CENTERS F	OR MEDICARE & MEDICAID SERVICES			"A" FORM					
STATEMENT C	OF ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY					
NO HARM WI	TH ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	_ COMPLETE:					
FOR SNFs ANI) NFs	345255	B. WING						
NAME OF PRO	OVIDER OR SUPPLIER	1	CITY, STATE, ZIP CODE						
CAROLINA	A CARE CENTER	111 HARRILSON CHERRYVILLE							
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIEN	CIES							
F 159	483.10(c)(2)-(5) FACILITY MANAGEM	MENT OF PERSONAL	L FUNDS						
		Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.							
The facility must deposit any resident's per accounts) that is separate from any of the f resident's funds to that account. (In pooled share.) The facility must maintain a resident's persaccount, interest-bearing account, or petty		e facility's operating acc	counts, and that credits all interest earned	on					
			ot exceed \$50 in a non-interest bearing						
	The facility must establish and maintain according to generally accepted accountifacility on the resident's behalf.		a full and complete and separate accounting resident's personal funds entrusted to the	ng,					
	The system must preclude any comming person other than another resident.	ling of resident funds w	with facility funds or with the funds of any	,					
	The individual financial record must be a or his or her legal representative.	available through quarte	erly statements and on request to the resid	lent					
	the Act; and that, if the amount in the acc	esource limit for one pe count, in addition to the	enefits when the amount in the resident's erson, specified in section 1611(a)(3)(B) of evalue of the resident's other nonexempt sident may lose eligibility for Medicaid or						
		ews the facility failed to	o provide cognitively intact residents with for personal funds (Resident #61 and #11						
	The findings included:								
Review of the medical record revealed Data Set dated 02/06/15 noted Resident #			mitted on 02/27/13. A quarterly Minimum act.	n					
	money she had in her personal funds according	During an interview on 03/10/15 at 9:42 AM Resident #61 stated the facility did not let her know how much money she had in her personal funds account and did not provide her with a quarterly personal funds statement. Resident #61 further stated she had to go to the office and ask if she wanted to know her account							

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

The above isolated deficiencies pose no actual harm to the residents

				A FURIN							
STATEMENT (OF ISOLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY							
NO HARM WI	TH ONLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:							
FOR SNFs ANI	SUMMARY STATEMENT OF DEFICIENCE Continued From Page 1 balance. Review of Resident #61's medical record member listed as an emergency contact. An interview was conducted with the Pati Funds Representative stated she sent out or responsible party listed in the computer we funds account statement for January 2015 been mailed to the family member listed a stated if a resident wanted a copy of their office window any time and request one. An interview with the Administrator on 00 quarterly personal funds account statement Resident #61 was her own responsible par funds account statement. 2. Review of the medical record revealed	345255	B. WING	3/12/2015							
		STREET ADDRESS, C 111 HARRILSON CHERRYVILLE									
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCE	IES									
F 159	Continued From Page 1	Continued From Page 1									
1 137											
Funds Representative stated she sent our responsible party listed in the computer funds account statement for January 201 been mailed to the family member listed stated if a resident wanted a copy of the		uarterly personal fund hich is usually a famil was reviewed during s her emergency conta	ive on 03/12/15 at 11:03 AM. The Patient is account statements to the residents' y member. Resident # 61's quarterly perso the interview and revealed the statement hat. The Patient Funds Representative furthes account statement they could come to the	nal ad ner							
	Resident #61 was her own responsible par	t to the residents' resp	onsible party. The Administrator confirme	d							
	I	2. Review of the medical record revealed Resident #111 was admitted on 01/10/14. A quarterly Minimum Data Set dated 02/06/15 noted Resident #111 was cognitively intact.									
	During an interview on 03/09/15 at 3:15 PM Resident #111 stated the facility did not let her know how much money she had in her personal funds account and did not provide her with a quarterly personal funds statement. Resident #111 further stated she had to go to the office and ask if she wanted to know her account balance.										
	Review of Resident #111's medical record and emergency contact.	Review of Resident #111's medical record revealed she had a family member listed as her responsible party and emergency contact.									
	Funds Representative stated she sent out q responsible party listed in the computer who personal funds account statement for Janua statement had been mailed to the family make Representative further stated if a resident of	An interview was conducted with the Patient Funds Representative on 03/12/15 at 11:03 AM. The Patient Funds Representative stated she sent out quarterly personal funds account statements to the residents' responsible party listed in the computer which is usually a family member. Resident # 111's quarterly personal funds account statement for January 2015 was reviewed during the interview and revealed the statement had been mailed to the family member listed as her responsible party. The Patient Funds Representative further stated if a resident wanted a copy of their quarterly personal funds account statement they could come to the office window any time and request one.									
	An interview with the Administrator on 03/12/15 at 2:53 PM revealed the facility automatically sent the quarterly personal funds account statement to the residents' responsible party. The Administrator stated if a resident wanted a copy of their quarterly personal funds account statement they could come to the office window any time and request one.										

	MEDICARE & MEDICAID SERVICES	 	+	A FORM			
STATEMENT OF IS	OLATED DEFICIENCIES WHICH CAUSE	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY			
NO HARM WITH O	NLY A POTENTIAL FOR MINIMAL HARM		A. BUILDING:	COMPLETE:			
FOR SNFs AND NFs							
1010111011110111	,	345255	B WING	3/12/2015			
			B. WING				
NAME OF PROVID	ER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE					
		111 HARRILSON STREET					
CAROLINA CA	ARE CENTER	CHERRYVILLE, NC					
		, , , , , , , , , , , , , , , , , , , ,					
ID							
PREFIX							
TAG	SUMMARY STATEMENT OF DEFICIENCIES						

PRINTED: 04/09/2015 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER CAROLINA CARE CENTER SUMMENT STATEMENT OF DEPICENCIES (LACH DEPICENCY MUST BE PRECEDED BY FULL PROUD FOR TIGHT OF DEPICENCIES AND ASSESSED PROVIDED BY THE PROPERSE PLAN OF CORRECTION INCIDIAL BE COMPLETION CONSTRUCTION SHOULD BE COMPLETION TO BE COMPLETION OF THE PROPERSE PLAN OF CORRECTION AND ASSESSED PROVIDED BY THE PROPERSE PLAN OF CORRECTION SHOULD BE COMPLETION TO BE COMPLE				(X3) DATE SURVEY COMPLETED		
STREET ADDRESS, CITY, STATE, ZP CODE: 111 MARRILSON STREET CHERRYVILE, NC 28021 PROVIDER'S PLAN OF CORRECTION CONSTREET CHERRYVILE, NC 28021 PREDIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREDIX PROVIDER'S PLAN OF CORRECTION CAMPACTORY CAMPACTORY OR LSC IDENTIFYING INFORMATION) PREDIX PROVIDER'S PLAN OF CORRECTION CAMPACTORY CAMPACTORY OR LSC IDENTIFYING INFORMATION) PREDIX PROVIDER'S PLAN OF CORRECTION CAMPACTORY OR LSC IDENTIFYING INFORMATION) PREDIX			345255	B. WING		03/12/2015
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F253 SS=D The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label and properly store 2 bedpans lying in the floor and bath tub in a shared resident's bathroom on 1 of 3 halls. The findings included: An observation made on 03/09/15 at 2:53 PM revealed 1 pink bedpan and 1 gray bedpan lying on the floor of the bathroom beside the commode, shared by room 101 and 103 unlabeled and uncovered. An observation made on 03/10/15 at 8:55 AM revealed 1 pink and 1 gray bedpan lying on the floor of the bathroom beside the commode, shared by room 101 and 103 unlabeled and uncovered. An observation made on 03/11/15 at 8:46 AM revealed 1 pink and 1 gray bedpan lying on the floor of the bathroom beside the commode, shared by room 101 and 103 unlabeled and uncovered. An observation made on 03/12/15 at 11:45 AM revealed 1 pink and 1 gray bedpan lying on the floor of the bathroom beside the commode, shared by room 101 and 103 unlabeled and uncovered. An observation made on 03/12/15 at 11:45 AM revealed 1 pink and 1 gray unlabeled, uncovered bedpan lying in the bath tub shared by room 101 and 103 unlabeled and uncovered. An observation made on 03/12/15 at 11:45 AM revealed 1 pink and 1 gray unlabeled, uncovered bedpan lying in the bath tub shared by room 101 and 103 unlabeled and uncovered. See Table T				1	11 HARRILSON STREET	
The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to label and properly store 2 bedpans lying in the floor and bath tub in a shared resident's bathroom on 1 of 3 halls. The findings included: The findings included: An observation made on 03/09/15 at 2:53 PM revealed 1 pink bedpan and 1 gray bedpan lying on the bathroom floor beside the commode, shared by room 101 and 103, unlabeled and uncovered. An observation made on 03/10/15 at 8:55 AM revealed 1 pink and 1 gray bedpan lying on the floor of the bathroom beside the commode, shared by room 101 and 103 unlabeled and uncovered. An observation made on 03/11/15 at 8:46 AM revealed 1 pink and 1 gray bedpan lying on the floor of the bathroom beside the commode, shared by room 101 and 103 unlabeled and uncovered. An observation made on 03/12/15 at 11:45 AM revealed 1 pink and 1 gray unlabeled, uncovered bedpan lying in the bath tub shared by room 101 and 103 unlabeled and uncovered. An observation made on 03/12/15 at 11:45 AM revealed 1 pink and 1 gray unlabeled, uncovered bedpan lying in the bath tub shared by room 101 and 103 unlabeled and uncovered. An observation made on 03/12/15 at 11:45 AM revealed 1 pink and 1 gray unlabeled, uncovered bedpan lying in the bath tub shared by room 101 and room 103.	PREFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	E COMPLETION
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	SS=D	The facility must provimaintenance services sanitary, orderly, and This REQUIREMENT by: Based on observation facility failed to label a bedpans lying in the findings included An observation made revealed 1 pink bedpan on the bathroom floor shared by room 101 a uncovered. An observation made revealed 1 pink and 1 floor of the bathroom shared by room 101 a uncovered. An observation made revealed 1 pink and 1 floor of the bathroom shared by room 101 a uncovered. An observation made revealed 1 pink and 1 floor of the bathroom shared by room 101 a uncovered. An observation made revealed 1 pink and 1 floor of the bathroom shared by room 101 a uncovered. An observation made revealed 1 pink and 1 bedpan lying in the bathroom 103.	ide housekeeping and a necessary to maintain a comfortable interior. is not met as evidenced and staff interviews the and properly store 2 loor and bath tub in a a noom on 1 of 3 halls. on 03/09/15 at 2:53 PM an and 1 gray bedpan lying beside the commode, and 103, unlabeled and on 03/10/15 at 8:55 AM gray bedpan lying on the beside the commode, and 103 unlabeled and on 03/11/15 at 8:46 AM gray bedpan lying on the beside the commode, and 103 unlabeled and on 03/12/15 at 11:45 AM gray unlabeled, uncovered ath tub shared by room 101		Carolina Care Center provides housekeeping and maintenance necessary to maintain a sanitary, order and comfortable interior. Corrective action for unlabeled bedpan room 101 and 103 was achieved during survey by removing bedpans from room and disposing of the bedpans on 3/12/1 No one in room 101 and 103 was currently using a bedpan. Corrective action for other residents having the potential to be affected by the alleged deficient practice was corrected by other resident rooms and bathrooms being checked during survey for unlabe bedpans and none were found on 3/12 Bedpans will continue to be labeled wit resident's name on admission and when new bedpans are issued to residents. 3/12/15 Measures put into place to ensure alleged deficient practice does not recur includithe following: -Sign was placed in supply room as reminder for labeling all personal items including bedpans, with resident name.	s in gens 15. ne de seled //15. h en ged ee

04/02/2015

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.

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345255	B. WING			03/	12/2015
	ROVIDER OR SUPPLIER A CARE CENTER		1	11	REET ADDRESS, CITY, STATE, ZIP CODE 1 HARRILSON STREET HERRYVILLE, NC 28021		
(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 253	An interview was con AM with Nurse Aide (I not know why there we unlabeled and uncover that was shared by rostated all bedpans shand stored in the resistated she had no ide belonged to because shared the bathroom bathroom and the 4th bedpan. An interview was con PM with the Director of stated it was her expellabeled with the resid	ducted on 03/12/15 at 11:45 NA) #1. She stated she did vas 1 pink and 1 gray ered bedpan in the bath tub som 101 and room 103. She ould be labeled, covered dent's closet. NA #1 further sa who the bedpans 3 of the 4 residents that took themselves to the resident did not use a ducted on 03/12/15 at 12:10 of Nursing (DON). She ectation that all bedpans be ent's name, covered and s closet. She stated it was dpans to be stored ered on the resident's	F	253	when issued to resident.3/12/15 - CNA's were instructed to request bedpans from nurses or ward clerks, place in bag and store in resident's clos or bedside table. In-service on proper storing and labeling of bedpans was he on 3/12/15. -Procedure for issuing of bedpans has been revised to allow licensed nurse or ward clerks only to enter medical suppl obtain bedpan and place resident's nar on bedpan. 3/30/15 Monitors put into place to ensure propel labeling and storage of bedpans included Weekly audits of rooms for proper labeling and storage of bedpans are conducted by Assistant Administrator, Director of Nursing, Assistant Director of Nursing, MDS Nurses, Housekeeping Supervisor, Staff Development Coordinator, Activity Staff, Social Workers, Admission Nurses, Restoration Nurses and Ward Clerks. Any unlabel or inappropriately stored bedpans are reported to weekly tracking committee to inappropriately stored bedpans are reported to weekly tracking committee any corrective actions needed. The results of the weekly tracking reports are reviewed monthly in the Quality Assurance and Assessment committee determine the effectiveness or change procedure or plan. Quality Assurance and Assessment Committee reviews Tracking Reports for the serviews Tracking Reports for the serview Tracking Reports for the service tha	y, ne e: of red for tts to in	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345255	B. WING	 	03/12/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 111 HARRILSON STREET CHERRYVILLE, NC 28021	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 253	Continued From page 2		F 25	period of one year.	
F 278 SS=D	(0)	SSMENT DINATION/CERTIFIED	F 27		4/8/15
	The assessment must resident's status.	st accurately reflect the			
	A registered nurse meach assessment with participation of health				
	A registered nurse massessment is comp	ust sign and certify that the leted.			
		completes a portion of the grand certify the accuracy of sessment.			
	willfully and knowing false statement in a r subject to a civil mor \$1,000 for each asse willfully and knowing to certify a material a	Medicaid, an individual who ly certifies a material and resident assessment is bey penalty of not more than essment; or an individual who ly causes another individual and false statement in a is subject to a civil money han \$5,000 for each			
	Clinical disagreemer material and false sta	it does not constitute a atement.			
	by: Based on record rev facility failed to corre	T is not met as evidenced riews and staff interviews, the ctly code the on the MDS) for 2 of 2 residents		Carolina Care Center provides an F assessment nurse to conduct and coordinate accurate completion of M	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345255	B. WING			03/	12/2015
NAME OF P	ROVIDER OR SUPPLIER	<u>I</u>		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 001	12/2013
CAROLIN	A CARE CENTER				I1 HARRILSON STREET HERRYVILLE, NC 28021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 278	sampled for PASRR in Resident #10) and the code the MDS for 1 of hospice review (Resident #2 was a 10/31/00. Diagnoses development disability A review of Resident revealed the resident Level II PASRR. A review of the most 10/07/14 indicated the evaluated by Level II resident needed specimental illness. An interview was condon 03/11/15 at 11:21 of the MDS should have because Resident #2 Level II PASRR. She information was autocomputer software the MDS. An interview was condomputer software the MDS.	review (Resident #2 and e facility failed to correctly of 1 resident sampled for dent #160). admitted to the facility on a included an intellectual y. #2's medical record had been evaluated by recent annual MDS dated e resident had not been PASRR to determine if the cialized services related to ducted with MDS Nurse #1 AM. She stated the section are been marked "Yes" had been evaluated by e explained she believed the matically filled out by the e facility used for completing ducted with Assistant 13/11/15 at 2:23 PM. She in was the MDS was to be She explained the MDS ineduled to attend a class on clarified she had spoken with de their computer software	F	2278	assessments. Corrective action for resident #2 and # PASRR coding was achieved by MDS coordinator completing modification an resubmitting MDS to CMS on 3/11/15. Corrective action for resident #106 Hospice coding was accomplished by MDS Coordinator doing a modification and submitting MDS to CMS on 3/12/1 Corrective action for other residents having the potential to be affected by the alleged deficient practice was corrected by MDS coding of other residents with Level II PASRR and Hospice services were reviewed and corrected by MDS Coordinator on 3/13/15. Measures put into place to ensure alleged deficient practice does not recur included - Admission Coordinator places all PASRR numbers on face sheet in Electronic Health Record. Level II PAS numbers will be identified on face sheet Admissions Coordinator will report any changes in stand up meeting. 4/2/15 - MDS staff reviews physician orders for changes in status or services and report in stand up meeting. 3/17/15 Monitors put into place to ensure MDS coded accurately includes the following MDS Coordinator audits with MDS	d 5. ne d ged e: RR tt.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345255	B. WING		03/12/2015
	ROVIDER OR SUPPLIER A CARE CENTER	,		STREET ADDRESS, CITY, STATE, ZIP CODE 111 HARRILSON STREET CHERRYVILLE, NC 28021	
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 278	A review of Resident revealed the resident Level II PASRR. A review of the most MDS dated 01/15/15 not been evaluated has been sent the MDS. An interview was con Administrator #1 on Control of the MDS soon. She the evaluated been sent the MDS soon. She the company that may and they told her the automatically filled out 12/04/14 with diagnor abnormal loss of weigkidney disease, HTN. The facility's provider	readmitted to the facility on a included schizophrenia. #10's medical record had been evaluated by recent significant change indicated the resident had y Level II PASRR. ducted with MDS Nurse #1 AM. She stated the section ave been marked "Yes" 0 had been evaluated by explained she believed the matically filled out by the erfacility used for completing adducted with Assistant 103/11/15 at 2:23 PM. She in was for the MDS to be She explained the MDS ineduled to attend a class on clarified she had spoken with de their computer software	F 27	process to ensure correct coding of MDS and reports results at weekly Tracking Meeting weekly. The results of the weekly Tracking are reviewed monthly in Quality Assurance and Assessment Commodetermine effectiveness or change procedure or plan. Quality Assurance and Assessment Committee reviews Tracking Report period of one year.	Report mittee to e in

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY PLETED
		345255	B. WING _		03	3/12/2015
	ROVIDER OR SUPPLIER A CARE CENTER		•	STREET ADDRESS, CITY, STATE, ZIP CODE 111 HARRILSON STREET CHERRYVILLE, NC 28021	·	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 278	Resident #106's mos Minimum Data Set (M 02/03/15 was perform #106's admission to I the resident was received a further decline and a	t recent significant change MDS) assessment dated ned following Resident nospice but did not indicate eiving hospice services. Area Assessment dated significant change related to dmission to hospice care. In plan dated 02/05/15 listed a ler hospice care and support as and approaches Inducted with MDS Nurse #1 If PM. She stated that not coded as receiving most recent significant erbalized that Resident #106 ded as receiving hospice ent MDS. Inducted on 03/12/2015 at urse #2. She verbalized that and Resident #106 as the on the most recent MDS	F 2	78		
	483.25(h) FREE OF A HAZARDS/SUPERV		F 3	23		4/8/15

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345255	B. WING _		03/12/2015	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 111 HARRILSON STREET CHERRYVILLE, NC 28021	,	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION	
F 323	environment remain as is possible; and e	ge 6 sure that the resident as as free of accident hazards each resident receives on and assistance devices to	F3	23		
	by: Based on observation interviews the facilities side rails for 8 of 37 #31, #50, #52, #54, The findings included 1. Review of the macket has a diagnoses including amputation and dialated Review of a signification (MDS) dated 02/09/was cognitively interviews.	edical record revealed dmitted on 01/22/15 with left above the knee betes mellitus. ant change Minimum Data Set 15 revealed Resident #31 ct, required extensive mobility, and was totally		Carolina Care Center ensures to resident environment remains for accident hazards as is possible; resident receives adequate supplied and assistance devices to preveaccidents. No Accidents or Incide occurred involving entrapment in rails. Corrective action for the loose so for resident #31,#50,#52,#54,#101#34,#71, identified by surveyor were review maintenance staff during survey side rails were secured to bedfrom 3/12/15	ee of and each ervision ent ents have n side ide rails #35 ewed by to ensure	
	side rails were as for On 03/09/15 at 12 loose and the top of edge of the mattress. The left side rail was On 03/11/15 at 9:0 loose and the top of	sident #31's bilateral 1/2 bed allows: 45 PM the right side rail was the rail leaned away from the sapproximately 6 inches. In some some some side rail was the rail leaned away from the sapproximately 6 inches.		Corrective action for other resident having the potential to be affected alleged deficient practice was conduring survey by reviewing sident ensure all were secure. No other were found. 3/12/15 Nursing audited bed rails on 3rd ensure initial compliance.3/13/13/20/15	ed by the prrected rails to rails ar side rails	

Facility ID: 923063

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345255	B. WING _			0:	3/12/2015
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
				11	1 HARRILSON STREET		
CAROLIN	A CARE CENTER			CI	HERRYVILLE, NC 28021		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From pag	ne 7	F3	323			
		s not loose and fit properly.			Bed rails were replaced on beds in roc 103 & 115.	ms	
	- On 03/12/15 at 9:3	7 AM the right side rail was					
	loose and the top of	the rail leaned away from the			Medical Supply Vendor was contacted	for	
		approximately 6 inches.			possible recommendations for loose b	ed	
	The left side rail was	not loose and fit properly.			rails. 3/13/15		
					Vendor examined rails and recommen		
		rse Aide (NA) #2 on 03/11/15			a thread locker to be used as needed	ior	
		staff notified maintenance of			loose rails.3/16/15		
		riting them on the board on			Thread locker applied to bed rails for		
		ng maintenance staff or II maintenance staff member.			additional security.4/1/15		
		ecked bed side rails while			Measure put into place to ensure the		
		residents and when she			alleged deficient practice does not rec	ur	
	T -	rail she tightened it up. NA			include the following:		
		he was not able to tighten a			3		
	loose side rail herse	If she contacted a			-CNA's and assigned staff have been	re	
	maintenance staff m	ember.			in-serviced on proper functioning and side rails. 3/12/15	it of	
	_	on 03/12/15 at 10:16 AM the					
		visor stated staff notified him			-CNA's will continue to check side rails	;	
		es and needed repairs by			each time a resident is transferred.		
		n or documenting the issue			3/12/15		
		maintenance office door. upervisor further stated the			-In-service included written		
		d not conduct routine audits			communication to maintenance		
		relied on the NAs to notify			department for any side rail repairs,		
		ill was loose. The interview			replacements, etc as needed. 3/12/15		
		istant Administrator #1 and					
	the Housekeeping S	upervisor conducted regular			Monitors put into place to ensure side	rails	
	room rounds and ch	ecked for potential hazards			are secure include the following:		
	and maintenance iss	sues.			-		
					Weekly audits assigned and conducted	d by	
		nducted with Assistant			Assistant Administrator, Director of		
	Administrator #1 on				Nursing, Assistant Director of Nursing,		
		tor #1 stated loose side rails			MDS Nurses, Housekeeping Supervise		
	•	as she wanted the residents			Staff Development Coordinator, Activit		
	-	le. The interview further			Staff, Social Workers, Admission Nurs		

Facility ID: 923063

PRINTED: 04/09/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	· /	ATE SURVEY DMPLETED
		345255	B. WING			03/12/2015
	ROVIDER OR SUPPLIER A CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 111 HARRILSON STREET CHERRYVILLE, NC 28021		3011212010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY 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) COMPLETION DATE
F 323	Supervisor and Assis accompanied to Res examined the right b Maintenance Superv was loose and needed Maintenance Superv NAs might be using the up and down which wiside rail. The Maintenstated he planned to himself and make sure 2. Review of the me Resident #50 was accepted diagnoses including of coordination. Review of the admission (MDS) dated 11/14/1 short and long-term in impaired cognitive stransfers. Observations of Reside rails were as followers of the mattress appropriate to mattress appropriate and the top of the rail of the mattress appropriate and loosen of the mattress appropriate rail was not loosen on 03/10/15 at 9:13 observed awake in band the top of the rail of the mattress appropriate rail was not loosen on 03/10/15 at 9:13 observed awake in band the top of the rail of the mattress appropriate rail was not loosen on 03/10/15 at 9:13 observed awake in band the top of the rail of the mattress appropriate rail was not loosen on 03/10/15 at 9:13 observed awake in band the top of the rail of the mattress appropriate rail was not loosen on 03/10/15 at 9:13 observed awake in band the top of the rail of the mattress appropriate rail was not loosen on 03/10/15 at 9:13 observed awake in band the top of the rail of the mattress appropriate rail was not loosen on 03/10/15 at 9:13 observed awake in band the top of the rail of the mattress appropriate rail was not loosen on 03/10/15 at 9:13 observed awake in band the top of the rail of the mattress appropriate rail was not loosen on 03/10/15 at 9:13 observed awake in band the top of the rail of the mattress appropriate rail was not loosen on 03/10/15 at 9:13 observed awake in band the top of the rail of the mattress appropriate rail was not loosen on 03/10/15 at 9:13 observed awake in band the top of the rail of the mattress appropriate rail was not loosen on 03/10/15 at 9:13 observed awake in band the top of the rail of the mattress appropriate rail was not loosen on 03/10/15 at 9:13 observed awake in band the top of the rail of the mattress appropriate ra	nance staff member. 2 AM the Maintenance stant Administrator #1 were ident #31's room and ed side rail. The isor confirmed the side rail ed to be tightened down. The isor stated he thought the she knob to bring the side rail was actually loosening the enance Supervisor further start checking bed side rails re they fit properly. dical record revealed similar they fit properly with muscle weakness and lack sion Minimum Data Set 4 revealed Resident #50 had memory loss and severely sills for daily decision making. noted Resident #50 required with bed mobility and dident #50's bilateral 1/2 bed lows: Dispense of the fit properly. I leaned away from the edge oximately 6 inches. The left	F 32	check all side rails to be secure bedframe. Any unsecured rail w reported to maintenance immed Weekly audits results will be reported the weekly Tracking Committee. Weekly audits for preventative maintenance will be conducted maintenance staff on all side rais submitted to the weekly tracking committee. The results of the Weekly Track reports will be reviewed in the meguality Assurance and Assessm Committee to determine effective change in procedure or plan. Quality Assurance and Assessm Committee reviews Tracking Reperiod of one year.	ill be liately. liately. loorted in by ls and ling loonthly leeness or	

Facility ID: 923063

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345255	B. WING		03/12/2015
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE I11 HARRILSON STREET CHERRYVILLE, NC 28021	1 337.12.23.10
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
F 323	edge of the mattres The left side rail wa On 03/11/15 at 9:1 observed awake in loose and the top of edge of the mattres The left side rail wa On 03/12/15 at 9:3 observed awake in loose and the top of edge of the mattres The left side rail wa An interview with Na at 3:16 PM revealed needed repairs by with office door, pag contacting the on or NA #2 stated she of providing care to he noticed a loose side #2 further stated if s loose side rail herse maintenance staff in During an interview Maintenance Super of maintenance isso overhead paging hi on the board on the The Maintenance S maintenance staff of bed side rails and them if a bed side ra further revealed Ass	s approximately 6 inches. s not loose and fit properly. 10 AM Resident #50 was bed. The right side rail was f the rail leaned away from the s approximately 6 inches. s not loose and fit properly. 32 AM Resident #50 was bed. The right side rail was f the rail leaned away from the s approximately 6 inches. s not loose and fit properly. urse Aide (NA) #2 on 03/11/15 d staff notified maintenance of writing them on the board on ing maintenance staff or all maintenance staff member. hecked bed side rails while er residents and when she e rail she tightened it up. NA she was not able to tighten a lef she contacted a	F 323		

NAME OF PROVIDER OR SUPPLIER CAROLINA CARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 111 HARRILSON STREET CHERRYVILLE, NC 28021 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	03/12/2015 (X5) COMPLETION DATE
CAROLINA CARE CENTER 111 HARRILSON STREET CHERRYVILLE, NC 28021	COMPLETION
(VALID SLIMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORDECTION	COMPLETION
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 323 Continued From page 10 and maintenance issues. An interview was conducted with Assistant Administrator #1 on 03/12/15 10:23 AM. Assistant Administrator #1 stated loose side rails were not acceptable as she wanted the residents to be safe as possible. The interview further revealed she expected the NAs to report loose side rails to a maintenance staff member. On 03/12/15 at 10:35 AM the Maintenance Supervisor and Assistant Administrator #1 were accompanied to Resident #50's room and examined the right bed side rail. The Maintenance Supervisor confirmed the side rail was loose and needed to be tightened down. The Maintenance Supervisor stated he thought the NAs might be using the knob to bring the side rail up and down which was actually loosening the side rail. The Maintenance Supervisor further stated he planned to start checking bed side rails himself and make sure they fit properly. 3. Review of the medical record revealed Resident #52 was admitted on 12/30/11 with diagnoses including Alzheimer's disease. Review of a significant change Minimum Data Set (MDS) dated 02/12/15 revealed Resident #52 had short and long-term memory loss and severely impaired cognitive skills for daily decision making. The admission MDS noted Resident #52 required extensive assistance with bed mobility and transfers. Observations of Resident #52's bilateral 1/2 bed side rails were as follows: - On 03/10/15 at 10-48 AM the right side rail was	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345255	B. WING		03/12/2015
	ROVIDER OR SUPPLIER A CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 111 HARRILSON STREET CHERRYVILLE, NC 28021	, 00.12.20.10
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION
F 323	edge of the mattres The left side rail wa On 03/11/15 at 9:1 loose and the top of edge of the mattres The left side rail wa On 03/12/15 at 9:3 loose and the top of edge of the mattres The left side rail wa An interview with Nr at 3:16 PM revealed needed repairs by voor the office door, pag contacting the on ca NA #2 stated she of providing care to he noticed a loose side #2 further stated if so loose side rail herse maintenance staff in During an interview Maintenance Super of maintenance issue overhead paging hi on the board on the The Maintenance S maintenance staff of bed side rails and them if a bed side ra further revealed Ass the Housekeeping S	s approximately 4 inches. s not loose and fit properly. 12 AM the right side rail was fithe rail leaned away from the s approximately 4 inches. s not loose and fit properly. 13 AM the right side rail was fithe rail leaned away from the s approximately 4 inches. s not loose and fit properly. 14 AM the right side rail was fithe rail leaned away from the s approximately 4 inches. s not loose and fit properly. 15 AM the right side rail was fithe rail leaned away from the sapproximately 4 inches. s not loose and fit properly. 16 AM the right side rail was fither all staff notified maintenance of writing them on the board on ing maintenance staff or all maintenance staff or all maintenance staff member. 16 AM the right side rail was fither and when she are residents and when she are residents and when she are rail she tightened it up. NA she was not able to tighten a left she contacted a member. 17 AM the visor stated staff notified him was and needed repairs by mor documenting the issue maintenance office door. 18 AM the right side rail was fither and seed on the NAs to notify all was loose. The interview sistant Administrator #1 and supervisor conducted regular necked for potential hazards	F 323	3	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345255	B. WING		03/12/2015
NAME OF PROVIDER OR SUPPLIER CAROLINA CARE CENTER SUMMARY STATEMENT OF DESIGNATIONS			STREET ADDRESS, CITY, STATE, ZIP CODE 111 HARRILSON STREET CHERRYVILLE, NC 28021	, 333,2233	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE COMPLETION
F 323	Administrator #1 on Assistant Administrator were not acceptable to be safe as possible revealed she expect side rails to a mainter on 03/12/15 at 10:30 Supervisor and Assistance accompanied to Researmined the right be Maintenance Supervisor and Assistance and need Maintenance Supervisor and down which was loose and need Maintenance Supervisor and down which will be using up and down which will be using up and down which will be using up and down which will be a stated he planned to himself and make sufficient will be a sufficient with the stated of the planned to himself and make sufficient will be used to be	inducted with Assistant 03/12/15 10:23 AM. tor #1 stated loose side rails as she wanted the residents de. The interview further led the NAs to report loose enance staff member. 6 AM the Maintenance stant Administrator #1 were sident #52's room and led side rail. The risor confirmed the side rail led to be tightened down. The risor stated he thought the the knob to bring the side rail was actually loosening the enance Supervisor further le start checking bed side rails are they fit properly. The admitted to the facility on loses of hypertension, anxiety terly Minimum Data Set and required extensive	F 32	3	
	transfers. Observations of Res side rails were as fol - On 03/09/15 at 2:5 loose and leaned aw	3 PM the left side rail was vay from the bed nes. The right side rail was vay from the bed			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345255	B. WING			03/	12/2015
	ROVIDER OR SUPPLIER A CARE CENTER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 11 HARRILSON STREET CHERRYVILLE, NC 28021		
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	loose and leaned awa approximately 3 inche loose and leaned awa approximately 2 inche - On 03/11/15 at 8:46 loose and leaned awa approximately 3 inche loose and leaned awa approximately 2 inche - On 03/12/15 at 10:2 loose and leaned awa approximately 3 inche loose and leaned awa approximately 3 inche loose and leaned awa approximately 2 inche An interview with Nurat 3:16 PM revealed needed repairs by writhe office door, pagin contacting the on call NA #2 stated she che providing care to her noticed a loose side rill herself maintenance staff me During an interview of Maintenance Supervior of maintenance Supervior of maintenance Supervior of maintenance Supervior maintenance Supervior the Maintenance Supervior maintenance staff did	is AM the left side rail was ay from the bed es. The right side rail was ay from the bed es. AM the left side rail was ay from the bed es. AM the left side rail was ay from the bed es. AM the left side rail was ay from the bed es. AM the left side rail was ay from the bed es. AM the left side rail was ay from the bed es. AN AM the left side rail was ay from the bed es. AN AM the left side rail was ay from the bed es. AN AM the left side rail was ay from the bed es. AN AM the left side rail was ay from the bed es. AN AM the left side rail was ay from the bed es. AN AM the left side rail was ay from the bed es. AN AM the left side rail was ay from the bed es. AN AM the left side rail was ay from the bed es. AN AM the left side rail was ay from the bed es. AN AM the left side rail was ay from the bed es. AN AM the left side rail was ay from the bed es. AN AM the left side rail was ay from the bed es. AN AM the left side rail was ay from the bed es. AN AM the left side rail was ay from the bed es. AN AM the left side rail was ay from the bed es. AN AM the left side rail was ay from the bed es. AN AM the left side rail was ay from the bed es.	F	323			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMPLETED
		345255	B. WING		03/12/2015
	ROVIDER OR SUPPLIER A CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 111 HARRILSON STREET CHERRYVILLE, NC 28021	,
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
F 323	further revealed As the Housekeeping	rail was loose. The interview sistant Administrator #1 and Supervisor conducted regular hecked for potential hazards	F 32	3	
	Supervisor and Ass accompanied to Re examined the left a Maintenance Supe was loose and nee Maintenance Supe NAs might be using up and down which side rail. The Main stated he planned	20 AM the Maintenance sistant Administrator #1 were esident #54's room and and right bed side rail. The rvisor confirmed the side rail ded to be tightened down. The rvisor stated he thought the gothe knob to bring the side rail in was actually loosening the attenance Supervisor further to start checking bed side rails sure they fit properly.			
	Administrator #1 or Assistant Administration were not acceptable to be safe as possi revealed she expense	onducted with Assistant n 03/12/15 10:23 AM. rator #1 stated loose side rails le as she wanted the residents ble. The interview further cted the NAs to report loose tenance staff member.			
	05/07/13 with diagonal diabetes, Alzheime The annual Minimurevealed Resident impaired and requi	vas admitted to the facility on noses of hypertension, er's disease and osteoporosis. Im Data Set dated 12/19/14 #101 was severely cognitively red extensive assistance of 2 obility and transfers.			
	Observations of Re	esident #101's bilateral ½ bed			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
		345255	B. WING	 -	03/12/2015
	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 111 HARRILSON STREET CHERRYVILLE, NC 28021	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETIC
F 323	Continued From pa	_	F 32	23	
	loose and leaned at approximately 5 income and leaned at approximately 3 income and leaned at approximately 5 income and leaned at approximately 3 income and leaned at approximately 5 income and leaned at approximately 3 income and leaned at approximately 5 income and l	55 PM the left side rail was way from the bed hes. The right side rail was way from the bed hes. 58 AM the left side rail was way from the bed hes. The right side rail was way from the bed hes. 58 AM the left side rail was way from the bed hes. 59 AM the left side rail was way from the bed hes. 50 AM the left side rail was way from the bed hes. The right side rail was way from the bed hes. 50 CAM the left side rail was way from the bed hes. 51 CAM the left side rail was way from the bed hes. The right side rail was way from the bed			
	providing care to he noticed a loose side	er residents and when she e rail she tightened it up. NA she was not able to tighten a elf she contacted a			

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345255	B. WING		03/12/2015
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 111 HARRILSON STREET CHERRYVILLE, NC 28021	7 00.12.2010
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION
F 323	Maintenance Supe of maintenance iss overhead paging his on the board on the The Maintenance Staff of bed side rails and them if a bed side rails and maintenance is On 03/12/15 at 10:: Supervisor and Ass accompanied to Reexamined the left a Maintenance Supe was loose and nee Maintenance Supe NAs might be using up and down which side rail. The Main stated he planned is himself and make so An interview was contained to the planned of the planned	on 03/12/15 at 10:16 AM the rvisor stated staff notified him uses and needed repairs by im or documenting the issue maintenance office door. Supervisor further stated the did not conduct routine audits d relied on the NAs to notify rail was loose. The interview sistant Administrator #1 and Supervisor conducted regular hecked for potential hazards	F 32	<u> </u>	
	were not acceptabl to be safe as possi revealed she expec side rails to a main	rator #1 stated loose side rails e as she wanted the residents ble. The interview further cted the NAs to report loose tenance staff member.			
	o. Resident #34 wa	is admitted to the facility on			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345255	B. WING			03/	12/2015
	ROVIDER OR SUPPLIER A CARE CENTER		•	1	TREET ADDRESS, CITY, STATE, ZIP CODE 11 HARRILSON STREET CHERRYVILLE, NC 28021	•	
(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 323	hypertension. The an (MDS) dated 12/26/14 was cognitively intact assistance with 2 per and transfers. Observations of Residual transfers. Observations of Residual transfers. Observations of Residual transfers. Observations of Residual transfers. On 03/09/15 at 3:00 Foot loose and leaned aware approximately 3 inchestors and leaned aware approximately 2 inchestors and leaned aware approximately 2 inchestors and leaned aware approximately 3 inchestors and leaned aware approximately 2 inchestors and leaned aware approximately 2 inchestors and leaned aware approximately 2 inchestors and leaned aware approximately 3 inchestors and leaned aware approximately 2 inchestors and leaned aware approximately 3 inchestors and leaned aware approximately 2 inchestors and leaned aware approximately 2 inchestors and leaned aware approximately 2 inchestors and leaned aware approximately 3 inchestors and leaned aware approximately 2 inchestors and leaned aware approximately 2 inchestors and leaned aware approximately 3 inchestors and	ses of anemia, diabetes and nual Minimum Data Set 4 revealed Resident #34 and required extensive son assist for bed mobility dent #34's bilateral ½ bed ows: PM the left side rail was ay from the bed es. The right side rail was ay from the bed es. The right side rail was ay from the bed es. The right side rail was ay from the bed es. AM the left side rail was ay from the bed es. AM the left side rail was ay from the bed es. AM the left side rail was ay from the bed es. AM the left side rail was ay from the bed es. The right side rail was ay from the bed es. The right side rail was ay from the bed es. The right side rail was ay from the bed es. The right side rail was ay from the bed es. The right side rail was ay from the bed es. The right side rail was ay from the bed es.	F	323			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION B	(X3) DATE SURVEY COMPLETED
		345255	B. WING	 	03/12/2015
	ROVIDER OR SUPPLIER A CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 111 HARRILSON STREET CHERRYVILLE, NC 28021	,
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 323	providing care to h noticed a loose sid #2 further stated if	checked bed side rails while er residents and when she e rail she tightened it up. NA she was not able to tighten a self she contacted a	F 32	23	
	Maintenance Super of maintenance is soverhead paging hon the board on the The Maintenance staff of bed side rails are them if a bed side further revealed Asthe Housekeeping	or on 03/12/15 at 10:16 AM the envisor stated staff notified him sues and needed repairs by im or documenting the issue a maintenance office door. Supervisor further stated the did not conduct routine audits and relied on the NAs to notify rail was loose. The interview assistant Administrator #1 and Supervisor conducted regular shecked for potential hazards ssues.			
	Administrator #1 o Assistant Administ were not acceptab to be safe as poss revealed she expe	onducted with Assistant n 03/12/15 10:23 AM. rator #1 stated loose side rails le as she wanted the residents ible. The interview further cted the NAs to report loose itenance staff member.			
	Supervisor and As accompanied to Re examined the left a Maintenance Supervisor was loose and need to be accompanied to Recompanied to Recompa	25 AM the Maintenance sistant Administrator #1 were esident #34's room and and right bed side rail. The ervisor confirmed the side rail eded to be tightened down. The ervisor stated he thought the			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345255	B. WING		03/12/2015
	ROVIDER OR SUPPLIER A CARE CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 111 HARRILSON STREET CHERRYVILLE, NC 28021	,
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 323	up and down which side rail. The Maint stated he planned to himself and make so	the knob to bring the side rail was actually loosening the enance Supervisor further start checking bed side rails ure they fit properly.	F 32	3	
	02/14/14 with diagn pulmonary disease, quarterly Minimum I 02/27/15 revealed F	s admitted to the facility on oses of chronic obstructive anemia and depression. The Data Set (MDS) dated Resident #71 was cognitively bendent in transfers and for bed mobility.			
	side rails were as for - On 03/09/15 at 3:0 loose and leaned av	ps PM the left side rail was way from the bed hes. The right side rail was way from the bed			
	and leaned away fro inches. The right sic away from the bed a - 03/11/15 at 8:55 A	M the left side rail was loose om the bed approximately 3 le rail was loose and leaned approximately 3 inches. M the left side rail was loose			
	inches. The right side away from the bed and and leaned away from the side and leaned away from the side and right side.	om the bed approximately 3 le rail was loose and leaned approximately 3 inches. AM the left side rail was loose om the bed approximately 3 le rail was loose and leaned approximately 3 inches.			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345255	B. WING		03/12/2015
NAME OF PROVIDER OR SUPPLIER CAROLINA CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 111 HARRILSON STREET CHERRYVILLE, NC 28021	1 00/12/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE COMPLETION
F 323	An interview condu with Resident #71 r side rails to help he An interview with N at 3:16 PM reveale needed repairs by the office door, page contacting the on c NA #2 stated she c providing care to he noticed a loose side	revealed she used the ½ bed er get out of bed. Jurse Aide (NA) #2 on 03/11/15 d staff notified maintenance of writing them on the board on ging maintenance staff or all maintenance staff member. hecked bed side rails while er residents and when she er rail she tightened it up. NA she was not able to tighten a elf she contacted a	F 32	3	
	Maintenance Super of maintenance issued overhead paging his on the board on the The Maintenance Staff of bed side rails and them if a bed side refurther revealed As the Housekeeping of the side of t	on 03/12/15 at 10:16 AM the rvisor stated staff notified him uses and needed repairs by im or documenting the issue emaintenance office door. Supervisor further stated the did not conduct routine audits d relied on the NAs to notify rail was loose. The interview sistant Administrator #1 and Supervisor conducted regular hecked for potential hazards ssues.			
	Administrator #1 or Assistant Administr were not acceptabl to be safe as possi revealed she expec	onducted with Assistant n 03/12/15 10:23 AM. ator #1 stated loose side rails e as she wanted the residents ble. The interview further cted the NAs to report loose tenance staff member.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345255	B. WING			03/	12/2015
NAME OF PROVIDER OR SUPPLIER CAROLINA CARE CENTER				1	STREET ADDRESS, CITY, STATE, ZIP CODE 11 HARRILSON STREET CHERRYVILLE, NC 28021		
(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 323	Continued From page 21		F	323			
	Supervisor and Assis accompanied to Resi examined the left and Maintenance Supervi was loose and neede Maintenance Supervi NAs might be using the up and down which wide rail. The Maintestated he planned to himself and make sur	I right bed side rail. The sor confirmed the side rail d to be tightened down. The sor stated he thought the ne knob to bring the side rail was actually loosening the nance Supervisor further start checking bed side rails					
	diabetes, cerebrovas The significant chang 02/18/15 revealed Re cognitively impaired a	ses of anemia, heart failure cular accident and anxiety. e Minimum Data Set dated esident 335 was severely and required extensive son assist of bed mobility					
	Observations of Residence rails were as follows:	dent #35's bilateral $rac{1}{2}$ bed ows:					
	loose and leaned awa	es. The left side rail was ay from the bed					
	loose and leaned awa	es. The left side rail was ay from the bed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345255	B. WING			03/	12/2015
NAME OF PROVIDER OR SUPPLIER CAROLINA CARE CENTER			•	1	STREET ADDRESS, CITY, STATE, ZIP CODE 11 HARRILSON STREET CHERRYVILLE, NC 28021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	323			
	further revealed Assisthe Housekeeping Su	stant Administrator #1 and pervisor conducted regular cked for potential hazards					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345255	B. WING _			03/12/2015
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 111 HARRILSON STREET CHERRYVILLE, NC 28021		DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE
F 323	Continued From pag	e 23	F	323		
F 441 SS=D	Administrator #1 on Assistant Administrative were not acceptable to be safe as possible revealed she expective side rails to a mainter of the control of the control of disease and infection Control of the control of	tor #1 stated loose side rails as she wanted the residents e. The interview further ed the NAs to report loose mance staff member. O AM the Maintenance stant Administrator #1 were ident #35's room and dright bed side rail. The risor confirmed the side rail ed to be tightened down. The risor stated he thought the the knob to bring the side rail was actually loosening the enance Supervisor further start checking bed side rails are they fit properly. CONTROL, PREVENT ablish and maintain an gram designed to provide a offertable environment and evelopment and transmission tion. Program	F	441		4/8/15
	The facility must esta Program under which (1) Investigates, con in the facility;	ablish an Infection Control				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345255	B. WING _			03/	12/2015
NAME OF PROVIDER OR SUPPLIER CAROLINA CARE CENTER			11	TREET ADDRESS, CITY, STATE, ZIP CODE 1 HARRILSON STREET HERRYVILLE, NC 28021	1 00/	12/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC 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 441	Continued From page 24 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.		F 441				
	by: Based on observation interviews, the facility implement contact put had a wound infected organism (Resident in Findings included: 1. A review of the fasection of the infection following: "Implement interviews."	recautions for a resident who d with a multi-drug resistant			Carolina Care Center has an infection control program that establishes and maintains a safe, sanitary and comfortable environment to help prevedevelopment and transmission of diseand infection. Corrective action was accomplished for Resident#69 by Nurse#2 being in-serviced of facility's policy related to personal protective equipment.	nt ase r	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ') MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		345255	B. WING			3/12/2015	
	ROVIDER OR SUPPLIER A CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP COE 111 HARRILSON STREET CHERRYVILLE, NC 28021		0/12/2010	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 441	Continued From pag	e 25	F 44	11			
F 441	microorganisms that contact with the residential surfactinstructed staff to we entering a contact property on 02/16/15, the factifrom the laboratory the wound contained a bound methicillin-resistant is (MRSA). During the initial tour Resident #69's room orange sign on the distaff the resident had precautions. There we sanitizer on the insidiculation door frame. No othe equipment was observation was observation was observationed assisted the resident #69's anitized her hands we assisted the resident wound care. She the	can be transmitted by direct dent or indirect contact with dees". The policy further ar disposable gowns when ecautions room. Ility received a final report mat indicated Resident #69's acteria known as ataphylococcus aureus of the facility on 03/09/15, was observed to have an oor that informed visitors and a been placed on contact were gloves and hand e of the room and next to the resonal protective rived to be immediately conducted of Resident #69's ex/15 at 7:16 AM. Nurse #2 Design conducted of Resident #69's ex/15 room after knocking, with a hand sanitizer, and into the proper position for en sanitized her hands with	F 44	Corrective actions for those r having potential to be affecte alleged deficient practice incl in-service of all licensed nurs CNA's regarding contact precepts facility policy.3/30/15 Measures put into place to endeficient practice does not related to the contact precautions.3/12/15 -Ensure all necessary PPE is accessible and available for replaced on contact precaution policy. (i.e. gown, gloves, magoggles)3/12/15 PPE is stored outside resider cart. Monitors put into place to ensemble deficient practice does not related to ensemble deficient practice does not related to contact precautions during change until contact precautions during change until contact precautions.	d by the uded es and cautions and cautions and cautions and cautions and cautions and cautions alleged cur included: areadily residents as per facility sk, or ant room in caure alleged cur include: anducts a cause pertaining dressing		
hand sanitizer and put on clean gloves. She removed the old dressing from Resident #69's pressure ulcer, cleansed the wound, and replaced the dressing with a new dressing. During the dressing change, Nurse #2's uniform was observed to come into contact with Resident #69's bed sheets several times. The nurse then cleaned the work area and washed her hands with soap and water.			- Weekly audits are reported tracking committee for any er immediate corrective actions -Tracking committee reports a in monthly Quality Assurance Assessment Committee mee recommendations or changes	rors or needed. are reviewed and ting for			
	An interview was cor	nducted with Nurse #2 on		plan.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION 3	, ,	(X3) DATE SURVEY COMPLETED	
		345255	B. WING		0	3/12/2015
	NAME OF PROVIDER OR SUPPLIER CAROLINA CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 111 HARRILSON STREET CHERRYVILLE, NC 28021		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 441	Resident #69's woul it was positive. She resident had been p Nurse #2 stated she policy related to persit related to contact pshe had to wear glow before placing them She stated Resident antibiotics, but the fasecond culture of the An interview was con Nursing (DON) on 0 stated it was her expand gowns when en who has been place She stated Nurse #2 disposable gown du Resident #69. An interview was con Assistant (PA) on 03 stated she had reviet that indicated Residem MRSA. She explain resident on contact precautions	I. She stated she knew and was tested for MRSA and explained she knew the laced on contact precautions. It did not know the facility's sonal protective equipment as precautions, but she did know wes and clean any used items back into the treatment cart. It #69 had just finished acility had not obtained a exwound. Inducted with the Director of 3/12/15 at 8:02 AM. She precautions are wound a resident don contact precautions. It should have been wearing a ring the dressing change for anducted with the Physician's 1/12/15 at 10:52 AM. She was the laboratory results ent #69's wound contained ed the decision to place a precautions was a facility cated the facility to implement according to its policy and it of the infection control policy	F 44	Quality Assurance and Assess Committee reviews Tracking F period of one year.		