 with DON in attendance. 04/04/2016, 04/06/2016 Training will be reinforced at next nurses meeting on 04/13/2016. Monitoring of Corrective Action and Quality Assurance: 5. Omnicare Pharmacy Representative (PharmD) monitored medication pass with no deficiencies found on 03/23/2016 6. To ensure quality assurance compliance with securing storage of medications, a Pharmacy Representative will monitor medication pass once a month. 7. DON and/or ADON will also monitor and observe a medication pass on shifts 7-3, 3-11 and 11-7 each month (Total of 4 observations per month including Pharmacy Representative review). Starting 04/13/2016 8. All new hires will be checked off by a Lead Nurse on medication administration which will include properly locking the medication cart. Starting 04/13/2016 9. Results of monthly medication pass observations and any corrective actions taken will be reported to the QA		

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F 431	Continued From page 6	F 431			
F 520 SS=E	<p>483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility's Quality Assessment and Assurance (QAA) Committee failed to implement, monitor and revise as needed the action plan developed to correct deficiencies in the area of dignity (F</p>	F 520	<p>Committee meeting. Starting next QA meeting on 4/21/2016</p> <p>F520 Corrective Action for Affected Residents: 1. Resident #30 urinary collection bag was immediately covered at the time of survey on 03/16/2016.</p>	4/13/16	

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F 520	<p>Continued From page 7</p> <p>241) cited during the recertification survey of 5/20/2015. As a result, a deficiency in the area of dignity was cited again on the current survey. The findings included: This tag is cross referenced to: F 241: Based on observations and staff interviews the facility failed to cover the urinary collection bag for 1 of 2 residents, (resident # 30) observed with indwelling urinary catheters.</p> <p>During the recertification survey on 5/20/2015 the facility was cited for failing to serve food close to the time the other residents were served, and provide prompt feeding assistance.</p> <p>On 3/16/2016 at 12:24 PM, an interview was conducted with the Director of Nursing (DON). The DON stated the dignity issue last year was in the dining room, with feeding residents seated together at the same times. She stated the QAA committee met and created a seating plan to better assist the residents. She indicated the resident's urine collection bag should have been covered and they will be more mindful of residents with urine collection bags in the future.</p>	F 520	<p>Procedure for Identifying Potentially Affected Residents:</p> <ol style="list-style-type: none"> Currently two residents have an indwelling urinary catheter, one with a diagnosis of Neurogenic Bladder and the other resident with diagnosis of Comfort/Palliative Care. The Nurses and CNAs assigned to residents with indwelling urinary catheters are required to check and ensure the residents' bags are covered at all times. 03/16/2016. To serve as a reminder for the Nurses, "Keep Foley Bag Covered" is documented on the residents' MARs. As a reminder for the CNAs, the same alert was added to the resident's Kardex in the electronic health record, Point of Care. 04/06/2016 Measures Adopted for Systemic Changes: DON, ADON, NHA and/or a QA Committee Member will conduct daily rounds at random times during the week to ensure that staff delivers personalized care to our residents in an environment that maintains or enhances each resident's dignity in respect to his or her individuality. Management will utilize The Skilled Nursing Dignity Rounds Checklist (SEE Attachment A) to document any findings and corrective action(s) taken. Starting 04/01/2016. Measures of Corrective Action and Quality Assurance: As a means of Quality Assurance, the QA Committee will meet monthly exceeding the quarterly requirement. Findings documented on The Skilled Nursing Dignity Rounds Checklist and any immediate corrective actions (such as 		

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F 520	Continued From page 8	F 520	coaching, inservice or disciplinary actions)will be presented by the DON, ADON and/or NHA to the QA Committee who in turn will review and execute any further corrective action plans as warranted. Starting 04/21/2016		