DEPARTI	MENT OF HEALTH AN	D HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>			COMF	E SURVEY PLETED
		345264	B. WING				C /20/2013
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
STANI EV	TOTAL LIVING CENTER			5	14 OLD MOUNT HOLLY ROAD		
STANLET	TOTAL LIVING CENTER			S	TANLEY, NC 28164		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 242 SS=E	MAKE CHOICES	ERMINATION - RIGHT TO	F	242			1/17/14
	schedules, and health her interests, assess interact with members inside and outside the	right to choose activities, in care consistent with his or ments, and plans of care; is of the community both a facility; and make choices for her life in the facility that resident.					
	by: Based on observatio resident and staff inter honor resident choice morning medication p residents for their mo residents who were a #4 and #108). The findings included 1. Resident #18 was 09/17/13 with diagnost dementia, depression (heartburn). The most Data Set dated 11/14 had short term and lo and was severely imp decision making. A review of a monthly Record dated 12/01/1	ass at 5:00 AM and woke rning medications for 4 of 4 sleep (Resident #18, #135, : admitted to the facility on ses which included and esophageal reflux st recent 60 day Minimum /13 indicated Resident #18 ng term memory problems baired in cognition for daily Medication Administration			Medication times for residents #18, #1 and #4 were reviewed and changed to more appropriate times during the resident's normal waking hours on 1/14/14. The specific medication in question for resident #108 was a scheduled antibiotic that was complete on 12/20/13 and no longer of concern- other medications for resident #108 we reviewed and changed to a more appropriate time during normal waking hours on 1/14/14. Nurses were in-serviced by the Administrator on 12/26/13 of the importance of not waking residents for medications unless medically necessar for acute needsthis in-service include discussion specifically with the 11-7 nurses (including Nurse #3) that routing medications not be given prior to the resident waking for their day.	d -all ere fy d	
	During an observation medication pass on the	ne 500 hall at 5:04 AM all of			All medications and treatment times, including fingerstick blood sugars, were reviewed by the Nursing Management	9	
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	E		TITLE		(X6) DATE

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

01/16/2014

						O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · ·	E SURVEY
			A. BUILDING	3		
		345264	B. WING			С
		345264	B. WING			2/20/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	JODE	
STANLEY	TOTAL LIVING CENTER			514 OLD MOUNT HOLLY ROAD		
	1			STANLEY, NC 28164		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC		(X5) COMPLETIO
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	DATE
F 242	Continued From page	e 1	F 24	12		
	the lights on the 500	halls were turned on and the		Team to determine a more	routine	
		right. Nurse #3 who was a		scheduling of medications		
		nurse pulled a pill labeled		any from being scheduled		
		s from a medication cart		hours of sleep unless med		
	parked in the hallway			for acute medical needs.	• •	
	Resident #18's room	and knocked on her door.		medication time policy imp	lemented on	
	Nurse #3 opened the	door and entered the room.		1/17/14 allows residents to	o sleep	
	There were no lights	on in the room and Nurse #3		uninterrupted as desired a	nd also	
	turned on a light and	called Resident #18's name		includes directions for any	medications	
	and stated it was time			specifically ordered around		
		#18 was lying in bed and		(every 6 hours, every 8 ho		
		raised her head up off her		will verify the specific times		
		aced the medication in		physician required for acut		
		h and gave her a sip of water		will obtain this in writing or		
		hands, turned off the lights		order for such medications		
		of the room and walked back		necessity, and will ensure		
	to the medication car	t in the hallway.		resident/responsible party		
	During on interview o	n 12/10/12 at E:20 AM tha		specific timing requiremen		
		n 12/19/13 at 5:30 AM the pervisor verified the early		needs on a short-term bas affect hours of sleep.	is that may	
		bass always started at 5:00		allect hours of sleep.		
	- ·	ained she sometimes		In-servicing was conducted	d for nursing	
		ft nurse with her medication		staff by the ADON/SDC or	•	
		ish her medications before		revised policy/procedure a		
		ncoming day shift nurses.		importance of not allowing		
				choice in not be awakened		
	During an interview of	n 12/19/13 at 7:32 AM		purposes unless medically		
	-	was routine practice to start		acute medical needs.		
	medication pass at 5	•				
	-	lered to be given at 6:00 AM		The Social Worker will rev	iew any	
		nad a 1 hour window before		possible concerns regardir	-	
	and after the medicat	ion was ordered to give the		waking residents for routin		
	medication so they st	arted the medication pass at		and/or treatments with the	monthly	
	-	d have all of the medications		Resident's Council meeting		
		shift arrived and shift report		beginning with the January	y meeting. Any	
		 She further stated she 		concerns voiced by reside		
		nately 80 percent of the		reported to the DON and a		
		ve morning medications to		through specific monitoring		
	on a regular basis bu	t if nurse aides were doing		staff, re-education, and pro	aroonivo	1

Facility ID: 953470

If continuation sheet Page 2 of 21

CENTER	S FOR MEDICARE &	ID HUMAN SERVICES			OMB N	RM APPROVE 10. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	LE CONSTRUCTION		TE SURVEY MPLETED
		345264	B. WING		1	2/20/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STANI EV	TOTAL LIVING CENTER			514 OLD MOUNT HOLLY ROAD		
STANLET	TOTAL LIVING CENTER			STANLEY, NC 28164		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 242	Continued From page	e 2	F 24	2		
	their rounds then the	resident would already be d not have to wake them.		disciplinary action as necessary	/.	
	She explained most of during the 5:00 AM m medications given by sugar checks and she about their choices re- medications. Nurse a lights were always tur During an interview of Director of Nursing st for resident choices to morning medication p did not want their me medication time shou resident could not sta staff should watch for not want to be awake He also confirmed the of the lights off during expectation for the lig should not be burning 2. Resident #135 was 07/03/13 with diagnos disease and dementia Minimum Data Set (N indicated Resident #* long term memory pri impairment in cognition The MDS further india required extensive as activities of daily livin A review of a monthly Record dated 12/01/2	of the medications she gave nedication pass included mouth or finger stick blood e had not asked residents egarding their early morning #3 confirmed the hallway rmed on brightly at night. In 12/20/13 at 5:42 PM the tated it was his expectation to be honored regarding early bass. He stated if residents dications given early the ld be adjusted and if a the their choices the nursing r indications a resident did ened early for medications. ere was a way to turn some g the night and it was his ghts to be turned down and g brightly at night. Is admitted to the facility on ses which included heart a. The most recent quarterly MDS) dated 10/02/13 135 had no short term or oblems and had no on for daily decision making. cated Resident #135 ssistance from staff for g. / Medication Administration		The Quality Assurance Nurse w medication times specifically du of sleep Monday (viewing Frida through Sunday night) through month, weekly x 1 month, and r months to ensure staff continue the written policy and procedure residents are not being given m prior to 7:00am unless medicall necessary for acute conditions. concerns will be reported to the follow-up as necessary. This a begin on 1/17/14. The DON will monitor the results trends or patterns to the QA&A monthly x 6 months. The QA&A Committee will determine if any interventions or systemic change needed to assure continued con with F242.	uring hours y night Friday x 1 monthly x 4 to follow e and that hedications y Any to DON for udit will ts of the t's Council and any Committee A further ges are	

If continuation sheet Page 3 of 21

	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/12/2014 APPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
		345264	B. WING			_		C 20/2013
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
STANLEY	TOTAL LIVING CENTER				4 OLD MOUNT HOLLY R TANLEY, NC 28164	OAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 242	Continued From page	23	F 2	42				
	the lights on the 500 f hallways were very br 11:00 PM to 7:00 AM Protonix 40 milligrams parked in the hallway Resident #135's room roommate of resident door. Nurse #3 open room. There were no Nurse #3 turned on a #135's name and stat morning medication. If bed and opened her e off her pillow. Nurse a Resident #135's mout water to drink, washe lights and closed the back to the medication During an interview of night shift nursing sup morning medication p AM. She further expla assisted the night shift pass so she could find shift report with the or During an interview of Nurse #3 explained it medication pass at 5: medications were ord or 6:30 AM but they h and after the medicati	he 500 hall at 5:06 AM all of halls were turned on and the right. Nurse #3 who was a nurse pulled a pill labeled is from a medication cart outside the door of h who was also the #18 and knocked on her ed the door and entered the lights on in the room and light and called Resident ed it was time for her Resident #135 was lying in eyes and raised her head up #3 placed the medication in th and gave her a sip of d her hands, turned off the door of the room and walked n cart in the hallway. h 12/19/13 at 5:30 AM the pervisor verified the early ass always started at 5:00 ained she sometimes ft nurse with her medication ish her medications before nooming day shift nurses. h 12/19/13 at 7:32 AM was routine practice to start						

		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345264	B. WING				C
	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	20/2013
					514 OLD MOUNT HOLLY ROAD		
STANLEY	TOTAL LIVING CENTER				STANLEY, NC 28164		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 242	had to wake approxim residents that she gay on a regular basis but their rounds then the awake and she would She explained most of during the 5:00 AM m medications by mouth checks and she had r their choices regardin medications. Nurse # lights were always tur During an interview of Resident #135 she co her up every morning stated nursing staff has choices regarding wh medication so she jus needed it for her storr During an interview of Director of Nursing sta for resident choices to morning medication p did not want their medication p did not want their medication for not want to be awake He also confirmed the of the lights off during expectation for the lig should not be burning 3. Resident #4 was a	 She further stated she hately 80 percent of the verify 81 percent of the medications she gave edication pass included in or finger stick blood sugar not asked residents about g their early morning 43 confirmed the hallway med on brightly at night. In 12/20/13 at 3:22 PM with onfirmed nursing staff woke for her stomach pill. She ad not asked her about her en to take her morning at took it because she hach. In 12/20/13 at 5:42 PM the ated it was his expectation to be honored regarding early hass. He stated if residents dications given early the ld be adjusted and if a ted their choices nursing indications a resident did ned early for medications. For was a way to turn some the night and it was his his to be turned down and prightly at night. 	F	242			
	09/01/10 with diagnos osteoarthritis, depress	ses which included sion and anxiety. The most					

Facility ID: 953470

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 11/12/2014 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION		(X3) DATE S COMPL	SURVEY .ETED
		345264	B. WING		_	C 12/2	; 20/2013
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
				514 OLD MOUNT HOLLY R	OAD		
STANLET	TOTAL LIVING CENTER			STANLEY, NC 28164			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 242	Continued From page	5	F 24	2			
	recent quarterly Minin 11/17/13 indicated Re	num Data Set dated esident #4 had no short term					
	or long term memory impairment in cognition	problems and had no on for daily decision making.					
	Record dated 12/01/1	0					
	, , , , , , , , , , , , , , , , , , ,	ne/APAP 10-325 milligrams at 6:00 AM and 6:00 PM.					
	-	n on 12/19/13 of a ne 500 hall at 5:08 AM all of nalls were turned on and the					
	hallways were very br 11:00 PM to 7:00 AM	right. Nurse #3 who was a nurse pulled a pill labeled					
	medication cart parke	0-325 milligrams from a d in the hallway outside the room and crushed the					
	medication and place	d it in jelly in a cup. The already open and Nurse #3					
	Resident #4 was mak	and entered the room. ing snoring sounds and					
	time for her morning r	sident to wake up, it was medications. Resident #4					
	tapped Resident #4 o	oring noises and Nurse #4 n her shoulder and again r her morning pill. Nurse #3					
	continued to call Resi	dent #4's name, raised the Resident #4 partially opened					
	#4's mouth and told h	laced a straw in Resident er to take a sip of water,					
	told her to swallow the	Resident #4's mouth and e pill and gave her another					
		a lowered the head of rned off the light and walked r medication cart in the					
	hallway.						
	During an interview of	n 12/19/13 at 5:30 AM the					

Facility ID: 953470

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/12/2014 APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345264	B. WING		-		C 20/2013
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
STANLEY	TOTAL LIVING CENTER				DAD		
				STANLEY, NC 28164			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 242	morning medication p AM. She explained s night shift nurse with 1 could finish her medic with the oncoming day During an interview of Nurse #3 explained it medication pass at 5: medications were ord or 6:30 AM but they h and after the medicati medication so they sta 5:00 AM so they could given by the time first was given at 7:00 AM had to wake approxim residents that she gay on a regular basis but their rounds then the awake and she would She explained most of during the 5:00 AM m	bervisor verified the early ass always started at 5:00 he sometimes assisted the her medication pass so she cations before shift report y shift nurses. In 12/19/13 at 7:32 AM was routine practice to start 00 AM. She stated ered to be given at 6:00 AM ad a 1 hour window before ion was ordered to give the arted the medication pass at d have all of the medications shift arrived and shift report . She further stated she hately 80 percent of the ve morning medications to t if nurse aides were doing resident would already be I not have to wake them. of the medications she gave edication pass included	F 242				
	checks and she had r their choices regardin	n or finger stick blood sugar not asked residents about g their early morning 43 confirmed the hallway					
		ned on brightly at night.					
	Resident #4 she state she could. She state asked her about her c morning medications gave her.	n 12/20/13 at 2:52 PM with ad she liked to sleep when d nursing staff had not choices regarding her and she just took what they n 12/20/13 at 5:42 PM the					
		ated it was his expectation					

Facility ID: 953470

If continuation sheet Page 7 of 21

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345264	B. WING				C 20/2013
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•	
					514 OLD MOUNT HOLLY ROAD		
STANLEY	TOTAL LIVING CENTER				STANLEY, NC 28164		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 242	for resident choices to morning medication p did not want their medi- medication time shour resident could not star staff should watch for not want to be awake He also confirmed the of the lights off during expectation for the lig should not be burning 4. Resident #108 was 12/28/12 with diagnos Alzheimer's disease, inflammation of eyelic Minimum Data Set da Resident #108 had sh memory problems and cognition for daily dec A review of a monthly Record dated 12/01/1 indicated Sulfacetami left eye every 6 hours 6:00 AM; 12:00 PM at During an observation medication pass on th the lights on the 500 I hallways were very br 11:00 PM to 7:00 AM Sulfacetamide Eye dr parked in the hallway Resident #108's room Nurse #3 entered the on, washed her hands Resident #108's eyes	 be honored regarding early ass. He stated if residents dications given early the ld be adjusted and if a te their choices the nursing indications a resident did ned early for medications. Are was a way to turn some the night and it was his hts to be turned down and a brightly at night. admitted to the facility on sees which included dementia, cataracts and ls. The most recent annual ted 12/04/13 indicated nort term and long term d was severely impaired in cision making. Medication Administration 3 through 12/31/13 de 10 percent (2) drops in for 7 days at 12:00 AM; and 6:00 PM. n on 12/19/13 of a he 500 hall at 5:26 AM all of halls were turned on and the right. Nurse #3 who was a nurse pulled a bottle labeled ops from a medication cart outside the door of a and knocked on his door. room and turned the lights 	F	242	2		

Facility ID: 953470

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/12/2014 APPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		345264	B. WING		_		C 20/2013
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
			5	14 OLD MOUNT HOLLY R	ROAD		
STANLEY	TOTAL LIVING CENTER		s	STANLEY, NC 28164			
(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 PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 242	Resident #108 but he continued to make sn patted Resident #108 drops in Resident #108 drops in Resident #10 stretched his arms out open his eyes. Nurse washed her hands, tu out into the hallway to During an interview of night shift nursing sup morning medication p AM. She further expla assisted the night shift pass so she could find shift report with the or During an interview of Nurse #3 explained it medication pass at 5: medications were ord or 6:30 AM but they h and after the medicat medication so they st 5:00 AM so they could given by the time first given at 7:00 AM. Sh wake approximately & that she gave morning regular basis but if nu rounds then the reside and she would not ha explained most of the during the 5:00 AM m medications given by sugar checks but som to give. She stated sh about their choices re	did not open his eyes and oring sounds. Nurse #3 's chest then placed the eye 08's left eye. Resident #108 t to his sides but did not e #3 removed her gloves, irned off the light and walked o her medication cart. In 12/19/13 at 5:30 AM the pervisor verified the early ass always started at 5:00 ained she sometimes ft nurse with her medication ish her medications before nooming day shift nurses. In 12/19/13 at 7:32 AM was routine practice to start 00 AM. She stated ered to be given at 6:00 AM ad a 1 hour window before ion was ordered to give the arted the medication pass at d have all of the medications shift arrived and report was e further stated she had to 80 percent of the residents	F 242				

Facility ID: 953470

If continuation sheet Page 9 of 21

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,			(X3) DATE COMF	
		345264	B. WING				20/2013
	ROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE 14 OLD MOUNT HOLLY ROAD TANLEY, NC 28164		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 242 F 252 SS=D	Director of Nursing st for resident choices to morning medications. not want their medica medication time shou resident could not sta staff should watch for not want to be awake He also confirmed the of the lights off during expectation for the lig should not be burning 483.15(h)(1) SAFE/CLEAN/COMF ENVIRONMENT The facility must prov comfortable and hom- the resident to use his to the extent possible	n brightly at night. n 12/20/13 at 5:42 PM the ated it was his expectation b be honored regarding early He stated if residents did tions given early the Id be adjusted and if a te their choices the nursing indications a resident did ned early for medications. ere was a way to turn some the night and it was his hts to be turned down and brightly at night. ORTABLE/HOMELIKE ide a safe, clean, elike environment, allowing s or her personal belongings.		242			1/17/14
	by: Based on observation facility failed to provid when a resident 's so on her bed for 1 of 2 r Review of the medica 60 was admitted to th diagnoses including A depression, anxiety, o and lack of coordinati	is not met as evidenced ns and staff interviews the le linens in clean condition iled linen was not changed residents (Resident # 60). I record revealed Resident # e facility on 11/08/10 with Izheimer's, dementia, debility, muscle weakness on. A review of the most m Data Set (MDS) dated			Linens for Resident #60 were changed immediately upon notifaction to the DOI on 12/19/13. NA #2 was re-educated o the current policy and expecation for changing linens with each shower and a needed on 12/23/13. Linens for all residents were checked an any discovered to be soiled were chang by assigned nursing staff on 12/19/13. Nursing staff (including NA #2) were	N n as ny	

Event ID: EUXG11

Facility ID: 953470

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			(20) 1411			IO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		TE SURVEY MPLETED
			A. BUILDING			С
		345264	B. WING		1	2/20/2013
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP		
STANLEY	TOTAL LIVING CENTER			514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETION DATE
F 252	Continued From page	e 10	F 25	52		
	10/28/13 revealed Re impaired for cognitive making and required	esident # 60 was severely eskills for daily decision extensive assistance with g which included bathing and		in-serviced by the Adminis 12/26/13 of the current po expectations for changing each shower and as need soiled.	licy and linens with	
	Resident # 60 was so on Mondays and Weo	record shower list revealed cheduled to receive showers dnesdays. n on 12/17/13 at 8:34 AM		The policy for bed linens we effective 1/16/14 to includ be stripped by the 1st shift on the day the resident reskin assessment (once we	e "bed linens will ft Shower Aide ceives his/her	
	Resident # 60's bed w turned down at the he revealed a 2 inch long	was made with the sheet ead of the bed which g by $\frac{1}{2}$ inch wide purple		be replaced by the assign assistant". The revised po to state "bed linens will be	ed nursing olicy continues	
		n the middle of the top edge own below the pillow at the		needed by the assigned n when visibly soiled". The sheet for the nursing assis	assignment	
		n on 12/18/13 at 9:36 AM		aides will indicate daily sk assessmentsthe shower	in aide will initial	
	the same purple color	inen sheets remained with red stain on the middle of neet folded down below the		when the bed has been si assigned nursing assistar the new linens have been	t will initial when	
	pillow at the head of t			In-servicing was conducted staff on this revised policy	d for all nursing	
	Resident # 60's bed l	n on 12/18/13 at 5:21 PM inens sheets remained with red stain on the middle of		expecations for clean line ADON/SDC on 1/15/14.		
	the top edge of the sh pillow at the head of t	neet folded down below the the bed.		The Unit Nurse on each h will monitor 2 beds per nu assignment per shift daily	rsing assistant x 4 weeks,	
	Resident # 60's bed the same purple color	n on 12/19/13 at 8:50 am linen sheets remained with red stain on the middle of		weekly x 4 weeks, and mo months in random order to linens are in place and are	o verify clean e changed as	
	the top edge of the sh pillow at the head of t	neet folded down below the he bed.		required and necessary. noted in the failure to follo be identified, documented	w this policy will	
	Nursing Assistant (NA	n 12/17/13 at 11:47 AM with A) # 4 responsible for the s 5 days a week stated		during the observation. S be re-educated or issued disciplinary action as nece	taff involved will progressive	

Facility ID: 953470

If continuation sheet Page 11 of 21

	OF DEFICIENCIES	MEDICAID SERVICES			CONSTRUCTION		<u>NO. 0938-039</u> TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· /		CONSTRUCTION	· · ·	MPLETED
							С
		345264	B. WING			1	2/20/2013
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
STANLEY	TOTAL LIVING CENTER	t			4 OLD MOUNT HOLLY ROAD TANLEY, NC 28164		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 252	Continued From page	e 11	F 25	52			
	Resident # 60 receive	ed showers on Mondays and stated Resident # 60			audits will begin on 1/17/14.		
	received her shower	on Monday as was			The ADON/SDC will monitor the result		
	scheduled. NA # 4 fu				the nursing audits for completion and		
		ents on the halls were ging the bed linens on the			report results and any trends or patte to the QA&A Committee monthly x 6	ms	
		ays and as needed when			months. The QA&A Committee will		
	linens were soiled.	-			determine if any further interventions		
					systemic changes are needed to assu	lre	
	-	on 12/18/13 at 4:30 PM with hift for Resident # 60 stated			sustained compliance with F252.		
		rom the day shift NA that					
		er was completed today and					
		eported as incomplete. NA #					
		vers included, hair washing,					
	nail care, clean clothe	es and clean linens.					
	During an interview o	on 12/19/13 at 9:00 AM the					
		C) floor supervisor confirmed					
		t was soiled with a grape					
		middle of the top edge of the					
		elow the pillow at the head of have been changed on the					
		y and any time they were					
		pervisor further stated it was					
		sheets were changed on					
		s and Wednesdays for this					
	resident or any time t	they were solled.					
	During a telephone ir	nterview on 12/20/13 3:26					
	PM with NA # 2 for th	e day shift responsible for					
		# 60 on Monday, Tuesday					
	-	ed Resident # 60 shower					
		nd Wednesday. NA # 2 Resident # 60's sheets on					
	-	the morning after breakfast.					
		did not change the linens on					
	Resident # 60's bed of	on Tuesday or Wednesday.					
	NA # 2 further reveale	ed that she did not give a					

If continuation sheet Page 12 of 21

	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		CONSTRUCTION		
	345264	B. WING				20/2013
PPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
G CENTER						
DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	x			(X5) COMPLETION DATE
e next shift iterview o Nursing (E that bed I k on the r ad Wedne ere soiled 50's shee ed stain o folded do bed. iterview o or verified ourple gra e top edg illow at the or stated i s should b ys and mo NAINTE ABLE SOI must prov sound le REMENT bservatio he facility sound le the 500 h	t NA to change the linens. In 12/19/13 at 09:04 AM the DON) stated it was his linens should be changed esident shower days sdays and more often when I. The DON confirmed t were soiled with a purple In the middle of the top edge were below the pillow at the In 12/19/13 at 9:32 AM the Resident #60's linens were pe colored stain on the te of the sheet folded down the head of the bed. The t was her expectation that the changed on resident 's bore frequently when they ENANCE OF JND LEVELS ide for the maintenance of vels. T is not met as evidenced Ins, resident and staff failed to maintain vels for sampled residents all during the night shift			There were no residents named specifically in the citation; however, shi supervisors addressed concerns of noi level during hours of sleep with all shift immediately following the survey on	se	1/17/14
	ICARE & ICARE & ICA	ICARE & MEDICAID SERVICES s (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345264 PPLIER G CENTER UMMARY STATEMENT OF DEFICIENCIES A DEFICIENCIES A DEFICIENCY MUST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION) From page 12 e next shift NA to change the linens. A DYNON) stated it was his that bed linens should be changed ek on the resident shower days nd Wednesdays and more often when vere soiled. The DON confirmed 60's sheet were soiled with a purple ed stain on the middle of the top edge t folded down below the pillow at the bed. herview on 12/19/13 at 9:32 AM the or verified Resident #60's linens were purple grape colored stain on the e top edge of the sheet folded down illow at the head of the bed. The or stated it was her expectation that s should be changed on resident 's ys and more frequently when they	ICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULI IDENTIFICATION NUMBER: A. BUILDI JENTIFICATION NUMBER: B. WING 345264 B. WING PPLIER G CENTER JUMMARY STATEMENT OF DEFICIENCIES ID IDEFICIENCY MUST BE PRECEDED BY FULL PREFIL ATORY OR LSC IDENTIFYING INFORMATION) TAG From page 12 F 2 e next shift NA to change the linens. Interview on 12/19/13 at 09:04 AM the Nursing (DON) stated it was his that bed linens should be changed ek on the resident shower days ad Wednesdays and more often when vere soiled. The DON confirmed 60's sheet were soiled with a purple ed stain on the middle of the top edge tholded down below the pillow at the bed. bed. nterview on 12/19/13 at 9:32 AM the or verified Resident #60's linens were purple grape colored stain on the e top edge of the sheet folded down illow at the head of the bed. The or stated it was her expectation that s should be changed on resident 's ys and more frequently when they . . . MAINTENANCE OF F 2 <t< td=""><td>ICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE S (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE JUBULDING B. WING </td><td>ICARE & MEDICAID SERVICES s [A1] PROVIDERSUPPLERCLIA IDENTIFICATION NUMBER: (A2) MULTIPLE CONSTRUCTION A BUILDING g center street ADDRESS, CITY, STATE, ZIP CODE Sta OLD MOUNT HOLLY ROAD STANLEY, NC 28164 DEPCIER STREET ADDRESS, CITY, STATE, ZIP CODE Sta OLD MOUNT HOLLY ROAD STANLEY, NC 28164 UMMARY STATEMENT OF DEFICIENCIES LIDEPCIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) ID PREPRIC TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BUILD CROSS-REFERENCED TO THE APPROPRIM DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) From page 12 en ext shift NA to change the linens. F 252 a next shift NA to change the linens should be changed ik on the resident shower days that bed linens should be changed ik on the resident shower days to verified Resident folded down illow at the head of the top edge folded down below the pillow at the bed. F 258 OS sheet were solied with a purple ed statin on the ed po edge of the sheet folded down illow at the head of the bed. The or verified Resident #60's linens were purple grape colored stain on that s should be changed on resident's ys and more frequently when they interview on 12/19/13 at 9:32 AM the or verified Resident #60's linens were purple grape colored stain on that s should be changed on resident's ys and more frequently when they interview on the sheet folded down illow at the head of the bed. The or verified Resident that should be changed on resident's ys and more frequently when they interview on the as evidenced F 258 IREMENT is not met as evidenced There were n</td><td>ICARE & MEDICAID SERVICES OMB NC s (x1) PROVIDERSUPPLERCLA DENTIFICATION NMMER: (x2) MULTPLE CONSTRUCTION A BUILDING (x3) DATE CONSTRUCTION 348264 B. WING Iteration pPLER STREET ADDRESS, CITY, STATE, ZIP CODE 514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164 122 pPLER STREET ADDRESS, CITY, STATE, ZIP CODE 514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164 122 providers PLAN OF CORRECTION IDEFICIENCY MUST BE PRECEDED BY FULL ACORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION STANLEY, NC 28164 Torm page 12 a next shift NA to change the linens. D PREFIX PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) From page 12 a next shift NA to change the linens. F 252 From page 12 a next shift NA to change the linens. F 252 From page 12 be of the book of the word ays and Wednesdays and more of often when ere soiled. The DON confirmed 60's sheet were soiled with a purple ded stain on the indide of the top edge to folded down below the pillow at the bed. F 258 MINITENANCE OF ABLE SOUND LEVELS F 258 IREMENT is not met as evidenced observations, resident and staff the facility failed to maintain is sound levels for sampled residents the 500 hail during the night shift supervisors addressed concerns of noise level during hours of sleep with all shifts inmediately following the survey on</td></t<>	ICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE S (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE JUBULDING B. WING	ICARE & MEDICAID SERVICES s [A1] PROVIDERSUPPLERCLIA IDENTIFICATION NUMBER: (A2) MULTIPLE CONSTRUCTION A BUILDING g center street ADDRESS, CITY, STATE, ZIP CODE Sta OLD MOUNT HOLLY ROAD STANLEY, NC 28164 DEPCIER STREET ADDRESS, CITY, STATE, ZIP CODE Sta OLD MOUNT HOLLY ROAD STANLEY, NC 28164 UMMARY STATEMENT OF DEFICIENCIES LIDEPCIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) ID PREPRIC TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BUILD CROSS-REFERENCED TO THE APPROPRIM DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) From page 12 en ext shift NA to change the linens. F 252 a next shift NA to change the linens should be changed ik on the resident shower days that bed linens should be changed ik on the resident shower days to verified Resident folded down illow at the head of the top edge folded down below the pillow at the bed. F 258 OS sheet were solied with a purple ed statin on the ed po edge of the sheet folded down illow at the head of the bed. The or verified Resident #60's linens were purple grape colored stain on that s should be changed on resident's ys and more frequently when they interview on 12/19/13 at 9:32 AM the or verified Resident #60's linens were purple grape colored stain on that s should be changed on resident's ys and more frequently when they interview on the sheet folded down illow at the head of the bed. The or verified Resident that should be changed on resident's ys and more frequently when they interview on the as evidenced F 258 IREMENT is not met as evidenced There were n	ICARE & MEDICAID SERVICES OMB NC s (x1) PROVIDERSUPPLERCLA DENTIFICATION NMMER: (x2) MULTPLE CONSTRUCTION A BUILDING (x3) DATE CONSTRUCTION 348264 B. WING Iteration pPLER STREET ADDRESS, CITY, STATE, ZIP CODE 514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164 122 pPLER STREET ADDRESS, CITY, STATE, ZIP CODE 514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164 122 providers PLAN OF CORRECTION IDEFICIENCY MUST BE PRECEDED BY FULL ACORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION STANLEY, NC 28164 Torm page 12 a next shift NA to change the linens. D PREFIX PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) From page 12 a next shift NA to change the linens. F 252 From page 12 a next shift NA to change the linens. F 252 From page 12 be of the book of the word ays and Wednesdays and more of often when ere soiled. The DON confirmed 60's sheet were soiled with a purple ded stain on the indide of the top edge to folded down below the pillow at the bed. F 258 MINITENANCE OF ABLE SOUND LEVELS F 258 IREMENT is not met as evidenced observations, resident and staff the facility failed to maintain is sound levels for sampled residents the 500 hail during the night shift supervisors addressed concerns of noise level during hours of sleep with all shifts inmediately following the survey on

Event ID: EUXG11

Facility ID: 953470

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	-	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/12/2014 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345264	B. WING		12/20/2013
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
STANLEY	TOTAL LIVING CENTER	1		514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLETION
F 258	Continued From page	e 13	F 258	3	
	The findings included	l:			
	During an observation maintenance staff ma back door of the 500 On 12/19/13 at 5:04 / the door at the 500 h door the door alarm in and the nursing supe the alarm but was und 4 attempts. During he door alarm, she had t door 4 times. She the the 3rd shift 500 hall door alarm. During an observation maintenance staff ma outside through the b Maintenance personn disengage the alarm	n on 12/19/13 at 4:53 AM a an entered and exited the hall. AM as surveyors knocked on all to alert staff to open the mmediately sounded loudly rvisor attempted to silence able to clear the alarm after er attempts to disengage the to open and slam shut the en asked for assistance from nurse who disengaged the n on 12/19/13 at 5:07 AM an entered the building from tack door on the 500 hall. hel used the key pad to prior to his entrance but the beeps and the door slammed		The Social Worker held a Reside Council meetings on 12/23/13 at discussed noise level throughou entire building during hours of sleepconcerns voiced by the re- were addressed with nursing sta Administrator through an in-serv 12/26/13. The Social Worker the 2nd meeting with the Resident's on 1/8/14 for any further concerr to noise levels and they stated it "getting better". All areas of concern related to comfortable sound levels during sleep were reviewed and change made to certain policies and pro that had the potential to affect re while sleepingall changes were 1/17/14. Routine nursing assista (passing ice, delivering nursing s taking routine vital signs, and sp application) and all housekeeping/maintenance serv including wheelchair washing wi	hd t the esidents ff by the ice on en held a Council hs related was hours of es were cedures esidents e effective ant duties supplies, lint vices
	back door on the 500 every night and unloc morning and confirme activated during these who entered and/or e times would cause th	as interviewed. He stated the hall was locked at 9:00 PM cked at 6:00 AM each ed the door alarm was e times. He revealed anyone exited the door during these e alarm to sound loudly. He		occur prior to 7:00am and will en than 8:00pm unless a resident s requests such actions. All door closers will be checked monthly basis by Maintenance to each is properly working to man	pecifically on a o ensure age the
	of the building therefor 500 hall door to enter went in and out the d when staff took break	s parking lot was at the back ore all employees used the r and exit. He revealed staff oor to smoke as well as ks and/or for their meal c, 2nd, and 3rd shifts. He		An Employee Only entrance/exit designated for staff between the 8:00pm to 8:00amno employee or exit the doors on resident hall	has been hours of will enter

Facility ID: 953470

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CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES			OMB N	RM APPROVE O. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SU COMPLET	
		345264	B. WING		12	2/20/2013
NAME OF P	ROVIDER OR SUPPLIER	•	STREET ADDRESS, CITY, STATE, ZIP CODE			
STANLEY TOTAL LIVING CENTER			514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 258	wheelchairs out the 5 wheelchair pressure 9:00 PM and 12:00 M wheelchairs dried, the back in through the b around 2 to 3 hours a been taken out. He fu door was a like a reve staff/employees durin night, by visitors, eme (EMS), as well as for deliveries during the During an observation door bell sounded at the facility. A 3rd shift the 6:00 AM resident door loudly slammed During observations of until 7:53 AM the 500 loudly slammed shut maintenance men, ho staff, and nurse aids. During an observation 3rd shift maintenance maintenance man us screws on the door co the 500 hall.	assistants took resident 500 hall door to the washing machine between 100 hall door to the e wheelchairs were brought ack door of the 500 hall after the wheelchairs had after the wheelchairs had arther stated the 500 hall olving door used by all ng all hours of the day and ergency medical services vendor pickups and/or early morning hours. In on 12/19/13 at 5:52 AM a the front entrance door of t nurse opened the door for blood draw lady and the behind her. on 12/19/13 from 6:32 AM 0 hall door was opened and multiple times by busekeeping staff, nursing	F 25		tion yee Only that will not located services in they arrive ough the ed on all elevel by istrator on cluded the ssigned to at elevels lress any any bise level monthly any ed to the th the n progressive y. e HR	
	10:07 AM the 1st shift shift maintenance ma drill to replace the do of the 500 hall.	The first from 9.54 Air until ft maintenance man and 3rd an continued using the power or closure of the back door PM the Director of Nursing		random "pop-in" visits on 11-7 weekly x 6 weeks to determine concerns for noise level during sleep are of concern and will ad issues immediately with the em involved.	shift once if any hours of ddress any	

Facility ID: 953470

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/12/2014 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345264	B. WING		12/20/2013
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	•
STANLEY	TOTAL LIVING CENTER			14 OLD MOUNT HOLLY ROAD TANLEY, NC 28164	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
F 258	was for the noise leve during the early morn 11:00 PM and 8:00 A	e 15 ed. He stated his expectation el to be kept at a minimum ing and night time hours of M. He further stated he was g on the 500 hall at 7:00 AM	F 258	The Administrator will review video surveillance of all outside doors (2 or unit and the front door) to determine concerns related to employees and f to follow the policy regarding the Em Only entrance/exit between the hours 8pm - 8am. These reviews will be do daily x 4 weeks, weekly x 4 weeks, a monthly x 4 weeks and any issues w identified, documented, and correcte Staff involved will be re-educated or issued disclipinary action as necessa The audits will begin on 1/17/14. The DON will monitor the results of management inspections, video surveillance, and Resident's Council concerns related to noise levels and report results and any trends or patter to the QA&A Committee monthly x 6 months. The QA&A Committee will determine if any further intervention of systemic changes are needed to ass sustained complaince with F258.	any ailure poyee s of one nd ill be d. ary. will erns
	daily living receives the		F 312		1/17/14
	by:	is not met as evidenced		Upon notification of this concern to	

Event ID: EUXG11

Facility ID: 953470

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/12/2014 MAPPROVED D. 0938-0391
	OF DEFICIENCIES F CORRECTION	CTION (X1) PROVIDER/SUPPLIER/CLIA ((X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		345264	B. WING _				C 1 20/2013
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
STANLEY	TOTAL LIVING CENTER				4 OLD MOUNT HOLLY ROAD TANLEY, NC 28164		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312	interviews, and medic failed to clean the ski incontinence care to dependent on staff fo (ADL) and personal h The findings included Resident #99 was ad 11/01/13 with diagnos coordination, muscle and diabetes mellitus Data Set (MDS) date Resident #99 as cogr decision making and needs known. The MI Resident #99 for freq incontinence, and rec with 2 person physica toileting, and persona On the 11/13/13 plan identified as requiring and at risk for skin bra incontinence. Care pl staff would provide al incontinence care as On 12/18/13 at 2:28 F #1 and NA #2 entered she had removed her saturated with urine. up the urine saturated #1 placed a dry clean did not wash the reside water or with a perivation	cal record reviews the facility n of a resident during 1 of 4 sampled residents r activities of daily living hygiene (Resident #99). mitted to the facility on ses including lack of weakness, hypertension, . The admission Minimum d 11/09/13 assessed nitively intact for daily capable of making her DS further assessed uent bowel and bladder guired extensive assistance al assist with dressing, al hygiene. of care Resident #99 was passistance with all ADLs eakdown due to an interventions included the I personal hygiene and needed. PM Nursing Assistant (NA) d Resident #99's room were fown wet soiled brief NA #2 was observed picking d soiled brief off the floor. NA h brief on Resident #99 and dent's skin with soap and ash. Further observations no washcloths, basin of	F	312	management on 12/20/13, Resident a was assessed for any concerns relate urinary incontinence and any needs f perineal care were addressed immediately. NA#1 and NA#2 were re-educated or perineal care policy and the expectat of providing perineal care to all reside who are incontinent of bowel and/or bladder on 12/23/13. Nursing staff were in-serviced by the Administrator on 12/26/13 regarding f expectation for providing perineal car all residents who are incontinent of be and/or bladder. Random perineal care audits were conducted by unit nurses randomly x week (1/2/14 - 1/9/14) to ensure no o residents were affected and proper perineal care was being provided per policy. The ADON/SDC reviewed all audits on a daily basis for completion any concerns. The perineal care policy was revised effective 1/16/14 to include the expectation that perineal care be pro- to all residents who are incontinent of bowel and/or bladder with no exception Each Unit Nurse will observe 1 nursin assistant on his/her assigned hall dai weeks, weekly x 4 weeks, and month months randomly to ensure perineal is in fact being provided as required p	ed to or the ions ents the te to owel 1 ther ther and vided fon. ng ly x 4 ly x 4 care	

Facility ID: 953470

	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	יחוד וו או (אַי)	E CONSTRUCTION	OMB NO. 0 (X3) DATE SU	
	CORRECTION	IDENTIFICATION NUMBER:	· ,		COMPLET	
					С	
		345264	B. WING		12/20/	/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
STANLEY TOTAL LIVING CENTER			514 OLD MOUNT HOLLY ROAD STANLEY, NC 28164			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIOI DATE
F 312	Continued From page	e 17	F 312	2		
	On 12/18/13 at 2:45 F interviewed. She state it was so wet." She fut the NA's would not clion on a clean brief. On 12/18/13 at 2:53 F She stated incontiner collecting all incontine as explaining/talking f explained the process revealed the NA staff residents' perineal are using a clean area of stoke. She confirmed saturated with urine v floor. NA #2 stated Re should have been cle clean area of the was reapplying a brief. On 12/19/13 at 11:28 She confirmed she di skin before reapplying was in a hurry and ha She further stated she not the way incontine performed. On 12/20/13 at 5:00 F interviewed. She state be provided the same incontinence care as follow the incontinence her expectation for al	PM Resident #99 was ed "I took the brief off cause inther stated most of the time ean her skin prior to putting PM NA #2 was interviewed. Acc care consisted of ence care supplies as well to the resident. NA #2 s of incontinence care which were trained to cleanse ea by washing front to back the washcloth with each Resident #99's brief was when she picked it up off the esident #99's perineal area ansed front to back using a shcloth each time prior to AM NA #1 was interviewed. d not clean the resident's g the brief. She stated she ad gotten ahead of herself. e "did it wrong" and that was nce care should have been PM the charge nurse was ed incontinence care should e for all residents requiring well as the staff should ce care policy. She revealed		 will monitor these audits for com and any issues noted in the failt follow the perineal care policy w identified, documented, and cor during the observation. Staff im be re-educated or issued progred disciplinary action as necessary audits will begin on 1/17/14. The ADON/SDC will monitor the the perineal care audits for com and will report any trends/patter QA&A Committee monthly x 6 m The QA&A Committee will deter any further interventions or syst changes are needed to assure of compliance with F312. 	re to ill be rected volved will essive . These e results of pletion ns to the nonths. mine if emic	

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 11/12/20 FORM APPROV OMB NO. 0938-03	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345264	B. WING		C 12/20/2013	
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP			
STANLEY	TOTAL LIVING CENTER			514 OLD MOUNT HOLLY ROAD		
				STANLEY, NC 28164		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETIC	
F 312	Continued From page	e 18 oke technique, as well as	F 31	2		
	using a different part stroke. They should a resident after pericare further stated she wa	of the washcloth with each apply a clean, dry brief on the was completed. She s unaware NA #1 was not ace care according to the				
	(DON) was interviewe employee orientation throughout the year, I regarding proper inco stated NA staff were to cleanse the perineal a a clean washcloth or washcloth with each s expectation was for the incontinence care/peri	stroke. He further stated his ne NA's who performed ricare for a dependent clean the resident according	F 37	71	1/17/14	
	considered satisfacto authorities; and	sources approved or ry by Federal, State or local stribute and serve food ons				
	This REQUIREMENT	is not met as evidenced				
	Based on observatio		1		1	

Event ID: EUXG11

Facility ID: 953470

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		MEDICAID SERVICES				NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	· · · ·	TE SURVEY MPLETED
		345264	B. WING		1	C 2/20/2013
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
				514 OLD MOUNT HOLLY ROAD		
STANLEY	TOTAL LIVING CENTER			STANLEY, NC 28164		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 371	Continued From page	≥ 1 9	F 37	1		
	-	ely close frozen bags of	1.07	vegetables in the freezer that we	are without	
		t freezer burn on 5 boxes of		proper seals immediately upon o on 12/16/13.		
	During an observation on 12/16/13 at 11:30 AM with the Dietary Manager (DM) the walk in freezer temperature was observed at 10 degrees below zero. The DM observed 5 boxes of opened bagged vegetables including 2 bags of frozen			The Food Service Director check food storage for proper labeling, and seals after use with no other concerns noted on 12/16/13.	dating,	
	diced green peppers,	1 bag frozen peas, 1 bag and 1 bag of frozen okra.		The Food Service Director cond in-service with the staff responsi current procedures for checking	ble for the	
		dated of when they were egetables had frosted ice vegetables.		storage on the expectations for I dating, and properly sealing all u on 12/24/13.	•	
	was last served for supeppers were last use	menus revealed the okra upper on 12/12/13, the green ed in meat loaf on 12/14/13, rots were last served on		A policy/procedure effective 1/16 written for the guidelines and ex of labeling, dating, sealing, and s foods to include specific position the dietary department responsil auditing and correcting this on a	pectations storing s within ple for	
	During an interview on 12/20/13 at 10:30 AM the DM stated there were no written food storage protocols for frozen foods that were opened. The DM further stated that after an item was opened and not used it was thrown away after three days			basis, including weekends. Diet were in-serviced on this new pol Administrator and Food Service on 1/15/14.	ary staff icy by the	
	if it was thawed and it referred to the expirat The DM revealed the are the staff responsi	f an item was not open we tion dates on the packages. cooks and the cook's aids ble for stocking and pulling rs. The DM further revealed		The 1st shift Cook will audit all for storage in the freezers/refrigerat 4 weeks, weekly x 4 weeks, and 4 weeks to ensure all food items been properly labeled, dated, se	ors daily x monthly x have	
	that when an item in t staff they would have package and dated th	he freezer was opened by a		stored. Any issue noted in the fa follow the policy will be identified documented, and corrected duri observation. Staff involved will b	ailure to I, ng the	
	on the box. The DM v freezer were opened	rerified the boxes in the and the bags were open ing the vegetables. The DM		reported to the Food Service Dir re-education or progressive disc action as necessary. Audits will	ector for iplinary	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION (X3) DATE COMP		SURVEY PLETED	
		345264	B. WING _				C 20/2013
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
STANLEY	TOTAL LIVING CENTER				DLD MOUNT HOLLY ROAD NLEY, NC 28164		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	should be sealed and During an Interview o Administrator stated i	ectation that packages dated after opened. n 12/20/13 at 4:09 PM the t was her expectation that were dated, labeled, and	F 3	1 rr tr d s	I/17/14. The Food Service Director will monitor esults of the audit for completion and eport results and any trends or patter o the QA&A Committee monthly x 6 nonths. The QA&A Committee will determine any further interventions or systemic changes as needed to assur continued compliance with F371.	will ns	

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