### Statement of Deficiencies

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<tr>
<th>X4 ID</th>
<th>Prefix Tag</th>
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<tr>
<td>F 329</td>
<td>SS D</td>
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</tbody>
</table>

#### Summary Statement of Deficiencies

**483.25(l) Drug Regimen is Free from Unnecessary Drugs**

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review and staff interviews the facility failed to prevent excessive dosing a resident receiving anticoagulant therapy for 1 of 10 residents receiving unnecessary drug review. (Resident #34)

Findings include:

Resident #34 was admitted to the facility on

Resident #34 was assessed daily on 3/15, 3/16, 3/17 during the time that the Coumadin dosage error was administered. No adverse signs or symptoms were noted by resident or staff. On 3/18/11 the error was noted by staff and immediate action was taken to notify the physician and an order was received to obtain a PT INR to monitor resident's levels.

Physician visited resident and stated in progress note resident was stable and appears comfortable.

Nursing staff continued to monitor closely resident #34 with no adverse signs/symptoms noted.

3/21/11 A PT INR was obtained and physician was made aware of results. Facility implemented further instructions by physician.

### Laboratory Director's or Provider/Supplier Representative's Signature

Stephanie Knepper, Administrator

Date: 4-21-11

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 patient. (See Instructions.) Except for nursing homes, the findings stated above are discoverable 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 discoverable 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.
**NAME OF PROVIDER OR SUPPLIER**

<table>
<thead>
<tr>
<th>STANLY MANOR</th>
</tr>
</thead>
</table>

**STREET ADDRESS, CITY, STATE, ZIP CODE**

| 629 BETHANY CHURCH RD BOX 38 |
| ALBEMARLE, NC 28001 |

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

| (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: |
| 345281 |

| (X2) MULTIPLE CONSTRUCTION |
| A. BUILDING |
| B. WING |

**DATE SURVEY COMPLETED**

| 03/24/2011 |

<table>
<thead>
<tr>
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</table>
| F 329             | Continued From page 1 1/27/11. Diagnoses included; Thrombocytopenia, status post repair of right hip fracture and anemia. A review of the MAR (Medication Administration Record) for March 2011 for Resident #34 revealed, the resident was receiving 5mg (milligrams) of Coumadin (antiocoagulant medication) daily at 5:00pm. On 3/7/11 laboratory results showed the INR (International Normalized Ratio) was 4.6 (the normal range was 0.9 - 1.2) The NN (nurses note) dated 3/7/11 at 6:30pm revealed the physician was notified regarding the high INR and a new order was received to hold the Coumadin. A physician order dated 3/7/11 at 8:30pm read hold Coumadin 3 days, check PT/INR on 3/10/11. "Do Not give Coumadin until Dr. ----- aware of PT/INR results on 3/10/11."

A review of the MAR (Medication Administration Record) for the month of March 2011 revealed Resident #34 was not given Coumadin 5mg on 3/6, 3/9, and 3/10/11.

A review of the NN for 3/6, 3/9 and 3/10 revealed the resident was assessed daily and there were no signs or symptoms of bleeding documented. The laboratory results on 3/10/11 showed the INR was 5.0. This result documented that it was collected at 7:05am. The laboratory result had a hand written note that read "faxed 3/10/11 at 10:00am"

A physician order dated 3/10/11 read Stal (immediately) repeat PT/INR."

The laboratory results on 3/10/11 showed the INR was 4.8. The result documented that it was collected at 10:40am. The laboratory results had a hand written note that read "called to MD (medical doctor) on 3/10/11 at 1:15pm."

A physician order dated 3/10/11 read "Hold Pharmacy was contacted to place Coumadin orders on separate MAR from routine and PRN medications to ensure accuracy of administration of medication and assist with prevention of future med error.

Weekly QA Safety meeting met and discussed Coumadin error and further actions to be taken.

SDC/QA RN was directed to re-educate all nursing staff on practice of writing orders, reviewing orders, and reviewing Coumadin lab results.

All licensed nursing staff had completed Coumadin educational sessions.

All residents receiving Coumadin had their orders reviewed to ensure accuracies.

SDC/QA RN will review monthly all Coumadin orders to address any further issues for educational opportunities. SDC/QA will bring findings to the Monthly QA meeting for evaluation until three months of compliance is sustained and goals are met. | 3/21/11 |

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**FORM CMS-2580/(02-09) Previous Versions Obsolete**

**Event ID:** 863Y11

**Facility ID:** 925471

**If continuation sheet Page 2 of 7**
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<td>F 329</td>
<td>Continued From page 2 Courmadin until Monday (3/14/11). Re-check INR Mon. (Monday 3/14/11).&quot; A review of the MAR dated March 2011 revealed Courmadin 5mg was held on 3/11, 3/12 and 3/14/11. A review of the NN from 3/11, 3/12, 3/13 and 3/14 revealed the resident was assessed daily and there were no signs or symptoms of bleeding documented. The laboratory results dated 3/14/11, collected at 7:30am showed the INR was 1.8. A handwritten note on the laboratory result read &quot;faxed 3/14/11 at 11:50am.&quot; A physician order dated 3/15/11 read Courmadin 2.5mg by mouth every HS (hour of sleep). Re-check PT/INR on Friday 3/18/11. A review of the MAR dated March 2011 revealed Courmadin 5mg was given to Resident #34 on 3/14, 3/15, 3/16 and 3/17/11 at 5:00pm. Also Courmadin 2.5mg was given at 9:00pm on 3/15, 3/16, and 3/17/11. The Courmadin 5mg was documented on the MAR as being discontinued on 3/18/11. A review of the NN dated 3/15, 3/16, 3/17 and 3/18 revealed the resident was assessed daily and there were no signs or symptoms of bleeding documented. A laboratory result dated 3/18/11, collected at 6:50am showed the INR was 4.3. A handwritten note at the bottom of the laboratory results read &quot;faxed 3/18/11 at 12:15pm.&quot; A physician order dated 3/18/11 at 8:30pm read &quot;discontinue Courmadin 5mg, Discontinue Courmadin 2.5mg, PT/INR 3/21/11&quot;</td>
<td>F 329</td>
<td>Pharmacist in-serviced license staff on medication administration error prevention.</td>
<td>4-4-11</td>
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| F 329 | Continued From page 3  
A review of the physician progress note dated 3/20/11 revealed the resident was seen. The progress note documented "Unfortunately Coumadin was not stopped as ordered last Monday and Friday, INR up. Coumadin again ordered to be held. Re-check PT/INR tomorrow 3/21/11. At this time resident stable and appears comfortable."  
A laboratory result dated 3/21/11, collected at 7:40am showed the INR was 4.0. A handwritten note at the bottom read "called to MD 3/21/11 at 2:00pm.  
On 3/23/11 at 9:51am the resident was observed lying in bed. There were no bruises or skin coloration observed anywhere on the resident.  
On 3/23/11 at 3:37pm an interview with nurse #1 revealed she received a call from the physician's office questioning the resident's dose of Coumadin. Two separate faxes had been sent to the physician's office and each fax had a different dose of Coumadin written on it. I checked the MAR's and discovered the resident was receiving both 5mg and 2.5mg of Coumadin. The nurse on day shift who wrote the order did not discontinue the prior order and the nurse on the medication cart giving the medication did not catch the error.  
On 3/23/11 at 4:39pm an interview with the ADON (assistant director of nursing) revealed that a new system was in place. "It was put in place before this incident occurred. The process was all pink copies of physician orders were to be kept at the nursing station and the hall nurse was to go through and double check the orders. The
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(x1) PROVIDERS/SUPPLIER/CUA IDENTIFICATION NUMBER:

345281

(x2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(x3) DATE SURVEY COMPLETED

03/24/2011

NAME OF PROVIDER OR SUPPLIER

STANLY MANOR

STREET ADDRESS, CITY, STATE, ZIP CODE
625 BETHANY CHURCH RD BOX 38
ALBEMARLE, NC 28001

(x4) ID PREFIX
TAQ

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LBC IDENTIFYING INFORMATION)

ID PREFIX
TAQ

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(x5) COMPLETION DATE

F 329

Continued From page 4
Pink copies are to be checked within 24 hours but
I would expect they would be checked no later
than 2 days after the order was written. I would
have hoped these types of errors would have
been caught but it was not. We have not written
this up as an official policy yet."

On 3/24/11 at 11:53am an interview with nurse #2
revealed she had taken the order from the
physician for Coumadin 2.5mg. "I remember
taking the order. I had so many interruptions that
day I was training a new med-alice. I must have
just not gotten back to discontinue the other
order. I just can not think of any other way it could
have happened."

F 364

NUTRITIVE VALUE/APPEAR,
PALATABLE/PREFER TEMP

483.25(d)(1)-(2)

Each resident receives and the facility provides
food prepared by methods that conserve nutritive
value, flavor, and appearance; and food that is
palatable, attractive, and at the proper
temperature.

This REQUIREMENT is not met as evidenced by:
Based resident and staff interviews, record
reviews and a test tray observation, the facility
failed to serve foods that were palatable and at
appropriate temperatures to residents who
participated in the facility's meal services.

A review of the facility's Complaint/Concern
Reports revealed the most recent food complaints
were concerning the palatability of the food.

During an interview on 3/22/11 at 9:08am,
Resident #4 stated that sometimes the meat was

F 329

4/16/11

Resident #4, #117, #84 will be interviewed for
likes, dislikes and any issues they may have
with the quality of food services to ensure
satisfaction and expectation dietary services
are met.
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<td>F 364</td>
<td>Continued From page 5</td>
<td>cooked too hard (beef and pork roast); but, the chicken was not well cooked. During an interview on 3/22/11 at 9:40am, Resident #117 stated that the breakfast served in his room was usually cool/cold. During an interview on 3/22/11 at 2:48pm, Resident #84 stated that the salad greens served had no seasoning and sometimes the meat was not well cooked. The resident revealed that he ate his meals in his room and most of the time food the food was served cold. During an observation of the meal tray serving line in the kitchen on 3/23/11 at 11:40 am, the temperatures of all of the hot food items were above 135 degrees Fahrenheit and the temperature of the milk was 40 degrees Fahrenheit. The dinner plates were maintained in a plate warmer next to the meal serving line until used. Each resident’s plated meal was covered with a tray lid cover and bottom, and then placed on individual meal service trays. Each meal service tray was placed in an open-sided, stainless steel, multi-shelved delivery cart. During a dining room observation and interview on 3/23/11 at 12:55pm, Resident #117 stated that the chicken had &quot;no taste, wasn't cooked&quot;. On 3/23/11 at 1:05pm, a meal test tray observation was conducted. The last meal tray was served to a resident on the 600 hall at 1:13pm. Temperatures were taken and food items of regular consistency were tested on a test meal tray at 1:14pm with the assistance of the Dietary Manager and a staff nurse. The temperatures of the chicken, corn, cabbage, and</td>
<td>F 364</td>
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4/21/11 | 4/15/11 | 4-19-11 |
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<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>Completion Date</th>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER:** STANLY MANOR  
**STREET ADDRESS, CITY, STATE, ZIP CODE:** 625 BETHANY-CHURCH RD BOX-38  
**ALBEMARLE, NC 28001**

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<tr>
<td>K 018 SS=E</td>
<td><strong>NFPA 101 LIFE SAFETY CODE STANDARD</strong> Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/2 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impedance to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</td>
<td>K 018</td>
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<td>Roller latches are prohibited by CMS regulations in all health care facilities.</td>
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<td>K 038 SS=D</td>
<td><strong>NFPA 101 LIFE SAFETY CODE STANDARD</strong> Exit access is arranged so that exits are readily accessible at all times in accordance with section 42 CFR 483.70(a)</td>
<td>K 038</td>
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<td>Wedge was removed and cart preventing door from closing was removed. The monthly walk through audit was revised to include this element to review each month by maintenance director. A monthly walk through will occur throughout the facility. Dietary staff will be In-service on proper door closure by Certified Dietary Manager. The walkthrough will be reviewed monthly at the QA meeting to ensure compliance is met</td>
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**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:**  
**TITLE:**  
**DATE:** 5-13-11  

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 patient. (See instructions.) Except for nursing homes, the findings stated above are discloseable 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 discloseable 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.
| K 038 | Continued From page 1  
| 7.1. 19.2.1 |
|  
This STANDARD is not met as evidenced by:  
Based on observations and staff interview at 8:30 am onward, the following items were noncompliant, specific findings include: Med. room on left side of 100 hall and resident office requires two motion of hand to open door into egress.  

42 CFR 483.70(a)  
NFPA 101 LIFE SAFETY CODE STANDARD  

| K 147 |  
SS=E  
Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  

This STANDARD is not met as evidenced by:  
Based on observations and staff interview at 8:30 am onward, the following item was noncompliant, specific findings include: multi plug outlet was used for TV to be plug into.  

42 CFR 483.70(a)  
NFPA 101 LIFE SAFETY CODE STANDARD  

| K 211 |  
SS=E  
Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:  
- The corridor is at least 6 feet wide  
- The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)  
- The dispensers have a minimum spacing of 4 ft  

42 CFR 483.70(a)  
NFPA 101 LIFE SAFETY CODE STANDARD  

| K 038 |  
This inappropriate locks were immediately removed.  
The monthly walk through audit was revised to includes reviewing facility locks to ensure compliance by maintenance director.  
A monthly walk through will occur throughout the facility. The walkthrough will be reviewed monthly at the QA meeting to ensure compliance is met.  

| K 147 |  
6/1/11  
Facility removed multi-plug outlet.  
The monthly walk through audit was revised to include inspecting facility to ensure multi-plug outlets are not present by maintenance director.  
A monthly walk through will occur throughout the facility. The walkthrough will be reviewed monthly at the QA meeting to ensure compliance is met.  

| K 211 |  
6/1/11  

Facility removed multi-plug outlet.  
The monthly walk through audit was revised to include inspecting facility to ensure multi-plug outlets are not present by maintenance director.  
A monthly walk through will occur throughout the facility. The walkthrough will be reviewed monthly at the QA meeting to ensure compliance is met.
Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>X1) Provider/Supplier/CLA Identification Number:</th>
<th>X2) Multiple Construction</th>
</tr>
</thead>
<tbody>
<tr>
<td>346281</td>
<td>A. Building 01 - Main Building 01</td>
</tr>
<tr>
<td></td>
<td>B. Wing</td>
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**Name of Provider or Supplier:** Stanly Manor  
**Address:** 625 Bethany-Wurgh Rd, Box 38, Albemarle, NC 28001

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| K11|     | Continued from page 2  
- Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.  
- Dispensers are not installed over or adjacent to an ignition source.  
- If the floor is carpeted, the building is fully sprinklered.  
  19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 486.823  
- This STANDARD is not met as evidenced by:  
  Based on observations and staff interview at 8:30 am onward, the following item was noncompliant, specific findings include: an alcohol hand rub in Main Dining Hall was six inches of light switch.  
  42 CFR 483.70(s)  
- Facility removed alcohol rub in main dining hall.  
- The monthly walk through audit was revised to include inspecting facility for alcohol hand rub stations to ensure appropriate placement by maintenance director.  
- A monthly walk through will occur throughout the facility. The walkthrough will be reviewed monthly at the QA meeting to ensure compliance is met. |

**Completion Date:** 6/1/11