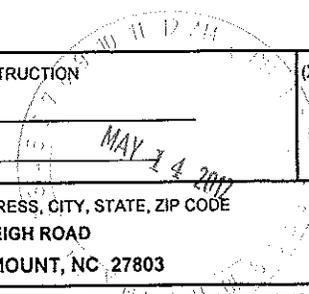


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345137 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 04/19/2012 |
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| NAME OF PROVIDER OR SUPPLIER SOUTH VILLAGE | STREET ADDRESS, CITY, STATE, ZIP CODE 2221 RALEIGH ROAD ROCKY MOUNT, NC 27803 |
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| F 157 SS=D | <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to ensure the</p> | F 157 | <p>"Submission of this response to the Statement of Deficiency by the undersigned does not constitute an admission that the deficiency existed and/or were correctly cited and/or require correction.</p> <p>F Tag 157</p> <p>Resident #94 is no longer a resident of the facility.</p> <p>24 hour reports since 04/16/12 were reviewed by the Director of Nursing to identify any responsible party notifications that should have occurred. The Director of Nursing and/or Charge Nurse has notified the responsible parties of any changes in those residents that were identified.</p> | 5/17/12 |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *5/9/12*

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.

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| F 157 | <p>Continued From page 1</p> <p>Responsible Party (RP) was notified of a change in condition for 1 of 7 (resident #94) sampled residents. Findings include:</p> <p>Resident #94 was admitted to the facility on 11/15/11 with cumulative diagnoses of muscle weakness, abnormality of gait, and recent back surgery.</p> <p>Resident #94's admission Minimum Data Set (MDS) dated 11/22/11 indicated that Resident #94 was moderately impaired cognitively. Resident #94 needed the extensive assistance of one person for transfers and walking.</p> <p>A review of the Changes in Condition Reporting/Documentation Guidelines showed that for an unwitnessed fall the nurse should notify the physician and the RP and document on the nurse's notes.</p> <p>A review of the grievance logs for November 2011 to April 2012 showed one entry on January 17, 2012 that notification of a transfer to the Emergency Department (ED) had not been made. Staff was retrained on January 19, 2012.</p> <p>A review of the Medication Administration Record for 11/15/12-11/30/12 showed Resident #94 received oxycodone (a narcotic used for pain) 5 milligrams (mg) by mouth for mild pain on her return to the facility on 11/19/12. Resident #94 had received no narcotics prior to her fall.</p> <p>A review of the Nurses Notes dated 11/18/11 at 11:30 PM showed the nurse was called to Resident #94's room. Resident #94 was found lying on the floor and stated she was trying to go</p> | F 157 | <p>Licensed nurses were in-serviced on Responsible Party Notification of Changes in Condition by the Director of Nursing on 04/23/12. New hires will receive the in-service during orientation by the Assistant Director of Nursing.</p> <p>24 hour nursing reports will be reviewed by the Interdisciplinary Team Monday – Friday during morning clinical meeting. Audits of Notification of Responsible Party will be completed by the Director of Nursing or Charge Nurse five times per week x 1 month, then once per week x 2 months to ensure compliance.</p> <p>Results of the audit will be forwarded to the QA Committee for review and recommendations monthly x 3 months.</p> | | |

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| F 157 | <p>Continued From page 2</p> <p>get some water. The over bed table had cups of fluid and a water pitcher and was within reach of Resident #94 while she had been in bed. The physician was notified and an order to send Resident #94 to the Emergency Department was received. A call was placed to Resident #94's RP and a voice mail message was left.</p> <p>A review of the Physician's Telephone Orders dated 11/18/11 instructed the facility to send Resident #94 to the ER (Emergency Room) for a complaint of left hip pain following a fall.</p> <p>A review of the Nurses Notes dated 1/19/11 at 4:20 AM indicated that an x-ray of the left hip was negative and Resident #94 was ready to go back to the facility.</p> <p>A review of the Nurses Notes dated 11/19/11 at 5:00 AM showed that Resident #94 returned to the facility and complained of pain. Resident #94 received pain medication as ordered by the physician.</p> <p>A review of the 24 Hour Report for 11/19/11 and 11/20/11 did not mention that notification of Resident #94's RP had been done only by voicemail and needed to be followed up.</p> <p>In an interview on 4/18/12 at 11:00 AM with Resident #94, she indicated that neither she nor her spouse were aware she had been sent to the hospital until they received a bill for transport and an x-ray. She stated she did not even know if there was documentation in the nursing notes. She stated she was "doped" up and did not know what had happened.</p> | F 157 | | |

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| F 157 | <p>Continued From page 3</p> <p>In an interview on 4/18/12 at 1:10 PM with the Director of Nursing (DON), she indicated that when notification needed to be made it was her expectation that nursing staff speak to the RP. She stated that leaving a voice mail message was not good enough. She indicated that the nurse who had originally left the voice mail message was no longer employed at the facility.</p> <p>In an interview on 4/18/12 at 3:15 PM with Nurse #1, she stated that she could not remember if she had spoken to Resident #94's RP. She indicated that since Resident #94 was already back in the facility when she came on shift she would have thought that it had already been done.</p> <p>In an interview on 4/18/12 at 4:40 PM with Nurse #2, she indicated that if a voice mail message was left for a RP when a resident was sent to the hospital then the nurse should attempt to reach the second contact listed. If no contact person could be reached the nurse should put the information on the 24 Hour Report and let the incoming nurse know so contact could be made.</p> <p>In an interview on 4/19/12 at 9:35 AM with Nurse #3, she stated that when a resident was sent to the hospital the physician and the Power of Attorney (POA) needed to be notified. If a message was left and the contact did not call back the nurse should keep calling. The nurse could also call the second contact. The nurse should keep calling until she was actually able to speak to someone.</p> <p>In an interview on 4/19/12 at 10:35 AM with Nurse #4, she indicated that it was not enough to just leave a message when a resident was sent to the</p> | F 157 | | |

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| F 157 F 315 SS=D | <p>Continued From page 4</p> <p>hospital. The nurse should pass it on in report and put it on the 24 hour report. She indicated that as the oncoming nurse, she did not remember being told that Resident #94's RP had not been notified of her trip to the hospital.</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to assess 1 of 1 sampled residents (Resident #4) for scheduled toileting who would benefit from bladder and/or bowel retraining. Findings include:</p> <p>Resident #4 was admitted to the facility on 02/28/12. Cumulative diagnoses included right below the knee amputation (BKA), depression and dementia.</p> <p>Resident #4's Admission Minimum Data Set (MDS) assessment of 03/06/12 noted she was moderately cognitively impaired. She needed limited assistance with bed mobility, transfer and</p> | F 157 F 315 | <p><u>F 315</u></p> <p>Resident #4 is receiving appropriate assistance with elimination needs. The resident was assessed on 05/08/12 by Director of Nursing and was determined to be continent.</p> <p>Residents residing in the facility assessed as being incontinent or requiring assistance to go to the bathroom or use a urinal to maintain continence may be affected by the deficient practice. These residents have been identified by the DON and ADON.</p> <p>The DON, ADON and Charge Nurse completed urinary incontinence assessments on all identified residents on 05/11/12.</p> | 5/17/12 |

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| F 315 | <p>Continued From page 5</p> <p>hygiene. She needed extensive assistance with toilet use and was occasionally incontinent of bowel and bladder. There was no urinary or bowel toileting program noted.</p> <p>Resident #4's care plan, dated 03/08/12, identified problems with functional urinary incontinence. In the approach section, it was noted for staff to observe her pattern of incontinence, and initiate a toileting schedule or bladder retraining if indicated. Staff were to provide bedpan and/or the commode.</p> <p>According to a nurse's note of 03/18/12 at 5:50 PM, Resident #4 was found sitting on the floor in her bathroom. She reported she was going to the bathroom and fell.</p> <p>The Resident/Incident report for her fall of 03/18/12 indicated she sat on the bathroom floor while transferring to the commode.</p> <p>Resident #4 was observed resident in her room sitting on the side of her bed on 04/17/12 at 3:30 PM.</p> <p>During an interview with Nurse Aide #1 (NA) on 04/18/12 at 2:45 PM, she stated Resident #4 was pleasant and cooperative. She commented she was able to toilet herself and was usually continent on day shift. She added that she might have accidents occasionally and she wore regular underwear. When questioned about scheduled</p> | F 315 | <p>Residents will be assessed for urinary incontinence on admission, quarterly and with a change in condition by the DON/ADON or charge nurse and all documentation will reflect changes or new information.</p> <p>Education was provided to Licensed Nurses and Certified Nursing Assistants by the Director of Nursing on 05/11/12. The topics of this in-service included the facility Bladder Management Program. New hires will receive the in-service during orientation by the ADON.</p> |

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| F 315 | <p>Continued From page 6</p> <p>toileting, she stated she was not on a scheduled toilet program but she felt she would cooperate if she was on such a program.</p> <p>The hall nurse (Nurse #4) stated Resident #4 could self transfer from the bed to the wheelchair and from the wheelchair to the toilet. She commented that she was capable of understanding instructions but most of the time she would yell out for assistance rather than using the call bell. When questioned about scheduled toileting, she responded that she was not aware of a scheduled toileting program but felt she would benefit from one.</p> <p>The Director of Nurses (DON) reported during an interview on 04/19/12 at 9:30 AM that the facility did not have a program for assessing residents for toileting needs and there was no formal toileting program. She stated Resident #4 would benefit from scheduled toileting as she was able to transfer herself and was aware of when she needed to go to the bathroom. The DON added that she would come to her doorway and yell for staff to come assist her with the commode.</p> <p>During an interview with Resident #4, on 04/19/12 at 9:45 AM, she stated she had awareness of when she needed to use the bathroom. She stated she was able to toilet herself but staff did not want her to do it alone due to her having only one leg and she had fallen. She stated staff did not ask her to go to the toilet nor offer on a scheduled basis to take her.</p> | F 315 | <p>The facility will monitor compliance through review of the 24 hour report in daily clinical meeting, through review of the urinary assessments in Standards of Care meeting weekly, and through individual resident observation of compliance. Audits will be completed three times per week x 4 weeks, then monthly x 3 months by the DON/ADON to ensure compliance.</p> <p>The QA committee will evaluate this plan monthly for 3 months and will adjust as indicated.</p> | |
| F 318 | 483.25(e)(2) INCREASE/PREVENT DECREASE | F 318 | | |

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| F 318 SS=D | <p>Continued From page 7</p> <p>IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to put in place interventions to prevent further decline in range of motion and contractures of the upper extremities of 1 (Resident # 2) of 4 residents reviewed for range of motion. Findings include:</p> <p>Resident #2 was readmitted to the facility on 02/06/12 with diagnoses of multiple sclerosis, diabetes, anemia, hypertension, depression, and contracture of left upper extremity.</p> <p>An Occupational Therapy screening, dated 02/10/12, documented Resident #2 as functional at the same level with extensive to total assistance needed, self feeding and grooming with set up. No skilled services were recommended at the time.</p> <p>Resident #2's care plan updated 02/12/12 identified her as having self care deficit and under interventions listed restorative nursing 6 x (times) week for bed mobility and PROM (passive range of motion).</p> | F 318 | <p>F318</p> <p>Resident #2 was seen by the Occupational Therapist on 04/20/12 for the use of splinting/contractures and the need for PROM. Orders were written for OT to treat one time per day 5 x per week for 4 weeks for orthotic fitting and training/splinting of the left hand for better positioning of digits and therapeutic exercise and patient/caregiver education by the OT on 04/20/12.</p> <p>Residents with the potential for contractures were identified by the Therapy Manager on 04/20/12. Therapists screened residents that were identified and will screen any new residents that may be identified.</p> | 5/17/12 |

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| F 318 | <p>Continued From page 8</p> <p>An admission Minimum Data Set (MDS) assessment completed 02/13/12 identified Resident #2 as having moderate cognitive impairment, dependant on staff for bed mobility, transfers, dressing, toileting, hygiene and bathing, as non-ambulatory, and self feeding with set up. Resident #2 was assessed as having impaired functional range of motion on one side of upper extremity and both sides of the lower extremities.</p> <p>Resident #2's Care Area Assessment's (CAA's) dated 02/21/12 triggered adl (activities daily living)/functional rehab potential and documented not to proceed to care plan.</p> <p>An observation made on 04/16/12 at 12:07 PM found Resident #2 lying in bed. Resident #2's left hand was observed to be closed with four digits resting on her palm. When asked, Resident #2 responded that she was unable to open her left hand.</p> <p>In an interview with Nurse #3 on 04/16/12 at 12:13 PM, Nurse #3 said Resident #2's left hand was contracted and she did not use a splint anymore or received range of motion exercises to her left hand.</p> <p>On 04/17/12 at 3:40 PM, Resident #2's left hand was observed closed with four digits resting on her palm.</p> <p>Another observation on 04/18/12 at 8:20 AM made of Resident #2's left hand revealed her hand to be in a closed position with four digits resting on her palm.</p> <p>During an interview with Nurse #3 on 04/18/12 at</p> | F 318 | <p>Nurse Aides/Licensed Nurses were in-serviced on 05/08/12 on observation for change in resident condition with range of motion, dependence on staff for ADL's, falls, weight loss and/or swallowing difficulties. New hires will receive the in-service during orientation by the ADON.</p> <p>Audits of recommendations for therapy screens will be conducted 3 x per week for 1 month, then monthly x 3 months by the DON/ADON to ensure compliance.</p> <p>Results of the audit will be forwarded to the QA Committee for review and recommendations monthly x 3 months.</p> | |

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| F 318 | <p>Continued From page 9</p> <p>11:14 AM, she said Resident #2 required total staff assistance with activities of daily living. Nurse #3 said Resident #2 was able to use her right hand for some things. Nurse #3 said she had not observed any change in Resident #2's left hand. Nurse #3 said Resident #2 was alert and oriented and was capable of making all her needs known.</p> <p>In an interview with Resident #2 on 04/18/12 at 12:10 PM, she said she had a hand splint a long time ago but did not like to wear it. Resident #2 said she was unable to open her left hand but said the nurse's aides were able to open it to clean her hand and trim her fingernails. Resident #2 said she did not do any exercises with her hand and did not remember having anything put in her hand to keep it opened. Resident #2 said she did not notice any changes in her hand.</p> <p>In an interview with the Rehab Manager (RM) on 04/18/12 at 2:45 PM, she said she had worked with Resident #2 several times in the past for physical therapy. The RM said Resident #2 had a problem with her left hand for many years. The RM said when the occupational screened Resident #2 on 02/10/12, there had been no change in her functional status and there was no mention of Resident #2's status of her contracted left hand.</p> <p>In an interview with Nurse Aide (NA) #2 on 04/18/12 at 3:35 PM, she said Resident #2 used her right hand to feed herself but her left hand was contracted. NA #2 said they were able to open Resident #2's left hand some to wash it. NA #2 said she had not seen any changes in Resident #2's left hand.</p> | F 318 | | |

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| NAME OF PROVIDER OR SUPPLIER SOUTH VILLAGE | | STREET ADDRESS, CITY, STATE, ZIP CODE 2221 RALEIGH ROAD ROCKY MOUNT, NC 27803 | | |
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| F 318 | <p>Continued From page 10</p> <p>An observation was made with NA #2 and NA #3 on 04/18/12 at 3:40 PM. Resident #2's left hand was observed to be in a closed position with four digits resting on the palm of her hand. NA #3 proceeded to open Resident #2's left hand approximately 50% until Resident #2 said she had discomfort. The skin on Resident #2's palm was intact where her nails were resting.</p> <p>In an interview with Nurse #2 on 04/18/12 at 4:03 PM, Nurse #2 said she had not seen any changes in Resident #2's left hand. Nurse #2 said staff sometimes would put a washcloth in Resident #2's left hand to keep it open.</p> <p>On 04/19/12 at 8:25 AM Resident #2 said she did not remember having anything put in her left hand to keep her hand open or prevent her fingernails from resting in her palm.</p> <p>During an interview with NA #4 on 04/19/12 at 8:40 AM, she said she was able to open Resident #2's left hand about 50% to wash it. NA#4 said she remembered Resident #2 had a splint several years ago but as soon as they put it on, Resident #2 would ask the next person to take it off. NA #4 said she did not remember ever putting anything else or doing anything else to Resident #2's left hand. NA #4 said she did not think there were any changes with Resident #2's left hand.</p> <p>In an interview with the Certified Occupational Therapy Assistant (COTA) on 04/19/12 at 9:30 AM, he said if a resident had a hand contracture it would be treated with some type of orthotic or splint. If a resident was unable to tolerate</p> | F 318 | | |

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| F 318 | <p>Continued From page 11</p> <p>splinting, then a hand roll, palm protector, or washcloth would be warranted to prevent the fingers from closing into the palm as the joints could become stiffer and the hand could eventually close tighter. The COTA said he had not treated Resident #2 and was not familiar with the status of her left hand contracture.</p> <p>During an interview with the Director of Nurses (DON) on 04/19/12 at 9:45 AM, the DON said she would expect to see passive range of motion exercises done by the nurse's aides during care for a resident with a hand contracture. The DON said she had just gotten approval for a restorative aide. The DON said if a resident did not have a splint, her expectation was to see something in the hand to prevent it from closing tight and prevent any breakdown from the fingernails embedding into the palm of the hand.</p> <p>In an interview with the RM on 04/19/12 at 10:35 AM, the RM said Resident #2 had been discharged from therapy on 12/02/08. Notes reviewed indicated Resident #2 had been fitted with a splint but had been uncomfortable wearing the splint and no longer opted to wear it.</p> | F 318 | |
| F 325 SS=D | <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> | F 325 | <p>F325</p> <p>The Director of Nursing placed the order for 60cc of med pass supplement on the MAR of Resident #72 on 04/18/12.</p> <p>Licensed nurses were in-serviced on transcription of dietary orders to the MAR by the Director of Nursing on 04/23/12.</p> <p style="text-align: right;">5/17/12</p> |

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| F 325 | <p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff interview and record review the facility failed to provide a nutritional supplement ordered by the physician to prevent weight loss and address poor meal intake for 1 of 4 sample residents (Resident #72) reviewed for nutrition concerns. Findings include:</p> <p>Resident #72 was admitted to the facility on 12/30/11 and readmitted on 02/24/12. The resident's documented diagnoses included dementia, glaucoma, diabetes, cerebrovascular accident (CVA), hypertension, and gastroesophageal reflux.</p> <p>Resident #72's Weight Record documented she weighed 117 pounds on 01/02/12, 124.6 pounds on 01/23/12, and 124 pounds on 02/07/12.</p> <p>A hospital Discharge Summary documented Resident #72 was hospitalized from 02/21/12 through 02/24/12.</p> <p>Resident #72's Weight Record documented she weighed 119.4 pounds on 02/24/12 and 116.8 pounds on 03/05/12.</p> <p>A Medical Nutrition Therapy Recommendation to place Resident #72 on 60 cubic centimeters (cc) of med pass supplement daily was faxed to the resident's primary physician on 03/06/12.</p> <p>On 03/07/12 Resident #72's primary physician</p> | F 325 | <p>The facility has audited 100% of dietary recommendations received since 04/01/12 for transcription of all orders to include dietary supplements. All dietary supplement orders will be reviewed by the interdisciplinary team 5 X per week for one month, then weekly x 2 months during morning clinical meeting to ensure transcription of orders to the MAR utilizing a Dietary Recommendation Transcription QA audit tool. The Director of Nurses will review the audit tool weekly for compliance.</p> <p>Results of the audit will be forwarded to the QA Committee for review and recommendations monthly x 3 months.</p> | |

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| F 325 | <p>Continued From page 13</p> <p>signed the recommendation in agreement, and faxed it back to the facility.</p> <p>The registered dietitian's (RD's) 03/08/12 Dietary Progress Note documented, "Readmitted after (symbol used) hospitalization from 2/21 to 2/24 r/t (in regard to) acute on chronic CVA, hypotension, mild dehydration, dementia. On a regular NAS (no-added salt) diet with (symbol used) fortified foods. Requesting 2.0 60 cc QD (daily) r/t poor intake (less than 50%)....Agree with (symbol used) liberalized diet r/t recent weight loss, poor p.o. (by mouth) intake...."</p> <p>A 03/08/12 physician's order documented, "Diet Clarification: Regular, NAS diet, Fortified foods. 2.0 product 60 cc QD."</p> <p>A 03/08/12 Diet Order Form documented, "Regular NAS diet, fortified foods, 2.0 product 60 cc QD."</p> <p>Resident #72's Weight Record documented she weighed 118 pounds on 03/12/12 and 120.8 pounds on 03/19/12.</p> <p>The RD's 03/23/12 Dietary Progress Note documented, "...Continue current interventions with (symbol used) 2.0 product."</p> <p>Review of Resident #72's March 2012 and April 2012 Medication Administration Record (MAR) revealed the resident did not receive any Med Pass 2.0 product at all because it did not appear on the MARs.</p> <p>Resident #72's Weight Record documented she weighed 120.12 pounds on 04/02/12.</p> | F 325 | |

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| F 325 | Continued From page 14 At 12:04 PM on 04/18/12 Nurse #3 stated the nurse who took the order for a new medication or nutritional supplement to be provided by nursing should have placed the medication or supplement on the MAR to make sure nursing was reminded to provide it. At 4:15 PM on 04/18/12 the dietary manager (DM) stated nursing provided 2.0 nutritional supplements to residents. She reported such liquid supplements were usually given to residents during medication passes. According to the DM, the nurse who took the order for such a supplement should have placed it on the MAR and provided a space to record resident intake so the RD could assess whether the supplement was an effective intervention for the resident's weight loss. At 9:27 AM on 04/19/12 the director of nursing (DON) stated the 2.0 nutritional supplement was usually ordered as an intervention to address weight loss, poor appetite and intake, or wound healing. She reported nursing administered the product, and the nurse who took the order for the supplement should have placed it on the MAR and created a place to record resident intake of the product. | F 325 | | |
| F 364 SS=E | 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. | F 364 | | |

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| F 364 | <p>Continued From page 15</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to preserve the vitamin and mineral content of green vegetables by exposing them to prolonged heat. Findings include:</p> <p>At 8:55 AM on 04/18/12 two tray pans of green beans, one tray pan of cabbage, and one tray pan of collard greens were bubbling on top of the stove.</p> <p>At 9:20 AM on 04/18/12 the cook cut the burner off under the cabbage, and reduced the heat under the small tray pan of green beans.</p> <p>At 9:34 AM on 04/18/12 the cook pureed the green beans in the small tray pan, and placed them in an oven set at 450 degrees Fahrenheit.</p> <p>At 9:46 AM on 04/08/12 the cook pureed the cabbage, and placed it in an oven set at 450 degrees Fahrenheit.</p> <p>At 9:58 AM on 04/08/12 the cook turned off the burner under the large tray pan of green beans, and they were left simmering in liquid on top of the stove.</p> <p>At 10:15 AM on 04/08/12 the collard greens were still bubbling on the back burner of the stove.</p> <p>At 11:30 AM on 04/08/12 the dietary manager (DM) reported the lunch trayline started up at approximately 11:55 AM, and observation revealed this to be true.</p> | F 364 | <p>F364</p> <p>No specific resident was identified in this citation. All residents have the potential to be affected by this citation. Food will be prepared in a manner to conserve nutrient value. An in-service on proper cooking methods to preserve the vitamin/mineral content of vegetables was completed by the Food Service Director on 04/18/12. Compliance with appropriate cooking methods will be monitored by the Food Service Director and/or designee daily using a preparation of vegetables audit tool. The audit tool identifies the vegetable menu item, start cooking time and end cooking time. Any inappropriate methods identified will be corrected by the Food Service Director and/or designee.</p> | 5/17/12 |
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| F 364 | Continued From page 16 At 10:28 AM on 04/19/12 the DM stated cooking vegetables was not covered in any monthly in-services because she was not aware that it was a problem previously. She commented overcooking vegetables could destroy their vitamin and mineral content. However, she reported vegetables had to be soft for most of the nursing home population because of mouth/teeth/denture problems. At 10:39 AM on 04/19/12 the AM cook stated she was instructed not to overcook the vegetables because it could destroy their nutrient content. She reported she received this guidance in a dietary in-service provided a long time ago. The cook commented during the in-service staff were warned not to put vegetables on the stove to cook too early before the trayline began operation. | F 364 | Results of the audit will be forwarded to the QA Committee for review and recommendations monthly x 3 months. | |
| F 371 SS=E | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain sanitizing solutions at the proper strength and failed to label and date opened food items. Findings include: | F 371 | | |

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| F 371 | <p>Continued From page 17</p> <p>1. At 8:57 AM on 04/18/12 a dietary employee wiped down preparation table #1 with a cloth from the red bucket at her work station.</p> <p>At 9:45 AM on 04/18/12, after placing hushpuppies on a large baking pan, the cook wiped down preparation table #2 with a cloth from the red bucket at her work station.</p> <p>At 9:52 AM on 04/18/12 after pureeing rib meat, green beans, and cabbage, the cook wiped down the Robot Coupe and the table where it sat with a cloth from the red bucket at her work station.</p> <p>At 10:01 AM on 04/18/12 strips were used to check the strength of the quaternary sanitizing solution in the red buckets from which cloths were taken to sanitize preparation table #1, preparation table #2, and the Robot Coupe/table. The strips only registered 100 parts per million (PPM). At this time the dietary manager (DM) stated the strips should register 200 PPM, and the dietary aide stated the red buckets were filled with quaternary sanitizer from the three-compartment sink dispensing system at approximately 7:30 AM that morning. The DM commented she thought the large rags in the buckets were absorbing some of the sanitizing solution.</p> <p>At 10:28 AM on 04/19/12 the DM stated the red buckets of quaternary sanitizer should be changed out when they became really dirty and at dietary shift change.</p> <p>At 10:39 AM on 04/19/12 the AM cook stated red buckets of quaternary sanitizer should be made</p> | F 371 | <p>F371</p> <p>No specific resident was identified in this citation. All residents have the potential to be affected by this citation. Dietary equipment will be sanitized using a sanitizing solution that is maintained at the manufacturer's recommended strength. Open foods will be labeled and dated. The sanitizing solution that is used to sanitize dietary equipment will be checked using the appropriate test strips. The sanitizer level will be recorded on a monitoring log. Any readings that fall below the recommended manufacturer strength will be corrected and reported to the Food Service Director. An in-service on this procedure was completed by the Food Service Director on 04/18/12. All opened food products will be appropriately sealed, labeled and dated. The Food Service Director and/or designee will complete an audit of all storage areas 5</p> | 5/17/12 |

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| F 371 | <p>Continued From page 18</p> <p>up fresh when the solution became dirty and at dietary shift change. She reported the staff filled the buckets with quaternary sanitizer from the three-compartment sink dispensing system. The cook commented strips used to monitor the buckets should register 200 PPM. She explained strips were to be used to check the strength of solution when red buckets were made up at 7:30 AM, 9:30 AM, 1:30 PM, and 5:30 PM.</p> <p>2. During initial tour of the kitchen on 04/16/12, beginning at 9:15 AM, opened food items were found in storage areas without labels and dates on them. A one-gallon container of mayonnaise, a one-gallon container of sweet pickle relish, a one-gallon container of barbecue sauce (all of which had been opened), and one tray pan of gelatin (which had been partially used) in refrigerated storage did not labels or dates on them. In the dry storage room opened cheddar cheese sauce mix, strawberry gelatin dessert mix, dried beans, and rotini pasta did not have labels or dates on them. Two plastic storage bags of pepperoni, one plastic storage bag of celery, and one plastic storage bag of egg rolls in the walk-in freezer did not have labels and dates on them.</p> <p>At 10:28 AM on 04/19/12 the DM stated any dietary staff member who opened a food item was responsible for placing a label and date on it. She commented she thought there was some confusion among dietary staff who thought that one date on food items was sufficient. The DM explained since the facility dated all food items when they were received in the kitchen, some staff did not realize that the dates the food items were opened also had to be placed on them. The</p> | F 371 | <p>x per week to monitor for compliance. An in-service on this procedure was completed by the Food Service Director on 04/18/12.</p> <p>Results of the audit will be forwarded to the QA Committee for review and recommendations monthly x 3 months.</p> | |

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DM reported she tried to conduct rounds about twice a week to make sure opened food items in storage areas were labeled and dated. She also remarked that dietary employees should be checking on labels and dates as they removed food items from storage areas. According to the DM, dietary staff should also be placing labels and dates on food items removed from their original packaging and on leftover food items.

At 10:39 AM on 04/19/12 the AM cook stated staff member who opened food items were responsible for placing labels/dates on them. She reported a date was placed on food items when they were received in the facility and when they were opened. The cook commented dietary staff should also be placing labels and dates on food items removed from their original packaging and on leftover food items.

F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS
SS=D

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

- (a) Infection Control Program
The facility must establish an Infection Control Program under which it -
- (1) Investigates, controls, and prevents infections in the facility;
 - (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
 - (3) Maintains a record of incidents and corrective actions related to infections.

F 371

F 441

F441

Nurse #5 was in-serviced on the facility procedure for cleaning/disinfecting glucometers and labeling of single use glucometers by the Director of Nursing on 04/18/12. All medication carts were checked for appropriately labeled glucometers by the Administrative Nurses on 04/17/12. Residents required to have a glucometer were identified by the DON/ADON on 04/17/12.

5/17/12

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| F 441 | <p>Continued From page 20</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to disinfect a glucose meter with an EPA registered germicide prior to use during medication pass observations. Findings include:</p> <p>The facility's policy for cleaning and disinfecting glucometers, revised 08/20/11, included cleaning for multi-use and single use glucometers (glucose meter). It indicated that multi-use glucometers were to be cleaned and disinfected before initial use and between each resident. All single use glucometers did not need to be cleaned after every use if they were strictly assigned to</p> | F 441 | <p>Licensed nurses were in-serviced on same on 04/23/12 by the Director of Nursing. New hires will receive the in-service during orientation by the ADON.</p> <p>Licensed nurses will be observed during process of cleaning glucometers utilizing a Glucometer Cleaning Observation Audit Tool to be completed by 05/14/12. Upon completion of the initial audit, observations will be conducted 1 x per week per shift x 1 month to monitor for compliance by the DON, ADON or Charge Nurse. The Director of Nursing will review the audit tool weekly for compliance. Weekly audits of medication carts will be conducted utilizing a Labeling of Individual Glucometers Audit Tool to monitor for compliance. The Director of Nursing will review the audit tool weekly for compliance.</p> | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345137 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 04/19/2012 |
| NAME OF PROVIDER OR SUPPLIER SOUTH VILLAGE | | STREET ADDRESS, CITY, STATE, ZIP CODE 2221 RALEIGH ROAD ROCKY MOUNT, NC 27803 | | |
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| F 441 | <p>Continued From page 21</p> <p>individual residents and there was no chance of sharing between two residents. The procedure section included cleaning the external device with soap and water after use. The external device was to be disinfected by thoroughly wiping all sides of the device with an "approved EPA-registered germicide with either a tuberculocidal or HBV/HIV label claim such as a Super Sani-Wipe or Clorox 1:10 wipe product between resident usages." In the "Additional information" section of the policy, it was noted that alcohol should never be used because it could damage the light emitting diodes (LED) readout. It also included the statement that alcohol "is also not an EPA-registered detergent/disinfectant."</p> <p>On 04/17/12 at 3:45 PM, Nurse #5 was observed preparing a Gluco Perfect 3 glucose meter for use. He stated each resident usually had their own glucose meter except for the short term rehab residents. He was observed picking up the meter and going into a resident's room. Before using the meter, he was questioned as to how he had been instructed to clean and/or disinfect the meter prior to use. Nurse #5 responded he was supposed to clean it with alcohol before and after each use and he had not done that. He commented that he should have cleaned it before entering into the resident's room to do a fingerstick.</p> <p>During medication pass observations on 04/18/12 at 8:25 AM, Nurse #4 stated all the residents on her hall had their own glucose meter. She commented that she noticed today that the rehab</p> | F 441 | <p>Results of the audit will be forwarded to the QA Committee for review and recommendations monthly x 3 months.</p> | |

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| F 441 | Continued From page 22 residents also had their own meters. When questioned as to how many residents that the unnamed meters were used to check their blood sugars, she stated there were 3 residents but all of them now had their own meters. During an interview with the Director of Nurses (DON), on 04/18/12 at 11:15 AM, she stated the facility used a Gluco Perfect 3 glucometer. She stated staff had been instructed to clean the meter in between residents with soap and water or use sani wipes before and after use. She stated every diabetic resident should have their own meter and should be labelled as such. The DON commented there were extra glucose meters in house. When questioned as to whether the unnamed meter would have been used for other residents, she responded it would have been used for the residents on that medication cart but it would not have been removed from the cart for use on another hall. The DON stated Nurse #5 had reported the incident of the day before and all of the rehab residents had their own dedicated glucose meter as of yesterday evening as well as any other resident who did not have a dedicated glucose meter. She commented that she had started inservicing staff and having them sign the policy. | F 441 | | | |

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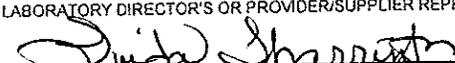
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| NAME OF PROVIDER OR SUPPLIER SOUTH VILLAGE | STREET ADDRESS, CITY, STATE, ZIP CODE 2221 RALEIGH ROAD ROCKY MOUNT, NC 27803 |
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| F 157 SS=D | <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to ensure the</p> | F 157 | <p>"Submission of this response to the Statement of Deficiency by the undersigned does not constitute an admission that the deficiency existed and/or were correctly cited and/or require correction.</p> <p>F Tag 157</p> <p>Resident #94 is no longer a resident of the facility.</p> <p>24 hour reports since 04/16/12 were reviewed by the Director of Nursing to identify any responsible party notifications that should have occurred. The Director of Nursing and/or Charge Nurse has notified the responsible parties of any changes in those residents that were identified.</p> | |
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE Administrator | (X6) DATE 5/9/12 |
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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.

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| NAME OF PROVIDER OR SUPPLIER SOUTH VILLAGE | | STREET ADDRESS, CITY, STATE, ZIP CODE 2221 RALEIGH ROAD ROCKY MOUNT, NC 27803 | | |
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| F 157 | <p>Continued From page 1</p> <p>Responsible Party (RP) was notified of a change in condition for 1 of 7 (resident #94) sampled residents. Findings include:</p> <p>Resident #94 was admitted to the facility on 11/15/11 with cumulative diagnoses of muscle weakness, abnormality of gait, and recent back surgery.</p> <p>Resident #94's admission Minimum Data Set (MDS) dated 11/22/11 indicated that Resident #94 was moderately impaired cognitively. Resident #94 needed the extensive assistance of one person for transfers and walking.</p> <p>A review of the Changes in Condition Reporting/Documentation Guidelines showed that for an unwitnessed fall the nurse should notify the physician and the RP and document on the nurse's notes.</p> <p>A review of the grievance logs for November 2011 to April 2012 showed one entry on January 17, 2012 that notification of a transfer to the Emergency Department (ED) had not been made. Staff was retrained on January 19, 2012.</p> <p>A review of the Medication Administration Record for 11/15/12-11/30/12 showed Resident #94 received oxycodone (a narcotic used for pain) 5 milligrams (mg) by mouth for mild pain on her return to the facility on 11/19/12. Resident #94 had received no narcotics prior to her fall.</p> <p>A review of the Nurses Notes dated 11/18/11 at 11:30 PM showed the nurse was called to Resident #94's room. Resident #94 was found lying on the floor and stated she was trying to go</p> | F 157 | <p>24 hour nursing reports will be reviewed by the Interdisciplinary Team Monday – Friday during morning clinical meeting. Audits of Notification of Responsible Party will be completed by the Director of Nursing or Charge Nurse five times per week x 1 month, then once per week x 2 months to ensure compliance.</p> <p>Results of the audit will be forwarded to the QA Committee for review and recommendations monthly x 3 months.</p> | |

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| NAME OF PROVIDER OR SUPPLIER SOUTH VILLAGE | STREET ADDRESS, CITY, STATE, ZIP CODE 2221 RALEIGH ROAD ROCKY MOUNT, NC 27803 |
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| F 157 | <p>Continued From page 2</p> <p>get some water. The over bed table had cups of fluid and a water pitcher and was within reach of Resident #94 while she had been in bed. The physician was notified and an order to send Resident #94 to the Emergency Department was received. A call was placed to Resident #94's RP and a voice mail message was left.</p> <p>A review of the Physician's Telephone Orders dated 11/18/11 instructed the facility to send Resident #94 to the ER (Emergency Room) for a complaint of left hip pain following a fall.</p> <p>A review of the Nurses Notes dated 1/19/11 at 4:20 AM indicated that an x-ray of the left hip was negative and Resident #94 was ready to go back to the facility.</p> <p>A review of the Nurses Notes dated 11/19/11 at 5:00 AM showed that Resident #94 returned to the facility and complained of pain. Resident #94 received pain medication as ordered by the physician.</p> <p>A review of the 24 Hour Report for 11/19/11 and 11/20/11 did not mention that notification of Resident #94's RP had been done only by voicemail and needed to be followed up.</p> <p>In an interview on 4/18/12 at 11:00 AM with Resident #94, she indicated that neither she nor her spouse were aware she had been sent to the hospital until they received a bill for transport and an x-ray. She stated she did not even know if there was documentation in the nursing notes. She stated she was "doped" up and did not know what had happened.</p> | F 157 | <p>Licensed nurses were in-serviced on Responsible Party Notification of Changes in Condition by the Director of Nursing on 04/23/12. New hires will receive the in-service during orientation by the Assistant Director of Nursing.</p> | |
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| F 157 | <p>Continued From page 3</p> <p>In an interview on 4/18/12 at 1:10 PM with the Director of Nursing (DON), she indicated that when notification needed to be made it was her expectation that nursing staff speak to the RP. She stated that leaving a voice mail message was not good enough. She indicated that the nurse who had originally left the voice mail message was no longer employed at the facility.</p> <p>In an interview on 4/18/12 at 3:15 PM with Nurse #1, she stated that she could not remember if she had spoken to Resident #94's RP. She indicated that since Resident #94 was already back in the facility when she came on shift she would have thought that it had already been done.</p> <p>In an interview on 4/18/12 at 4:40 PM with Nurse #2, she indicated that if a voice mail message was left for a RP when a resident was sent to the hospital then the nurse should attempt to reach the second contact listed. If no contact person could be reached the nurse should put the information on the 24 Hour Report and let the incoming nurse know so contact could be made.</p> <p>In an interview on 4/19/12 at 9:35 AM with Nurse #3, she stated that when a resident was sent to the hospital the physician and the Power of Attorney (POA) needed to be notified. If a message was left and the contact did not call back the nurse should keep calling. The nurse could also call the second contact. The nurse should keep calling until she was actually able to speak to someone.</p> <p>In an interview on 4/19/12 at 10:35 AM with Nurse #4, she indicated that it was not enough to just leave a message when a resident was sent to the</p> | F 157 | | |

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| F 157 | Continued From page 4 hospital. The nurse should pass it on in report and put it on the 24 hour report. She indicated that as the oncoming nurse, she did not remember being told that Resident #94's RP had not been notified of her trip to the hospital. | F 157 | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345137 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____ | <div style="border: 1px solid black; padding: 2px;"> DECLINED JUN 06 2012 05/17/2012 (X3) DATE SURVEY COMPLETED </div> |
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| NAME OF PROVIDER OR SUPPLIER SOUTH VILLAGE | STREET ADDRESS, CITY, STATE, ZIP CODE 2221 RALEIGH ROAD ROCKY MOUNT, NC 27803 | CONSTRUCTION SECTION |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| K 012 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: A. Based on observation on 05/17/2012 there was a hole in the ceiling of the old laundry (South Hall)around the sprinkler piping. 42 CFR 483.70 (a) | K 012 | <u>K 012</u> The hole in the ceiling of the old laundry was filled with fire rated foam by the Plant Operations Manager on 06/01/12. The Plants Operation Manager will monitor for holes during weekly rounds for 3 months. Any holes identified to require repair will be done at that time by the Plant Operations Manager. This weekly report will be brought to the monthly QA meeting for 3 months by the Plant Operations Manager. | 6/1/12 |
| K 018 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. | K 018 | <u>K 018</u> The door to the TV room has been adjusted to latch when closed. The Plants Operation Manager will monitor for doors latching and closing during weekly rounds for 3 months. Any doors identified to require repair to close and latch will be done at that time by the Plant Operations Manager. This weekly report will be brought to the monthly QA meeting for 3 months by the Plant Operations Manager. The privacy curtain tracks on the West Hall have been adjusted to allow corridor doors to close and latch. The Plants Operation Manager will monitor privacy curtains preventing doors from latching and closing during weekly rounds for 3 months. | 7/1/12 |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>David D. Harrington</i> | TITLE <i>Administrative</i> | (X6) DATE <i>6/4/12</i> |
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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.

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| NAME OF PROVIDER OR SUPPLIER SOUTH VILLAGE | STREET ADDRESS, CITY, STATE, ZIP CODE 2221 RALEIGH ROAD ROCKY MOUNT, NC 27803 |
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| K 018 | Continued From page 1 This STANDARD is not met as evidenced by: A. Based on observation on 05/17/2012 the door to the TV room (Blue Room) failed to latch when closed. B. Based on observation on 05/17/2012 there were rooms on the West Hall that the privacy curtains prevented the corridor doors from closing and latching 42 CFR 483.70 (a) | K 018 | Any privacy curtain tracks identified to require repair to allow doors corridor doors to close and latch will be done at that time by the Plant Operations Manager. This weekly report will be brought to the monthly QA meeting for 3 months by the Plant Operations Manager. | |
| K 038 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 | K 038 | K038 Door knobs to the Housekeeping Closet, Outside Storage Room and the two(2) corridor doors to the Activity Room have been replaced with knobs that require one motion of the hand to the exit the room/door. The Plants Operation Manager will monitor knobs for one motion of the hand to exit the room/door during weekly rounds for 3 months. Any knobs identified to require replacement to allow one motion of the hand to exit the room/door will be replaced at that time by the Plant Operations Manager. | 6/15/12 |
| K 061 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1 This STANDARD is not met as evidenced by: | K 061 | This weekly report will be brought to the monthly QA meeting for 3 months by the Plant Operations Manager. | |

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|--------------------|--|---------------|---|----------------------|
| K 061 | Continued From page 2 A. Based on observation on 05/17/2012 the valves on the back-flow device in the old laundry were not electrically supervised. 42 CFR 483.70 (a). | K 061 | <u>K061</u> A licensed contractor has repaired the valve on the back flow device in the old laundry area to provide electronic supervision of the valve. | 05/18/12 |
| K 147 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: A. Based on observation on 05/17/2012 there were incandescent light bulbs with no covers in the House-keeping closet and the outside storage room off the kitchen. 43 CFR 483.70 (a) | K 147 | Plant Operations Director will monitor the device weekly X 3 months. Results of this inspection will be presented to the monthly safety meeting and reviewed monthly at the QA Committee Meeting for the next 3 months. <u>K147</u> Covers on the incandescent light bulbs in the housekeeping closet and outside storage area have been replaced by the Plant Operations Manager. The Plant Operations Manager will monitor light covers during weekly rounds Any light covers identified to require replacement will be replaced at that time by the Plant Operations Manager. This weekly report will be brought to the monthly QA meeting for 3 months by the Plant Operations Manager. | 05/18/12 |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

RECEIVED
JUN 18 2012
CONSTRUCTION SECTION
PRINTED: 05/22/2012
FORM APPROVED
OMB NO. 0938-0391
(X3) DATE SURVEY COMPLETED
05/17/2012

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345137 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B WING _____ |
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| NAME OF PROVIDER OR SUPPLIER SOUTH VILLAGE | STREET ADDRESS, CITY, STATE, ZIP CODE 2221 RALEIGH ROAD ROCKY MOUNT, NC 27803 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| K 029 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 | K 029 | <u>K029</u> A closure has been installed on the Central Supply Door by the Plant Operations Manager. Any doors identified during weekly rounds to require closures will be replaced at that time by the Plant Operations Manager. This weekly report will be brought to the monthly QA meeting for 3 months by the Plant Operations Manager. | 6/15/12 |
| K 038 SS=D | This STANDARD is not met as evidenced by: A. Based on observation on 05/17/2012 the door to the Central Supply did not have a closer on it. 42 CFR 493.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 | K 038 | <u>K038</u> Door knobs to the Housekeeping Closer, Outside Storage Room and the two(2) corridor doors to the Activity Room have been replaced with knobs that require one motion of the hand to the exit the room/door. The Plants Operation Manager will monitor knobs for one motion of the hand to exit the room/door during weekly rounds for 3 months. Any knobs identified to require replacement to allow one motion of the hand to exit the room/door will be replaced at that time by the Plant Operations Manager. | 6/15/12 |
| K 062 SS=D | This STANDARD is not met as evidenced by: A. Based on observation on 05/17/2012 the two (2) corridor doors for the Annex Dining room require more than one motion of the hand to exit the door. 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD | K 062 | <u>K062</u> This weekly report will be brought to the monthly QA meeting for 3 months by the Plant Operations Manager. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Administrator* (X6) DATE: *6/18/12*

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/201
FORM APPROVE
OMB NO. 0938-039

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345137 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____ | (X3) DATE SURVEY COMPLETED 05/17/2012 |
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| NAME OF PROVIDER OR SUPPLIER SOUTH VILLAGE | STREET ADDRESS, CITY, STATE, ZIP CODE 2221 RALEIGH ROAD ROCKY MOUNT, NC 27803 |
|---|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|--|---------------|---|----------------------|
|--------------------|--|---------------|---|----------------------|

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|---------------|---|-------|---|---------|
| K 029 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 | K 029 | <u>K029</u> A closure has been installed on the Central Supply Door by the Plant Operations Manager. Any doors identified during weekly rounds to require closures will be replaced at that time by the Plant Operations Manager. This weekly report will be brought to the monthly QA meeting for 3 months by the Plant Operations Manager. | 6/15/12 |
| K 038 SS=D | This STANDARD is not met as evidenced by: A. Based on observation on 05/17/2012 the door to the Central Supply did not have a closer on it. 42 CFR 493.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 | K 038 | <u>K038</u> Door knobs to the Housekeeping Closet, Outside Storage Room and the two(2) corridor doors to the Activity Room have been replaced with knobs that require one motion of the hand to the exit the room/door. The Plants Operation Manager will monitor knobs for one motion of the hand to exit the room/door during weekly rounds for 3 months. Any knobs identified to require replacement to allow one motion of the hand to exit the room/door will be replaced at that time by the Plant Operations Manager. | 6/15/12 |
| K 062 SS=D | This STANDARD is not met as evidenced by: A. Based on observation on 05/17/2012 the two (2) corridor doors for the Annex Dining room require more than one motion of the hand to exit the door. 42 CFR 483.70 (a) NFPA 101 LIFE SAFETY CODE STANDARD | K 062 | This weekly report will be brought to the monthly QA meeting for 3 months by the Plant Operations Manager. | |

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

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.

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OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345137 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____ | (X3) DATE SURVEY COMPLETED 05/17/2012 |
|---|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER SOUTH VILLAGE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2221 RALEIGH ROAD ROCKY MOUNT, NC 27803 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| K 062 | Continued From page 1 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: A .Based on observation on 05/17/2012 there was no high and low air pressure alarm switch on the dry sprinkler system. 42 CFR 483.70 (a) | K 062 | <u>K062</u> A high low pressure alarm switch has been installed on the dry sprinkler system by a qualified contractor. Plant Operations Director will monitor the device weekly X 3 months. Results of this inspection will be presented to the monthly safety meeting and reviewed monthly at the QA Committee Meeting for the next 3 months. | 6/15/12 |