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 _____	06/02/2017

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 281 SS=D	483.21(b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews, the facility failed to transcribe a physician's order for weekly finger stick blood sugar (FSBS) monitoring for 1 of 2 residents reviewed with physician orders for FSBS monitoring (Resident #73). The findings included: Resident #73 was admitted to the facility on 11/08/11 with diagnoses that included diabetes mellitus. Review of Resident #73's medical record revealed a Consultant Pharmacist Communication to Physician (CPCP) form dated 03/30/17 which recommended a reduction in FSBS frequency to weekly. The form was signed by the physician on 04/03/17 with his response circled, "I agree. Please write order(s)." Review of Resident #73's Medication Administration Records (MARs) for May 2017 and June 2017 revealed FSBS were performed daily with results recorded. Review of the June 2017 physician orders for Resident #73 revealed an order for FSBS daily at	F 281	Disclaimer Clause: Preparation and or execution of this plan does not constitute admission or agreement by the Provider of the truth of facts alleged or conclusion set forth on the statement of deficiencies. The plan is prepared and executed solely because it is required by the provisions of State and Federal law. F281 483.21 (b)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS On June 2, 2017, an order was clarified by physician for Resident # 73, and processed so that resident receives weekly finger stick for blood sugar. On June 3, 2017 all active orders for residents with FSBS were audited by the Director of Nursing to ensure orders were processed correctly and timely. Between June 3 and June 20, 2017 Pharmacy consultant reports for past 90 days were reviewed by Director of Nursing to ensure that all recommendations from pharmacy consultant had been processed correctly and timely. On June 12, 2017 all Administrative	6/22/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/19/2017

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 281	Continued From page 1 6:00 AM. There was no evidence FSBS had been changed to weekly as ordered by the physician. An Interview with the Director of Nursing (DON) on 06/01/17 at 3:35 PM revealed the Unit Manager (UM) made rounds with the Physician and wrote down any new orders or changes to existing orders. The DON stated the UM entered the orders into the resident's medical record as indicated by the physician. An interview with UM #1 on 06/02/17 at 1:58 PM and 4:14 PM revealed orders were received either written or verbally by the Physician or Nurse Practitioner (NP). She added the nurses or UM could enter physician orders into a resident's medical record. UM #1 confirmed she had received Resident #73's signed CPCP form from the physician on 04/04/17 and had initialed the form in acknowledgement. During the interview, UM #1 reviewed the order history for Resident #73. She confirmed his order for FSBS was last changed on 02/06/17 and he had since continued to receive FSBS on a daily basis. UM #1 stated she was not sure how she had missed the order for weekly FSBS and acknowledged the order should have entered when she received the CPCP form from the physician on 04/04/17. An interview with the Administrator on 06/02/17 at 4:25 PM revealed it was her expectation for staff to enter orders into the computer system when received by the physician and follow orders as directed.	F 281	nurses were in- serviced on processing of orders from pharmacy report by Director of Nursing. Between June 15, 2017 and June 20, 2017 all licensed nursing employees including RNs and LPNs in-serviced by Director of Nursing and Assistant Director of Nursing on processing of physician□s orders correctly and timely. To ensure quality assurance, all Pharmacy consultant reports will be reviewed monthly by Director of Nursing to ensure orders are processed correctly and timely. Results of these audits and reviews will be reported in the facility Quality Assurance Meeting for a minimum of three consecutive meetings.	
F 367 SS=D	483.60(e)(1)(2) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN	F 367		6/22/17

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F 367	Continued From page 2 (e) Therapeutic Diets (e)(1) Therapeutic diets must be prescribed by the attending physician. (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and staff interviews, the facility failed to serve a prescribed therapeutic diet of pureed meats per physician's orders for 1 of 2 residents reviewed for nutrition (Resident #50). The findings included: Resident #50 was admitted to the facility on 01/27/14 with diagnoses that included Alzheimer's disease, cerebrovascular disease (stroke) and dysphagia (difficulty swallowing). The most recent Minimum Data Set (MDS) dated 02/10/17 coded Resident #50 with severe cognitive impairment. The MDS indicated he required set up assistance and supervision with eating, and received a therapeutic diet. Review of the care plans for Resident #50 revealed an active plan in place dated 02/24/17 which indicated he required diet modifications. Interventions included for staff to provide assistance as needed with eating. Review of Resident #50's medical record revealed a speech therapy note dated 05/22/17	F 367	F367 483.60(e)(1)(2) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN On 5-30-17 Resident # 50 was provided with correct diet consistency for consistency as prescribed by physician. Original plate with incorrect diet consistency was removed by Dietary Manager before resident consumed and a new plate was served with correct diet consistency in presence of surveyor. On 5-30-17 Dietary Manager audited all active orders for residents to ensure accuracy. Between 5-30-17 and 5-31-17 dietary employees were in serviced on therapeutic diets. Areas covered were consistency and importance to check consistency of diet and liquids on the serving line. Between May 30- June 20, 2017 all nursing employees including LPNs, RNs, and CNAs were in- serviced on therapeutic diets and consistency of diets during the delivery of meals by Director of Nursing and Assistant Director of Nursing. Diet cards placed on tray for delivery have been altered to assist staff in being	

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F 367	Continued From page 3 which read in part, "patient downgraded to mechanical soft solids with pureed meets and to continue with thin liquids at this time." Review of the physician's orders for Resident #50 revealed an order dated 05/24/17 which read, "Diet: mechanical soft with pureed meats." On 05/30/17 at 12:24 PM Resident #50 was observed in the dining room coughing heavily after taking a drink. Upon closer observation, Resident #50 had already received his meal tray which contained a regular textured salmon patty. His meal card indicated he was to receive mechanical soft diet with pureed meats. Resident #50 was observed picking up his fork and attempting to cut into the salmon patty. The Dietary Manager (DM) was called to his table and confirmed he had not received the correct diet. The DM removed Resident #50's plate and returned with a plate containing pureed meat. An interview was conducted with the DM on 05/30/17 at 12:30 PM. The DM was unable to explain how Resident #50 received the incorrect diet and stated his diet had recently been changed to mechanical soft with pureed meats. She added the dietary staff should have caught the error before his tray left the kitchen. An observation of the meal service line was conducted on 06/01/17 at 11:31 AM. There were 3 Dietary Aides on one side of the steam table preparing the tray for service and one Cook on the opposite side plating the meal. During the observation, the Cook explained the process as the trays were being prepared. The Cook indicated the Dietary Aides at the beginning of the service line placed the meal card on the tray, at	F 367	alerted to specific therapeutic diets and consistency of diet. Location of specific diets and consistency on card is now more visible for staff to identify. Audits were done by Dietary Manager, between May 31 and June 7, 2017 of the serving line with one meal each day for one week to ensure consistency of diets are correct. To ensure quality assurance audits will continue as follows: One meal per week for ninety days, and monthly for one year. Registered Dietician will continue to monitor orders, tray cards, and delivery of therapeutic diets to ensure proper diet and consistency as prescribed by physician monthly. Results of these audits and reviews will be reported in the facility Quality Assurance Meeting for a minimum of three consecutive meetings.	

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F 367	Continued From page 4 an angle leaning against the drinks, as the tray was pushed down the service line. The Cook stated she was able to view the meal card when she looked over the steam table to see what diet was indicated and plated the meal accordingly. Once the meal was plated, Dietary Aides at the end of the service line also reviewed the meal card, added any supplements indicated and placed the tray on the service cart for delivery. An interview with the Administrator on 06/02/17 at 4:25 PM revealed she expected all staff to look at residents' meal cards to ensure the meal tray contained the correct diet when preparing the plate, when putting the meal tray on the cart for delivery and when providing meal set-up or assistance to eat. She stated it was her expectation staff would read and follow what was indicated on the meal card.	F 367		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and	F 520		6/22/17

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F 520	Continued From page 5 (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain implemented procedures and monitor the interventions the committee put into place in May of 2016. This was for one recited deficiency that was originally cited in April of 2016 and was subsequently cited in June of 2017 on the current recertification survey. The repeated deficiency was in the area of services meet professional standards of quality. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program.	F 520	F520 483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS CCHR maintains a quality assessment and assurance committee consisting at a minimum of: The director of nursing services, Medical Director or his/her designee and at least three other members of the facility□s staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role. CCHR QAA meets at least quarterly to coordinate and evaluate activities such as	

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F 520	Continued From page 6 The findings included: This tag is cross referenced to: F 281: Based on medical record review and staff interviews, the facility failed to transcribe a physician's order for weekly finger stick blood sugar (FSBS) for 1 of 2 residents reviewed with physician orders for FSBS monitoring (Resident #73). The facility was recited for F 281 on the current recertification survey for failing to transcribe a physician's order for weekly finger stick blood sugar (FSBS). F 281 was originally recited during the April 2016 recertification survey for failing to follow up on a dietary recommendation to increase a nutritional supplement due to weight loss for 1 of 3 residents reviewed for nutrition. During an interview on 06/02/2017 at 5:51 PM the Administrator stated last years citation at F 281 was specific to dietary recommendations which were monitored for one year to achieve sustained compliance.	F 520	identifying 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. On June 2, 2017, an order was clarified by physician for Resident # 73, and processed so that resident receives weekly finger stick for blood sugar. On June 3, 2017 all active orders for residents with FSBS were audited by the Director of Nursing to ensure orders were processed correctly and timely. Between June 3, 2017 and June 20, 2017, Pharmacy consultant reports for the past 90 days will be reviewed by Director of Nursing to ensure that all recommendations from pharmacy consultant had been processed correctly and timely. On June 12, 2017 all Administrative nurses were in- serviced on processing of orders from pharmacy report by Director of Nursing. Between June 15, 2017 and June 20, 2017 all licensed nursing employees including RNs and LPNs in-serviced by Director of Nursing and Assistant Director of Nursing on processing of physician□s orders correctly and timely. To ensure quality assurance, all Pharmacy consultant reports will be reviewed monthly by Director of Nursing to ensure orders are processed correctly and timely. Results of these audits and reviews will be reported in the facility Quality Assurance Meeting for a minimum of three consecutive meetings.	

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F 520	Continued From page 7	F 520	Unprocessed pharmacy consultant recommendations will be reported by consultant/designee in QAA at least quarterly for follow up. Pharmacy consultant will continue to attend QAA meetings at least quarterly. All corrective action will be complete on or before June 22, 2017.	