PRINTED: 05/31/2012 FORM APPROVED

	•	MEDICAID SERVICES	1		JUN 1 & 2012		NO. 0938-039
	of deficiencies Correction	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI		LE CONSTRUCTION TO THE TOTAL	(X3) DATE S COMPL	ETED
		345420	8, W A	0		05	C i/11/2012
	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE 187 HILTON STREET		
ALAMAN	CE HEALTH GARE GENT	TER THE TERMINATION OF THE TERMI		ı	URLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	VLD BE	(X5) COMPLETION DATE
F 312 SS=D	DEPENDENT RESID A resident who is una daily living receives it maintain good nutritic and oral hyglene. This REQUIREMENT by: Based on observatio and staff interviews it oral (mouth) care for	RE PROVIDED FOR DENTS Table to carry out activities of the necessary services to the provided and personal to the provided and the facility failed to provided to f3 sampled residents asstance with oral care.	F	312	The statements included are not a admission and do not constitute a with the alleged deficiencies here plan of correction is completed in compliance of state and federal reas outlined. To remain in complial federal and state regulations that taken or will take the actions in the following plan of correction following plan of correction conscenter's allegation of compliance alleged deficiencies cited have be be completed by the dates indicate first and state of the completed of the constitution of the completed of the constitution of the constit	greement in. The athe segulations ance with we center set forth a. The titutes the All en or will ed.	
	(Resident # 194).				1. How the corrective action will accomplished for the resident(s) a		
	Resident # 194 was a 3/28/2011 and readm Cumulative diagnose side deficits. The qua (MDS) completed on Resident # 194 was drevealed that Resider assistance from staff and that she had limit	s Included stroke, with right rerly Minimum Data Set 3/27/2012 Indicated cognitive intact. The MDS at #194 required extensive for her personal hygione cations on one side of her dent # 194 had her natural	The second secon		Resident # 194 was assessed on 06/01/2012 by the Director of Nu receiving mouth care; resident stashe had received oral care this modern certified Nursing Assistants were serviced by the Staff Developmen Coordinator regarding mouth care performed at least daily for reside and any other resident requiring assistance. This in-service training completed by 06/09/2012.	ated that orning. In- t t nt #194	
	of Daily Living (ADL) that Resident # 194 v task independently re weakness and a histo intervention, approace			-	THLE		49/13 (X6) DATE

Any deficiency statement ending with an esterisk (*) 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 those documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2667(02-99) Provious Versions Obsolele

Event ID: 125011

Facility (D: 932930

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I'''	(X2) MULTIPLE CONSTRUCTION A. BUILDING			JRVEY ETED
		346420	8. WN			05/	C 11/2012
ALAMANO	NAME OF PROVIDER OR SUPPLIER ALAMANCE HEALTH CARE CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		10	19	EET ADDRESS, CITY, STATE, ZIP CODE 997 HILTON STREET URLINGTON, NC 27217 PROVIDER'S PLAN OF CORRECT	ном	(X5) COMPLETION
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE AGTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)		DATE DATE
F 312	should provide assist care, personal hygler in an interview on 5/7 194 stated that she in 194 stated that she in in a follow-up interview with Resident # 194, not received oral care in an interview on 5/9 was up in her brochasked about oral care not received oral care 194 natural teeth weldirty and yellowish in mouth. On 5/10/2012 at 9:52 was observed performed dressing. NA #1 petroleum ointment for hair, but did not proving the was asked if she Resident #194 this in she provided care in does, and to her known anything. When quest brushing Resident # that she forgot to brushing nervous becauperforming morning in the she forgot to brushing morning morning in the she forgot to brushing morning morning morning in the she forgot to brushing morning mo	ance as needed with oral ne and grooming needs. 1/2012 at 2pm, Resident # ever gets oral care. It wo on 5/8/2012 at 3:30pm she indicated that she had a this morning from her aide. 1/2012 at 1pm Resident # 194 chair looking at TV, when a, she indicated that she had a again today. Resident # re observed to be gunky, color when she open her 1/2012 at 11am with NA # 1) ming morning care on in involved bathing, grooming offered Resident #194 or her ilps after styling her ide oral care inside of line 1/2012 at 11am with NA # 1, a provided routine care to norning. She responded that the manner that she usually wiedge, she did not overlook estioned if she recalled 194's teeth, she admitted is she reteath, altributing it to use she was observed while	IL.	312	2. How corrective action will be accomplished for those residents we potential to be affected by the same practice? Audits of residents réquiring assistate with mouth care were completed on 06/09/2012 by the Unit Managers of Staff Development Coordinator. An inegative findings were immediately corrected. 3. Measures in place to ensure the practices will not occur. Certified Nursing Assistants were it serviced regarding assistance with care for dependent residents by the Manager and Staff Development Coordinator to be completed by 06/09/2012. All new Certified Nurshites will be trained during hire orientation that mouth care for Dependent resident is to be provided during ADL care no less than dally its Staff Development Coordinator. We audits of 10% each unit will be performed to ensure residents who are dependent receiving mouth care by the Urshanagers for four weeks, than mo two months.	ance and and ay at mouth the Unit sling ng new or led by the Veekly formed adent nit	6/9/12
1			1				1110

STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FOW OF	COMECTION	INGSTEE CONTOUR TRUBUCES.		LDING	<u> </u>		Ç
		345420	8. WI			06/1	1/2012
	OVIDER OR SUPPLIER E HEALTH CARE CENT	E R	STREET ADDRESS, CITY, STATE, ZIP CODE 1987 HILTON STREET BURLINGTON, NC 27217				į
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D 0E	(X5) COMPLETION DATE
F 312 F 329 SS=D	6/11/2012 at 8:61am she explained that she expected all nurse aides to provide oral care to residents needing extensive assistance. The mouth should be checked before completing oral hygiene. 483,25(I) DRUG REGIMEN IS FREE FROM		F 312		4. How the facility plans to monitor and ensure that correction is achieved and sustained? Weekly audits of 10% each unit will be performed to ensure residents who are dependent are receiving mouth care by the Unit Managers for four weeks, than monthly for two months. Audits will be presented and reviewed at the weekly Risk Meeting and at the Quarterly Quality Assurance Meeting for three months. Any concerns found will be taken to the weekly Risk Meeting and to the Quarterly Quality Assurance Committee Meeting for complete problem resolution.		6/9/12
	resident, the facility need a given these drugs un therapy is necessary as diagnosed and do record; and residents drugs receive gradual behavioral interventic contraindicated, in an drugs. This REQUIREMENT by: Based on record rev	effort to discontinue these is not met as evidenced iews and staff interviews, the			F 329 - 1. How the corrective action will be accomplished for the resident(s) at Staff II.4 was immediately suspend pending investigation. All Nurses' serviced by the Unit Managers and Development Coordinator on propidocumentation of behavior medical.	fected? ed were In- I Staff er	
t	facility falled to monit	or the effectiveness of					4/9/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DAYE SURVEY COMPLETED	
			8. WN	,	· · · · · · · · · · · · · · · · · · ·	l .	3
		346420	10,711	<u> </u>		05/1	1/2012
	COVIDER OR SUPPLIER CE HEALTH CARE CENT	ER		19	EET ADDRESS, CITY, STATE, ZIP CODE 987 HILTON STREET FURLINGTON, NG 27217		
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F 329		o 3 ic medications for 1 of 9 ent records reviewed.	, L.	329	2. How corrective action will be accomplished for those residents v potential to be affected by the sampractice?		
	administration and do 09/01/2011 revealed of preparation and Administration, Facility measures required by Applicable Law, included the following: 6.1 Document administration/treatment.	'6.0 General Dose nistration," read in part on aph 6 - "After medication y staff should take all r facility policy and ding, but not limited to the ent necessary medication	Activations of the second seco		Audits of residents who are given is medications for behaviors were medications for behaviors were medications for behaviors were medicated on 05/10/2012 by pharmacy. Any negative findings is immediately corrected. All Nurses in-serviced by the Unit Managers of Development Coordinator on propodocumentation of behavior medicated in the practices will not occur.	onitored ed. This vere 'were and Staff per ations.	
	facility after a hospital Alzheimer's disease at The record revealed the villa Alzheimer's disease at the record revealed the villa Alzheimer's disease at the plan dated 12/29/11 in focus care area. Focus care area in the resident will exhibit a by next review. Interesident for signs mechanisms of anxieum chanisms of anxieum Minimum Data Set (M.)	and increased dementia. the resident was diagnosed ase and dementia. The care indicated the resident had a see a second as a s			Licensed Nurse's were in-serviced 05/10/2012 by the RN Unit Manage the Staff Development Coordinate how and where to document Behaviors that are given as where and when to document the Behaviors. Any new Nurse hires we trained during new hire orientation proper documentation.	ger's and or on avior and s well as t vill be	ida lin

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WNG 05/11/2012 346420 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1987 HILTON STREET ALAMANCE HEALTH GARE CENTER BURLINGTON, NC 27217 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY 4. How the facility plans to monitor and F 329 F 329 Continued From page 4 ensure that correction is achieved and impaired and having no behaviors exhibited sustained? during the assessment time frame. Weekly audits of 5 residents per unit will The physician's orders revealed the physician be performed to ensure Behavior and PRN added the anxiolytic medication -Xanax 0.25 Medications are documented milligram (mg) 1 per oral (PO) as needed (PRN) appropriately per policy by the Unit to the resident's medication list on 02/10/12 due Managers for four weeks, than monthly for to the resident's Increased anxiety. A review of two months. Audits will be presented and the resident's Medication Administration Record reviewed at the weekly Risk Meeting and (MAR) revealed there were no initials or other at the Quarterly Quality Assurance documentation to indicate the resident had been Meeting for three months. Any concerns administered the anxiolytic medication during the found will be taken to the weekly Risk months of February, March, April, and May 2012. Meeting and to the Quarterly Quality The resident's 2012 behaviors sheet (all months **Assurance Committee Meeting for** inclusive) located with the resident's MAR had no complete problem resolution. documentation to show the resident had any behaviors indicating the need to administer the medication. A review of the resident's Xanax Controlled Medication Utilization Record log revealed staff member #7 whose signature could not be identified, had signed out one Xanax for the resident on 02/13/2012. Staff member #4, who was identified, had signed out Xanax for the resident on 6 occasions, 03/05/2012, 04/03/12, 04/04/12, 04/10/12, 04/23/12, and 05/06/12. A complete review of the resident's paper and electronic charts revealed there was no documentation to show the medication, Xanax. was administered to the resident by either nurse during the months noted. The back side of the resident's February, March, April, and May's MARs was observed to be blank and did not document a reason for giving the "As Needed" (PRN) anxiolytic medication or documentation the resident was monitored to evaluate the medication's effectiveness after administration.

The consultant pharmacist's monthly Medication

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CENTER	S FOR MEDICARE	MEDICAID SERVICES (XI) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	1	LDING		COMPLE	1
			B. WI			0.00	C 11/2012
		345420	D, Y11)			1 06/	1114014
NAME OF PR	OVIDER OR SUPPLIER				raddress, city, state, zip code Hilton street		
ALAMANO	E HEALTH CARE CE	NTER			LINGTON, NC 27217		
<u></u>	Valuation	STATEMENT OF DEFICIENCIES	lo	<u> </u>	PROVIDER'S PLAN OF CORRECT	TION	COMPLETION
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DAT	REGULATORY C	K F 20 IDEUALIE LINO DA CLIMA MONA	<u> </u>		DEFICIENCY)		
					·1		
F 329			1	329			
	Regimen Review (MRR) did not document					İ
	information concer	ning the 7 doses of Xanax anxiolytics log, the lack of	1		į		
	medication admini	stration documentation on the		Ì	y *		
	resident's MAR or	the lack of documented					ļ
	Information on the	resident's behaviors sheet.	1	l			
	The consultant ph	armacist had no documentation y other document to show she		1			Ţ
	on the MRR or any	ent's need for continued use of			•	•	Ì
	the Xanax or maki	ng a recommendation the	1		•		
	anxiolytic medical	on be discontinued.	Ì	-	,		
		w	1				
	An observation of	the resident was conducted on O PM. The resident was found					
	to be totally blind	but could speak and stated sho		1			
	did not know how	long she had lived in the lacility.		1			
1	I The resident did k	now she had family that would	-	-			
	visit. There was r	no behavior issues noted during					Į.
1	the observation.						
ł	An interview with	the facility's Director of Nursing	İ				
1	I (DON) was condi	icled on 05/10/2012 at 2:45 PM					
}	concerning her ex	xpeciations for documentation of					
	medications adm	inistered to the facility's ON explained her expectations		İ			
	to be . The mirse	s are required to sign out all					
	controlled medica	ations and document their	į				1
	comoval on the re	asident's controlled medication					
	logs. They are re	equired to document on the MAR					
	after any medica	lion is administered to a resident to document on the back of the					-
	and are required	eson a PRN medication is given					Ì
	and its effectiver						
	•						
	On 05/10/2012 a	at 3:15 pm an interview was staff nurse # 4 concerning the					
ļ	tack of administr	alion documentation, the reason					1 1.1
	the medication v	vas given, and follow up of the	ľ				4/9/12
1		·			<u> </u>		

CENTERS FOR MED	CARE &	MEDICAID SERVICES	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	\$	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUIL			COWNTELED	
AD LOW OF GOVERNMENT			B. WIN	IG		05/	111/2012
NAME OF PROVIDER OR SUI ALAMANCE HEALTH C	ARE CENT				REET ADDRESS, CITY, STATE, ZIP CODE 1987 HILTON STREET BURLINGTON, NG 27217 PROVIDERS PLAN OF CORRE	CTION	(X5)
1071197	· creinicule	NATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΉX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULDBE	DATE
anxiolytic and anxiolytic and anxiolytic and anxiolytic and anxiolytic and anxiolytic anxiolytic and anxiolytic anxiolyti	I's effective (anex pilling), I recall to a pout recall to a pout recall to a pout recall to a pout recall to a pout recall to a pout recall to a pout recall to a pout recall to a pout recall to a pout recall to a pout recall to a pout recall to a pout recall to a pout recall to a pout recall to a pout recall to a pout recall to a pout recall to a pour recall t	reness after signing out the 6 is for the resident. The nurse alking to the other surveyor resident # 245. I told her the exting Xanax. I looked in the on log book and told her the resident a Xanax was on urse explained the steps and alrements when giving a licility to be: Take the remedication on the NARC cated she had signed out the explained out the explained out the explained out the log. The nurse her because she was showing didn't know I was supposed to location on the back of the back of the MAR was only for over." The nurse indicated she was supposed to document explained in the medication administered. "I didn't initial the MAR for any ment administering the	IL I	329		•	491

	S DECICIENCIES	(XI) PROVIDER/SUPPLIER/CLIA	(X2) Mi	ILTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDENSUPPLIENCEN IDENTIFICATION NUMBER:		A. BUIL	DING		1	c	
		345420	B. WN	3		1	1/2012
	OVIDER OR SUPPLIER E HEALTH CARE CENT	rer		198	et address, city, state, zip code By Hilton Street Irlington, NC 27217		
(X4) ID PREFIX TAG	ACAPH DESIGNED	INTEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF YAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD 8E	COMPLETION OATE
F 329 F 425 SS=D	some time I will reco discontinuance of the consultant pharmaci review the resident's documented on the sheet (Controlled Mi when removed, doci given and document if the medication wa medication was give 483,60(a),(b) PHAR ACCURATE PROC The facility must pro- drugs and biological them under an agre §483.75(h) of this p uniteensed personn law permits, but on supervision of a lice A facility must prov (including procedur acquiring, receiving administering of all the needs of each The facility must er a licensed pharma on all aspects of th services in the facil the	mmend a reduction or e medication." The st explained she would administered medication resident 's declining count edication Utilization Record) umentation on the MAR when tation on the back of the MAR is a PRN and the reason the sin. MACEUTICAL SVC - EDURES, RPH Evide routine and emergency is to its residents, or obtain rement described in art. The facility may permit rel to administer drugs if State by under the general ensed nurse. Ide pharmaceutical services residents, and drugs and biologicals) to meet resident. Imploy or obtain the services of cist who provides consultation are provision of pharmacy lilly.		329	F 425— 1. How the corrective action will accomplished for the resident(s) Medications and House Stock was audited by the Unit Managers of 05/11/2012 and found to be wit compliance. 2. How corrective action will be accomplished for those resident potential to be affected by the spractice? Audits of Medications and Hous were completed on 05/11/2012 06/09/2012 and found to be in compliance. 3. Measures in place to ensure practices will not occur.	ere n thin ts with the same	10/10/10
	by: Based on facility	observations, record review,	•				4/9/16

CENTERS FOR MEDICARE & MEDICAID SERVICES

		MEDICAID SERVICES (XI) PROVIDER/SUPPLIER/CLIA	(X2) W	ULT(PL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
STATEMENT C AND PLAN OF	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUIL				
		345420	B, VMN			l .	C 1/2012
NAME OF PR	OVIDER OR SUPPLIER	345420			EEY ADDRESS; CITY, STATE, ZIP CODE		
ALAMANO	CE HEALTH CARE CENT	TER		BURLINGTON, NC 27217			
(X4) ID PREFIX TAG	reven uddicield NC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IX S	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	DULDUE	COMPLETION DATE
F 425	and staff interviews to expired medications storage areas (medications storage areas (medications). 1. On 5/8/2012 at made in the medication date of two bottles of Calian expiration date of 2/2 an expiration date of 2/2 an expiration date of checked the stock in Nurse #1 stated on Unit Manager usual indicated that the nuchecked the expiration 5/8/12 at 3:36 puresponsibility of all expired medication. 2. On 05/11/2012 was conducted of the medication storage nurse manager, storage and the control insulin medication in the control in the control of the con	the facility falled to remove from 2 of 3 medication callon slorage rooms). 3:30 pm an observation was allon room for rooms 44-74 of clum Oyster Cal 250 mg with fal/2012, five bottles of an expiration date of 3/2012, ed Aspirin 325 mg with an 2012, and one Arginald with fal/2012. When asked who nedications expiration dates, 5/8/12 at 3:35 pm that the lay checked them. She also curse using the cart at times alton dates. The Unit Manager m stated that it was the licensed staff to be sure swere removed. at 8:05 AM an observation he facility's Teal unit's aff member # 6. In the late the medication room an dication was observed: ot # AZF0544 Manufacturer's 2014. The vial's protective cap I and several needle marks the rubber top. The vial was afmacy on the Rx label as he vial was documented as	F	425	Licensed Nurse's, Unit Managers Central Supply Clerk were in-serv regarding compliance of expirati of House Stock Medications on 06/09/2012 by the Staff Develop Coordinator. Weekly'audits will performed to ensure House Stock Medications are in date complia have not expired by the Unit Ma four weeks, than monthly for tw 4. How the facility plans to more ensure that correction is achiev sustained? Weekly audits will be performe Medications and House Stock hare in date compliance and expired by the Unit Managers if weeks, than monthly for two in Audits will be presented and re the weekly Risk Meeting and a Quarterly Quality Assurance M three months. Any concerns it taken to the weekly Risk Meet the Quarterly Quality Assurance Committee Meeting for comp resolution.	ment be k nce and nagers for no months. Iltor and ed and d to ensure Medications have not or four months. Iviewed at t the meeting for found will be ting and to	4/9,

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CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (XI) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WNG 05/11/2012 345420 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1987 HILTON STREET ALAMANCE HEALTH CARE CENTER BURLINGTON, NC 27217 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) (D (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY TAG F 425 F 425 Continued From page 9 An interview with the Teal unit's manager was conducted on 05/11/2012 at 8:15 AM. The unit manager indicated the insulin was expired based on the documented date it was opened. The facility's policy and procedures for insulin storage dated 03/27/2012 and entitled Medication Storage Recommendations, page 3 of 8 in paragraph "Insulin Vials" read in part, "Based on American Diabetes Association guidelines, all unopened insulins are recommended to be stored In the refrigerator. All vials should be dated when opened and discarded 28 days after opening except for Novolin R which can be used up to 42 days after opening." A calculation of the days since the insulin boltle was opened was found to be - 51 days (March 10 days), (April 30 days), (May 11 days). The insulin F 431 -found in the facility's medication refrigerator was 1. How the corrective action will be 9 days past the discard date. accomplished for the resident(s) affected? F 431 483.60(b), (d), (e) DRUG RECORDS, F 431 LABELISTORE DRUGS & BIOLOGICALS SS=D Medications and House Stock were The facility must employ or obtain the services of audited by the Unit Managers on a licensed pharmacist who establishes a system 05/11/2012 and found to be within of records of receipt and disposition of all compliance. Treatment Carts were controlled drugs in sufficient detail to enable an immediately audited and all others were accurate reconciliation; and determines that drug records are in order and that an account of all found to be locked. controlled drugs is maintained and periodically reconciled. 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

STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	COMPLETED	
AND PLAN OF	CORRECTION	IDEAULIONION HOMBELL	A. BUILDIN	3	(Ç
		346420	B. WING		05/1	1/2012
	OVIDER OR SUPPLIER DE HEALTH CARE CENT	TER		REET ADDRESS, CITY, STATE, ZIP CODE 1987 HILTON STREET BURLINGTON, NG 27217		
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(X4) ID PREFIX TAG	(CACH DEPICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	IN SHOULD BE E APPROPRIATE	DATE
F 431	facility must store all locked compartment controls, and permit have access to the latest acc	State and Federal laws, the drugs and biologicals in a under proper temperature only authorized personnel to keys. In the separately locked, compartments for storage of a din Schedule II of the and other drugs subject to the facility uses single unit outlon systems in which the inimal and a missing dose can	F 43	2. How corrective action will accomplished for those resipotential to be affected by practice? Audits of Medication's and I-were completed on 05/11/2 06/09/2012 and found to be compliance. Treatment Carlimmediately audited and all found to be locked. License in-serviced on 06/09/2012 Managers and Staff Develoy Coordinator to not leave Traunlocked and to secure key: 3. Measures in place to enspractices will not occur	dents with the the same House Stock 2012 and e in its were I others were by the Unit pment eatment Cart s at all times.	
	by: Based on facility of and staff interviews opened Tuberculin rooms, and to assucant was locked in Findings include: 1. At 3:44 pm on Tubersol (Purified tuberculin test) was in the medication of 74. Nurse #2 indict that the person open the opening desired.	bservations, record review, the facility failed to date an test vial 1 of 3 medication are that the wound treatment 1 of 4 treatment carts. 5/8/2012 one bottle of Protein Derivative (PPD) sobserved open and undated from refrigerator for rooms 44-ated on 5/8/2012 at 3:46 pm ening the Tubersol should have the on it. The manufacturer's was if a vial of Tubersol had		Licensed Nurse's, Unit Mana Central Supply Clerk were in regarding compliance of exp of Medications and House S Medications on 06/09/2012 Development Coordinator, will be performed to ensure and House Stock Medication compliance and have not ex Unit Managers for four wee monthly for two months. T will be audited weekly for for monthly for two months to they are locked when not in the keys are secured by the Nurse.	n-serviced piration dates stock by the Staff Weekly audits medications ms are in date spired by the eks, than reatment Carts our weeks, than ensure that	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		346420	8. WING		l l	C 1/2012	
	COMDER OR SUPPLIER DE HEALTH CARE CENT	ER	1	EET ADDRESS, CHY, STATE, ZIP CODE 987 HILTON STREET FURLINGTON, NC 27217	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	CONTE	
F 431	be discarded because may have reduced the may have reduced the for medication storage 05/10/2012 at 5:00 Pi General Dose Prepar Administration indicate. "Facility should ensuralways locked when con 05/06/2012 at was made of one of the nurse's storatment cart was observed to he was observed to be just us treatment book lying drawers in the cart we prescription medicating unlocked. The key to observed to be just us treatment book lying drawers in the cart we prescription medicating the cart we prescription medication of the unit were and providing care ar away from the treatment station. Family memi	s in use for 30 days it should be exidation and degradation a potency. cility's policy and procedure to was conducted on M. The policy entitled 6.0 atlon and Medication ed on page 3 in paragraph 7 are that medication carts are but of sight or unattended." t 6:40 PM an observation ne facility's resident halls amed "MAUVE II." To the ation the unit's wound care better the treatment cart at the treatment cart was all of the drawers were the treatment cart was not not of the cart. Several are observed to contain ons for residents and their atments. During the initial to observed that the nursing administering medications addor serving the dinner meal ent cart and the nurse's pers were observed walking dents were in wheelchairs in	F 431	4. How the facility plans to moni ensure that correction is achieve sustained? Weekly audits will be performed Medications and House Stock Me are in date compliance and have expired by the Unit Managers for weeks, than monthly for two mo Treatment Carts will be audited of four weeks, than monthly for two to ensure that they are locked with use and that the keys are secured Licensed Nurse. Audits will be pradicted at the weekly Risk and at the Quarterly Quality Assumeting for three months. Any found will be taken to the weekly Meeting and to the Quarterly Quassurance Committee Meeting for complete problem resolution.	to ensure edications not rour nths. weekly for o months hen not in i by the essented Meeting trance concerns r Risk ality		
	05/06/2012 at 6:30 P was still observed to	ation was made on M. The unit's trealment cart be unlocked as the key lock In the out position indicating			··	10/9/12	

STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) I/	ULTIPL	LE CONSTRUCTION	(X3) DATE SUR	
AND PLAN OF	PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUI	LDING		С	
		345420	B. WI	IG		l .	1/2012
	OVIDER OR SUPPLIER DE HEALTH CARE CENT	ER		19	EET ADDRESS, CITY, STATE, ZIP CODE 187 HILTON STREET URLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TAG		Provider's Plan of Correct (Each Corrective action shot Cross-referenced to the Appri Deficiency)	JED BE	(X5) COMPLETION DATE
F 431	cart was observed to treatment book on to observed at the nurs treatment cart for ow were conducting mere assistants were givin treatment. A third observation at 6:65 PM. The treatment in the cart was still unlocked family members con passing the unlocked members were using close proximity of the On 05/08/2012 conducted with staff hall. The interview wound care treatment During observation member #3 she indinot locked and the k treatment book. The nurse stallocked up." The nurse s	re unlocked. The key to the still be under the lid of the p of the cart. No staff was e's station or near the ar 10 minutes. The nurses dication pass and nursing g after dinner care and on was made on 05/06/2012 atment cart's key lock button out position indicating the d. Several residents and linued to be observed it treatment cart. No staff it the treatment cart or in a nurse's station. at 7:00 PM an interview was member # 3, a nurse on the was concerning the unlocked and the wound care cart by staff cated the treatment cart was sell unlocked and the key was rebeen left in the treatment cart discursed in the treatment cart was sell unlocked and the key was rebeen left in the treatment cart dissecured it in unit's pon return the nurse stated, it the key in the treatment cart and last person to use the cart	F	431			
	On 05/10/2012 conducted with the	at 9:50 AM an Interview was acillly's Director of Nursing					6/9/12

STATEMENT C	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		ULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLVN OF	CORRECTION	IDEATH TO ATOM NOTICE	A. ĐVI				С
		345420	9. WA	IG		05/1	1/2012
	OVIDER OR SUPPLIER DE HEALTH CARE CENT	ER		19	eet address, City, State, Zip code 987 Hilton Street Urlington, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST DE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	Provider's Plan of Correct (Each Corrective action shou Cross-referenced to the Appro Deficiency)	LO BE	(X5) COMPLETION DATE
F 431	(DON) concerning he the wound care cart. should be locked who should have been see 483.75(i)(1) RES RECORDS-COMPLE LE The facility must mal resident in accordance standards and practical accurately document systematically organ. The clinical record mediantife resident's assessme services provided; the preadmission screen and progress notes. This REQUIREMEN by: Based record review facility failed to record anxiolytic medication needed on the Mediand falled to document findings included: The facility's policy administration and control of the preparation and Administration	ar expeciation for securing The DON stated the cart en not attended and the key cured. ETE/ACCURATE/ACCESSIB Intain clinical records on each ce with accepted professional ces that are complete; ted; readily accessible; and lized. Interest the plan of care and the resident; a record of the ints; the plan of care and the results of any sing conducted by the State; It is not met as evidenced we and staff interviews the red administration of an in that was prescribed as cation Administration Records ent its effectiveness. Interest the plan of care and procedures for medication focumentation dated if "6.0 General Dose inhistration," read in part on		514	F 514 - 1. How the corrective action will be accomplished for the resident(s) af Staff # 4 was immediately suspendent pending investigation. All Nurses' varied by the Unit Managers and Development Coordinator on propied ocumentation of behavior medical accomplished for the resident(s) af Audits of residents who are given for medications for behaviors were moved to me the complete on 05/10/2012 by pharmacy. Any negative findings were in-serviced by the Unit Mana Staff Development Coordinator on documentation of behavior medical 05/10/2012	fected? ed were in- Staff er itions. e fected? PRN conitored i. This were lurses' gers and proper	4/12
	page 2 of 3 in parag	reph.6"After medication lity staff should take all					ulalia

CENTER	S PUR MEDICARE &	MEDICAID SERVICES					
	of deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SUP COMPLETE	ED
		345420	B. WA	iG		1	0 1/2012
	OVIDER OR SUPPLIER CE HEALTH CARE CENT	ER		19	EET ADDRESS, CITY, STATE, ZIP CODE 987 HILTON STREET URLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D 8E	(X5) COMPLETION DATE
F 514	measures required by Applicable Law, Inclu following: 6.1 Docum administration/treatm medications are given appropriate forms." Resident #245 was a facility after a hospita Alzheimer's disease and tementia. The resident was diagnos and dementia. The clindicated the resident Focus - Resident has (AEB) being anxious exhibit a decrease in review. Interventions resident to use copin encourage the resident for clindicated by physician when needed. Staff will observe for anxiety, Staff will adrordered by physician when needed. Staff signs and symptoms anxiety. The resident to be: Cognino behaviors exhibite time frame. The physician's orde added the medication (PO) as needed (PR medication list on 02	y facility policy and ding, but not limited to the tent necessary medication ent information when n, PRN medications, on dmitted on 12/28/2011 to the 1 stay for worsening and increased demential at record revealed the ed with Alzhelmer's disease are plan dated 12/29/11 to had a focus care area. Anxiety as evidenced by Goals - The resident will anxious moods by next anxious moods by next anxious moods by next anxious moods by next anxious moods by next anxious moods by next anxious moods by next anxious moods by next anxious moods by next anxious moods by next anxious moods by next anxious moods by next anxious moods by next anxious moods by next anxious moods by next anxious moods by next anxious moods by next anxious moods by next and cell staff when anxious, signs and symptoms of ninister medications as and notify the physician will observe the resident for of iriggering mechanisms of iris quarterly Minimum Dala 22/2012 documented the tively impaired and having and during the assessment are revealed the physician nXanax 0.25mg 1 by mouth by to the resident's areview of the resident's retion Record (MAR)	F	514	3. Measures in place to ensure that practices will not occur. Licensed Nurse's were in-serviced of 05/10/2012 by the RN Unit Manage the Staff Development Coordinato how and where to document Behav PRN Medications that are given as where and when to document the Behaviors. Any new Nurse hires wit trained during new hire orientation proper documentation. 4. How the facility plans to monito ensure that correction is achieved a sustained? Weekly audits of 5 residents per un be performed to ensure Behavior a Medications are documented appropriately per policy by the Unit Managers for four weeks, than mot two months. Audits will be present reviewed at the weekly Risk Meeting at the Quarterly Quality Assurance Meeting for three months. Any cot found will be taken to the weekly R Meeting and to the Quarterly Quality Assurance Committee Meeting for complete problem resolution.	on er's and r on vior and well as li be about r and and lit will nd PRN t nthly for ted and ng and ncerns	tolaha

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		CONSTRUCTION	(X3) DATE 8 COMPL	
		345420	B. WIN			0.5	C 5/11/2012
	ROVIDER OR SUPPLIER DE HEALTH CARE CENT	ER		1987	raddress, city, state, zip code Hilton street Ilington, nc 27217		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 514	administered the mod February, March, Apr resident's 2012 behavinclusive) located will documentation to she behaviors indicating the medication. A review revealed staff member not be identified, had the resident on 02/13 who was identified, har resident on six occasion/04/12, 04/10/12,	icate the resident had been ilication during the months of ili, and May 2012. The viors sheet (all months in the resident's MAR had no by the resident had any he need to administer the of the resident's Xanax log or #7, whose signature could signed out one Xanax for /2012. Staff member #4, ad signed out Xanax for the ions, 03/05/2012, 04/03/12, 4/23/12, and 05/06/12. The resident's paper and aled there was no by the medication, Xanax, he resident by either nurse led. The back side of the warch, April, and May's lo be blank and did not or giving the "As Needed" documentation the resident durate the medication's iministration. The consultant Medication Regimen of the document information es of Xanax signed out on ation Utilization Record, the ministration documentation at the lack of documented sident's behaviors sheet. In a cist had no documentation ther document to show she its need for continued use of a recommendation the	F	514			49/13

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU	PLYIPLE CONSTRUCTION	K	(X3) DATE SURVEY COMPLETED
		346420	B, WING	<u></u>		C 05/11/2012
	COVIDER OR SUPPLIER DE HEALTH GARE CENT	turner in the second se		STREET ADDRESS, CITY, STA 1987 HILTON STREET BURLINGTON, NC 272	·	00/11/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRE CROSS-REFERE	'S PLAY OF CORRECTIO ECTIVE ACTION SHOULD INCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 514	Continued From page	o 16	F	514		
	(DON) was conducted concerning her expect medications administ residents. The DON to be - The nurses are controlled medication removal on the residents. They are required to dare required to day.	explained her expectations a required to sign out all s and document their out's controlled medication ed to document on the MAR is administered to a resident ocument on the a PRN medication is given				
	conducted with staff r lack of administration the medication was g medication's effective Xanax pills for the res responded, I recall ta on Monday about res resident had been tal controlled medication last time I gave the re 05/06/2012. The nu documentation requir medication to be to ta container, give it to th medication on the res medication log. The signed out the Xanax medication log (Rx C signature on the log, to her because she w I didn't know I was su	Iking to the other surveyor ident # 245. I told her the king Xanax. I looked in the log book and told her the esident a Xanax was on rese explained the steps & ements when giving a ske the medication out of the learnest steps.			•	10/9/12

STATEMENT AND PLAN O	of deficiencies F correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	IULTIF LDING	PLE CONSTRUCTION	(X3) DATE S COMPLE	
		345420	B. WI	16		05/	G /11/2012
	ROVIDER OR SUPPLIER CE HEALTH CARE CENTI	ER		1	REET ADDRESS, CITY, STATE, ZIP CODE 987 HILTON STREET RURLINGTON, NG 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		Provider's Plan of Corre (Each Corrective action sho Cross-referenced to the app Deficiency)	OULD BE	(X5) COVPLETION DATE
	given." The nurse inc she was supposed to resident's MAR when and monitor the resident the medication adminididn't initial the MAR for this resident, I must he administering the med. An interview with the formacist was conducted by the DON nursing documentation administer explain what she tooke reviews. The consultant process of the resident's Market in the resident's Market in the second the resident has not received the resident's administer con the resident's declination of the resident's declination of the resident's declination of the resident's declination the resident's declination of the re	only for pain medication ilicated she was not aware document on the back of a she gave a PRN medication ont for the effectiveness of stered. The nurse stated, "I or any of the Xanax I gave ave forgotten to document ication all 6 times." acility's consultant ored on 05/10/2012 at 5:35 marmacist stated she had there was an issue with the mof the anxiolytic and to #245 and wanted to ad at during her monthly on teplmen reviews to be: "I fARs, new orders, labs, at the Behaviors sheets to a in the resident's are stable and the ed the medication for medication. The consultant she would review the I medication documented ing count sheet Utilization Record) when on on the MAR when given the back of the MAR if the	-:-	514			
<u> </u>	(02.99) Proutous Varidone Oberla		ļ ·				6/9/12

06,	/25/2012 11:09	3362266247	A	ADMINISTRATING GETVE PAGE 03	3/1 '04'
v 3 2 ·		I AND HUMAN SERVICES & MEDICAID SERVICES		JUN 2 5 2012 FORM APP OMB NO. 093	'RO
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION SECTION COMPLETED UILDING 01 - MAIN BUILDING 01	Y
		345420	B. WIN	VING	12
	PROVIDER OR SUPPLIER NGE HEALTH CARE C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1987 HILTON STREET BURLINGTON, NC 27217	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREE	EXEACH CORRECTIVE ACTION SHOULD BE	(X5) (PLE) DATE
K 018 SS≓D	Doors protecting co required enclosures hazardous areas and those constructed o wood, or capable of minutes. Doors in sarequired to resist the no impediment to the are provided with a the door closed. Duare permitted, 19.	rridor openings in other than of vertical openings, exits, or a substantial doors, such as f 1½ inch solid-bonded core resisting fire for at least 20 prinklered buildings are only a passage of smoke. There is a closing of the doors. Doors means suitable for keeping the doors meeting 19.3.6.3.6 3.6,3	Ko	The latch to door in room 92 was repaired to close properly on June 8, 2012. Staff members will be re-educated concerning the necessity to provide work orders for needed repairs in a timely manner prior to June 30, 2012. Maintenance staff monitors status of doors on a monthly basis as a part of monthly inspections.	30,
K 029 SS=D	A. Based on observed to room 92 failed to 1 42 CFr 483,70 (a) NFPA 101 LIFE SAF One hour fire rated colline-rated doors) or a extinguishing system	not met as evidenced by: ation on 05/30/2012 the door atch when closed. ETY CODE STANDARD onstruction (with ¼ hour n approved automatic fire in accordance with 8.4,1 cts hazardous areas, When	K 02	All door wedges removed from the food storage area on the day of inspection. Food service staff will be educated about the fire hazards of using door props prior to June 30, 2012. The food service director will do weekly inspections checking for door props. July 13, Door closures are being installed on all linen room and shower room doors. The closures are scheduled to be completed by July 13, 2012. The addition of closures will correct the concern about the soiled linen storage	, 20

the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or

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

TITLE

maintenance program.

checked as a part of the monthly

within the shower room area: These doors,

along with the others in the facility, will be

(XB) DATE

レルリナム

6-14.

deticlency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that is safeguards provide sufficient protection to the patients. (See Institutions.) Except for nursing homes, the findings stated above are disclosable 90 days using 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 following the date these documents are made available to the facility. If deficiencies are clied an approved also of correction is contained.

PAGE 03/0

PRINTED: 06/04/2012 FORM APPROVED OMB NO. 0938-0391

EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES

TEMENT OF DEFICIENCIES PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

345420

A. BUILDING

01 - MAIN BUILDING 01

B. WING _

05/30/2012

STREET ADDRESS, CITY, STATE, ZIP CODE

WE OF P	ROVIDER OR SUPPLIER	STI	1987 HILTON STREET			
	CE HEALTH CARE CENTER		BURLINGTON, NC 27217	Y		
X4) ID REFIX 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)	COMPLETION OATE		
K 029	Continued From page 1 field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2,1	K 029	The door to the solled linen room was corrected to close and latch properly on June 13, 2012. These doors, along with the others in the facility, will be checked as a part of the monthly maintenance program.			
K 038	I control of the cont		Master door release switches have been added to each of the nurse's stations on June 8, 2012. The staff will be in-serviced prior to June, 30, 2012 concerning the proper use of the master switch in case of an emergency. This in-service will be repeated annually. The fire door near the beauty salon was repaired on June 12, 2012 and now closes properly. This door, along with others in the facility, will be checked monthly as a part of the maintenance program. The attic door access locks have been assessed and a locksmith will complete the work prior to July 13, 2012. The corrected locks will meet the required life safety code facility, will be checked monthly as a part of the maintenance program.	2.		

05/30/2012 the staff did not know about the master door release switch at the nurses station, 42 CFR 483.70 (a)

B. Based on observation on 05/30/2012 the fire door at the beauty shop was sticking when the doors closed.

C. Based on observation on 05/30/2012 there were attic access doors that bolt type latches that could lock someone in the attic. One is in the

between 34 and 48 inches on June 8, 2012. This door, along with others in the facility, will be checked monthly as a part of the

The lock on the door in the dining room has

been corrected to meet the state standard

maintenance program.

06/14/2012 15:34

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/04/; FORM APPRO OMB NO, 0938-0

CENTR	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	<u>, 0938-</u>
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A, BUILDING	LE CONSTRUCTION O1 - MAIN BUILDING 01	(X3) DATE COMPL	SURVEY .ETED
		345420	B. WNG		05/	30/2012
	ROVIDER OR SUPPLIER	ENTER	19	EET ADDRESS, CITY, STATE, ZIP CO B7 HILTON STREET JRLINGTON, NC 27217		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	COMPL DA
K 038	maintance office. D. Based on obsertion the Dining Roon must be between 3	ige 2 vation on 05/30/2012 the lock in door was too high. Locks 4 And 48 inches from the	K 038			June 13
K 047 ss=D	Exit and directional accordance with se	FETY CODE STANDARD signs are displayed in ction 7.10 with continuous rved by the emergency lighting 1	K 047	K 047 The sign indicating "Exit" is no so as not to be blocked by the This was completed on June 1 light fixtures in the future will installed if they block an exit s	e light fixture. 13, 2012. New I not be	
K 056 SS=D	A. Based on obser corridor light fixture exit sign over the fr 42 CFR 483.70 (a) NFPA 101 LIFE SA If there is an autominstalled in accordator the installation oprovide complete coulding. The syste accordance with Ni Inspection, Testing Water-Based Fire is supervised. There supply for the systems are equipped switches, which are	s not met as evidenced by: vation on 05/30/2012 the was blocking the view of the ont door. FETY CODE STANDARD ratic sprinkler system, it is noe with NFPA 13, Standard of Sprinkler Systems, to overage for all portions of the im is properly maintained in PA 25, Standard for the , and Maintenance of Protection Systems. It is fully is a reliable, adequate water in. Required sprinkler are with water flow and tamper a electrically connected to the system. 19,3,5	K 056	K 056 Storage in the closet near the office was corrected immedi have items stored too close thead. Storage closets have be indicate the maximum heigh may be stored. Storage area checked as part of the month maintenance program to pre re-occurring in the future.	ately to not to the sprinkler been marked to t that items is will be	June 1,

06/14/2012 15:34

PRINTED: 06/04 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPRI CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING 345420 05/30/2012 NAME OF PROVIDER OR SUPPLIER

ALAMANCE LIEAUTH CAME OFFICE

STREET ADDRESS, CITY, STAYE, ZIP CODE 1987 HILTON STREET

ALAMAI	NCE HEALTH CARE CENTER	ı	BURLINGTON, NC 27217
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI	PROVIDER'S PLAN OF CORRECTION (X5 (EACH CORRECTIVE ACTION SHOULD BE COMPLI
K 056	Continued From page 3	Ко	56
K 062 SS=D	This STANDARD is not met as evidenced by: A. Based on observation on 05/30/2012 there was storage in the closet near Admissions that was to close to the sprinkler head. 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: A. Based on observation on 05/30/22012 the	K 00	The valves on the sprinkler accelerator are scheduled for electronically supervision repairs prior to July 13, 2012. Documentation concerning the five year obstruction test and water flow trip test are now on file on site. These files were received on June 12, 2012. These documents will be kept up to date by the maintenance staff.
K 067 SS⊐D	valves on the sprinkler accelerator were not electrically supervised. B. Based on observation on 05/30/2012 the facility did not have documentation of the sprinkler systems five (5) five year obstruction test and the time of water flow for the trip test. 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2	K 06	July 13, 2 The sampling tube for the duct detector has been cleaned and is scheduled to be replaced by July 13, 2012. The sampling tube will be checked monthly as a part of the maintenance monthly preventative program,
	This STANDARD is not met as evidenced by: A. Based on observation on 05/30/2012 the	· 11	

ADMINISTRATION 3362266247 06/14/2012 15:34 PRINTED: 06/04/201: FORM APPROVED EPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO, 0938-039' ENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (XI) PROVIDER/SUPPLIER/CLIA COMPLETED ATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: 01 - MAIN BUILDING 01 D PLAN OF CORRECTION A, BUILDING 05/30/2012 B, WING_ 345420 STREET ADDRESS, CITY, STATE, ZIP CODE IME OF PROVIDER OR SUPPLIER 1987 HILTON STREET BURLINGTON, NC 27217 LAMANCE HEALTH CARE CENTER PROVIDER'S PLAN OF CORRECTION COMPLETION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX TΛG DEFICIENCY) TAG K 067 Continued From page 4 K 067 sampleing tube for the duct detector in the air June 1, 2012 handler needing cleaning. K 072 42 CFr 483,70 (a) K 072 NFPA 101 LIFE SAFETY CODE STANDARD The exit at the corridor near the front K 072 entrance was made free from obstruction SS≍D Means of egress are continuously maintained free on the day of the inspection. Office of all obstructions or impediments to full instant changes now dictate that the HR director use in the case of fire or other emergency. No will assist in monitoring that this exit furnishings, decorations, or other objects obstruct remains free of any item that prevents exits, access to, egress from, or visibility of exits. access to the egress. Monitoring will take 7,1,10 place on a regular basis. This STANDARD is not met as evidenced by: A. Based on observation on 05/30/2012 there was storage in the egress corridor at the side exit near the front entrance. 42 CFR 483.70 (a) K 147 NFPA 101 LIFE SAFETY CODE STANDARD K 147 Electrical wiring and equipment is in accordance SS=D

with NFPA 70, National Electrical Code. 9.1.2

This STANDARD is not met as evidenced by: A. Based on observation on 05/30/2012 there was storage in front of the electrical panels at Nurses Station on the Mauve Hall, 42 CFR 483.70 (a) B. Based on observation on 05/30/2012 the med. refrigerator on the Mauve Hall was not on the

emergency circult. C. Based on observation on 05/30/2012 room 44 was being remodeled and the covers were missing on all switches and receptacles.

Facility ID: 932930

If continuation sheet Page 5

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(Å3) DATE SURVEY

COMPLETED

FORM APPF 930, OO BMQ

05/30/201:

COMPL

June 30,

DA.

ADMINISTRATION 3362266247 06/14/2012 15:34 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING MAIN BUILDING 01 8, WING_ IUN 15 2012 345420 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STATE ZIP CODE 1987 HIL TOWNSTED CTION SECTION ALAMANCE HEALTH CARE CENTER BURLINGTON, NC 27217 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TÁG DEFICIENCY) K 147 K 147 Continued From page 5 K 147 D. Based on observation on 05/30/2012 the The electrical panels at the nurse's station receptacles in the toilets of rooms 8 & 10 were were made unobstructed on the day of the not GFCI protected. inspection. Taped warning areas have been 42 CFR 483.70 (a) placed as a reminder to staff. The staff will be in-serviced about the need for these panels to remain free of obstruction prior to June 30, 2012. These areas will be monitored as a part of the monthly maintenance preventative program. The med refrigerator was connected to a power source that is a part of the emergency circuit on the day of the Inspection. The location of the refrigerator and circuit are now such that this change will be permanent. The nursing staff will be in-serviced prior to June 30, 2012 on the necessity of the refrigerator to remain on the emergency power source. Room 44 remodeling was completed on June 6, 2012. The outlet covers are now in place. The maintenance staff will receive in-service education on the need to either prevent access to remodeling areas or to replace the outlets during times of

programs.

remodeling if the area has to be left unattended. In-services will be complete

The receptacles in rooms 8 and 10 are GFCI protected. This was completed on June 12, 2012 The maintenance staff will check such outlets monthly within the facility as a part of the monthly preventative maintenance

prior to June 30, 2012.

06/14/2012 15:34

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPI STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: OMB NO. 0931 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED A. DUILDING 01 - MAIN BUILDING 01 8. WING_ 345420 NAME OF PROVIDER OR SUPPLIER 05/30/201

VAME OF	PROVIDER OR SUPPLIER		-		0.5	5/30/20
	NCE HEALTH CARE CENTER		1	REET ADDRESS, CITY. STATE, ZIP CODE 1987 HILTON STREET		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROVED TO THE A	h be	COM.
K 147	Continued From page 5 D. Based on observation on 05/30/2012 the receptacles in the toilets of rooms 8 & 10 were not GFCI protected. 42 CFR 483.70 (a)	K1		The electrical panels at the nurse's st were made unobstructed on the day inspection. Taped warning areas have placed as a reminder to staff. The stabe in-serviced about the need for these panels to remain free of obstruction p June 30, 2012. These areas will be monitored as a part of the monthly maintenance preventative program. The med refrigerator was connected to power source that is a part of the emergency circuit on the day of the Inspection. The location of the refriger and circuit are now such that this chang will be permanent. The nursing staff willn-serviced prior to June 30, 2012 on the necessity of the refrigerator to remain of the emergency power source. Room 44 remodeling was completed on une 6, 2012. The outlet covers are now liace. The maintenance staff will received access to remodeling areas or to epilace the outlets during times of emodeling if the area has to be left mattended. In-services will be completed for to June 30, 2012.	ator to	June 3
			pr 20 -ou	ne receptacles in rooms 8 and 10 are GF otected. This was completed on June 1.712 The maintenance staff will check suctlets monthly within the facility as a partie monthly preventative maintenance ograms.), h	