STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	**710 JULIAN ROAD SALISBURY, NC 28147**

(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 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on record review, observations, and staff interviews, 3 of 3 male Dietary staff failed to use a chin guard or any type of facial hair covering while handling and serving food to residents for 2 of 2 meals observed. The Findings included: Review of the facility ' s Food and Nutrition Services Policies and Procedures with a revision date of 10/06/13 read: Policy: Food and Nutrition Services employees present a neat, clean, professional appearance and wear the uniform that meets the established guidelines of the department. Purpose: To maintain a professional appearance at all times. Process: Facial hair coverings are used to cover all facial hair. Kitchen/Food Service Observations on 7/29/14 from 10:50 AM -11:30 AM indicated the Food Service Director, the Cook, and the Dietary Aide who were observed with beards, were handling food in the walk-in refrigerator, and setting up foods for delivery to the dining rooms without the	F 371	1. On 7-29-14, Dietary Staff were trained on the use of beard guards by the Dietary Manager. As none were available, staff was trained on how to use a hair net as a temporary beard shield pending delivery of beard shields. 2. Residents who receive food from the kitchen have the potential to be impacted. 3. Training will be provided to Dietary Workers on the use of beard shields by the Dietary Manager by 8-29-14. This training will include how to use, when to use and expectations of usage. Staff with facial hair will provide return demonstration of successful application of training. Dietary Manager and or Assistant Manager will audit food preparation areas, service area and other designated area on a daily basis, Monday thru Friday and randomly on the weekends for four (4) weeks and weekly thereafter to ensure staff with facial hair are remain in compliance. Negative finding will be	8/29/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/22/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	**710 JULIAN ROAD SALISBURY, NC 28147**

(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 371	Continued From page 1 use of a chin guard or any type of facial hair covering. During dining Observations on 7/29/14 from 12:05 PM -12:30 PM in the Main Dining Room, the Cook (who had a 2 inch beard), was observed uncovering the foods for the steam table, placing the uncovered foods in the steam table wells, and serving 24 residents' trays without a chin guard or any type of facial hair covering. The Food Service Director(who had a 2 inch beard) was observed on 7/29/14 from 12:05 PM -12-30 PM going from the Main Dining Room to the separate dining area named Henry ' s Café, checking on the food at the steam tables without the use of a chin guard or any type of facial hair covering. A staff interview with the Food Service Director was conducted on 7/29/14 at 12:10 PM regarding the reason the staff were not wearing chin guards or any type of facial hair covering when serving food. The Food Service Director indicated, "They are so hard to find, so we don't have them." Dining observations conducted on 7/29/14 at 12:25 PM in a separate dining area named Henry's Cafe revealed the Dietary Aide (who had a light beard), was observed serving trays to 4 residents without a chin guard or any type of facial hair covering. Breakfast meal observations were conducted in the Main Dining Room on 7/30/14 at 7:55 AM. The Cook was observed serving resident meal trays without the use of a chin guard or any type of facial hair covering. The Cook stated he served 22 residents in the dining room for breakfast.	F 371	remediated immediately. 4. The Dietary Manager will complete tracking and trending on the audit results. The results of the audits and the trending will be reported to the Quality Assurance and Process Improvement (QAPI) Committee. The QAPI Committee will make recommendation on additional actions or changes that need to be taken to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	**710 JULIAN ROAD SALISBURY, NC 28147**

(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 371	Continued From page 2 An additional interview was conducted on 7/31/14 at 9:50 AM with the Food Service Director regarding his expectations about use of the chin guards or any type of facial hair covering during meal service. The Food Service Director indicated," My expectation is for the chin guards to be used at all times during meal service in the Dining rooms." The Food Service Director also stated the male Dietary staff was in-serviced on 7/29/14 to use beard hair nets until the chin guards were delivered. A staff interview was conducted with the Administrator on 8/1/14 at 9:15 AM regarding his expectations related to the use of chin guards or any type of facial hair covering. The Administrator indicated, "I expect the Dietary staff to follow the policy. If it says to use the chin guards/facial hair coverings in the policy, then I expect the Dietary staff to use them."	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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	F 431		8/29/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	**710 JULIAN ROAD SALISBURY, NC 28147**

(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 431	Continued From page 3 applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and interview with facility staff, the facility failed to remove the out of date medications in the medication storage rooms for 2 of 2 medication storage rooms . (Medication Storage Rooms 1 and 2) The findings included: Observations on 8/1/14 at 2:15 PM during medication storage inspection revealed the following medication on the shelf with other medications that facility staff would use for residents. Storage Room #1: 1 jar of Vitamin D 1,000 units expired 5/14	F 431	1. On 8-1-14, the Director of Nursing and Unit Clerks completed an inspection of medication storage room and medication carts to ensure no other medications were expired. No other medications were identified. The identified medications were sent to the pharmacy for disposal. 2. Residents who receive Over the Counter Medications (OTC), vitamins or supplements have the potential to be impacted. The Director of Nursing and or Unit Managers will complete an audit to identify residents who receive OTC□s, vitamins or supplements. They will ensure the medications those residents are receiving are not from expired stock.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 431	Continued From page 4 Observations on 8/1/14 at 2:45 PM during medication storage inspection revealed the following medication on the shelf with other medications that facility staff would use for residents. Storage Room #2: 3 jars of One daily multivitamin with iron, 100 tablet dietary supplement expired 4/14. 1 jar of Aspirin 325 mg 100 tablets expired 7/14. 1 jar of Slow Release Iron 50 mg , 60 tablets expired 7/14. 2 jars of Fiber-Caps 90 caplets expired 7/14. 1 16 oz. Liquid Pain Relief Acetaminophen expired 8//14. 2 Liquid Docusate Sodium 50 mg/5ml expired 8/14. Interview with the unit clerk on 8/1/14 at 3:30 PM revealed that the pharmacist checked the medication rooms for outdated medications monthly. It was also her responsibility to make sure they were not out of date. She was suppose to check for outdated medications when she brought in new stock, at least once a week.	F 431	Any negative findings will be immediately corrected. 3. NPE will provide education to nurses regarding checking of dates of OTC, vitamins and supplements prior to administration. Central Supply Clerks will be trained by the NPE on First In, First Out inventory management system with circling of expiration date for ease in auditing. Central Supply Clerks/Unit Secretaries will complete monthly audit of Supply Rooms to ensure no expired medications are on the shelf. Any negative findings will be documented and reported to the Unit Manager for that storage/room for proper disposal. The Director of Nursing, Assistant Director of Nursing □ Units and or other administrative nurses will complete an audit of medication carts on a monthly basis for 3 months to ensure no expired medications. Any negative findings will be documented and reported to the DON for proper disposal. The Administrator, DON and or other administrative nurses will complete a separate audit of medication storage rooms monthly for 3 months and randomly to ensure continued compliance. 4. The Director of Nursing will report the results of the audits monthly to the QAPI Committee for review. The QAPI Committee will make recommendations for changes or modifications necessary to ensure continued compliance.	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH	F 463		8/29/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 463	Continued From page 5 The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observations and interviews with facility staff and residents, the facility failed to install a call bell system or means to call for help in the community restroom that was utilized by 2 of 2 residents (Residents #14 and #75). The findings included: Observations on 7/29/14 at 11:30 AM revealed a community restroom in the front of the facility, had no call bell system or means to call for help while in the community restroom. Interview with the Activity Director on 7/29/14 at 4:30 PM revealed that if the resident asked to go to the restroom during activities, they would take the resident to the community restroom located in the front of the facility. If the resident required assistance, they would tell a recreation assistant. The resident was taken to the restroom up here (referring to the community restroom in the front of the facility) where we can utilize it. Interview on 7/29/14 at 4:32 PM with recreation assistant #1 revealed that she had taken residents to the community bathroom if they were independent but required an assistive device. Interview on 7/29/14 at 4:35 PM with recreation assistant #2 revealed that she had seen residents (Resident #14 and Resident #75) in the	F 463	1. On 7-23-14, the required locks needed to secure the community restroom and prevent resident access of an area without a call light were ordered. The locks were received on 8-11-14 and installed on 8-13-14. On 8-13-14, Administrator met with resident #14 and #75 and provided education regarding the lack of call system and restricted access. 2. An audit will be completed by the Director of Social Service by 8-20-14 to identify residents who have the potential to be impacted by this alleged deficient practice. Resident who accesses the community bathroom has the potential to be impacted. 3. Administrator will meet with Resident Council on or before 8-29-14 to review the reasoning for the restricted access of the identified bathrooms. The Administrator and or Director of Social Services will meet with identified residents at risk to review the restricted access to the identified bathrooms. The Nurse Practice Educator (NPE) and Director of Nursing and Assistant Director of Nursing □ Unit (ADNU)and or Administrator will provide training to staff regarding the restricted access community bathroom. Training will include how to access bathroom, the protection of pass code and what to do if	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 463	Continued From page 6 community restroom, that could transfer independently. Interview on 7/30/14 at 11:15 AM with Resident #75, revealed that when she was in activities, she used the community restroom. She continued that it was the nearest restroom to the activity room. Observations on 7/30/14 at 11:40 AM revealed a walker parked at the door of the community restroom. Shortly, the community restroom door opened and Resident #14 walked outside the community restroom door and left with her walker. At that time, there was a red hand bell setting on the back of the toilet. The red hand bell appeared on the back of the toilet the morning of 7/30/14. On 7/31/14 at 9:00 AM went into community bathroom, shut the door and rang the red hand bell. Another surveyor was standing outside of the community restroom with the door closed, in the hallway. She reported heard the bell. She said it was not very loud and the nurses ' station was not close enough to hear it. Interview with the maintenance man on 7/31/14 at 10:00 AM revealed that the restroom was 75 yards from the nurses ' station. Interview with the administrator 7/31/14 at 4:45 PM revealed that about 3 weeks ago he saw a resident using the restroom. They were waiting on a security lock that required a number code to enter, but it had not arrived. The company they had ordered it from had sent two different locks but they were not what the facility had required. Nothing was put in place to keep the residents	F 463	a resident should access the restricted bathrooms to include immediate notification of the Administrator. The Administrator will monitor community restroom assess through random rounds and feedback from staff to ensure residents are not access the rooms. If a resident should access the restricted access, the passcode will be immediately changed. 4. The Administrator will track the results of the audits and rounds for trends. The trends will be reported to monthly to the QAPI Committee. The QAPI Committee will make recommendation and or modification to ensure continued compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 463	Continued From page 7 from using the restrooms at the time the facility had discovered it could be a problem. He said he was aware that the bell placed on the back of the toilet could not be heard at the nurses ' station, 75 yards away. He continued that there was a lot of traffic during the day that passed the community bathroom and that someone walking by could hear it. In the evening, no one was in that part of the building.	F 463		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with facility staff, the facility failed to include up to date physician orders for wound care in the medical record for a stage 3 pressure ulcer for 1 of 2 residents with pressure ulcers. (Resident #56). The findings included:	F 514	1. On 7-31-14, the clarification order was obtained by the Unit Manager. On 7-31-14, the DON provided education to the wound nurse regarding obtaining clarification orders in a timely manner. 2. Residents who have wound treatments have the potential to be impacted by this practice. Therefore, an audit will be completed by the DON/ADNU	8/29/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345286	A. BUILDING _____ B. WING _____	C 08/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALISBURY CENTER	710 JULIAN ROAD SALISBURY, NC 28147

(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 514	Continued From page 8 Treatment orders from 7/1/14 to 7/31/14 on the physician order sheet revealed to cleanse coccyx with wound cleanser, pack with hydrogel gauze and apply skin prep to peri (surrounding) wound. Cover with optifoam every day. Observations on 7/31/14 at 10:00 am of pressure ulcer care for Resident #56 performed by the treatment nurse revealed she cleansed the pressure ulcer with wound cleanser, packed the pressure ulcer with calcium alginate and covered it with optifoam. There was no order for this treatment in the medical record. The treatment nurse kept saying she had written the order on July 3, 2014. A clarification order was received on 7/31/14 at 1:35 PM revealed to cleanse coccyx with wound cleanser, apply skin prep around wound, apply calcium alginate to wound bed and cover with optifoam every day.	F 514	and or administrative nurses by 8-29-14 to ensure Treatment Orders and Physician Orders and actual treatments match. Any negative findings will be resolved immediately and reported to the Director of Nursing. 3. Education will be provided by the NPE to licensed nurses regarding obtaining clarification orders in a timely manner and validation of the Treatment Administration Record (TAR) by 8-29-14. The Director of Nursing and or administrative nurses will complete a weekly audit for 4 weeks and then monthly for 3 months validating the physicians orders to the TAR to the actual treatment completed. Any negative finding will be immediately corrected. The results of the audit will be reported to the Director of Nursing 4. The Director of nursing will track the results of the audits for trends. The trends will be reported monthly to the QAPI Committee. The QAPI Committee will make recommendations and or modifications to ensure continued compliance.	