

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

PRINTED: 04/13/2015
FORM APPROVED
OMB NO. 0938-0391

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 03/26/2015
NAME OF PROVIDER OR SUPPLIER SOUTH VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2221 WEST RALEIGH BOULEVARD 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	
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff and resident interviews, the facility failed to maintain the dignity of residents requiring assistance with eating by preventing staff from calling residents "feeders" during 2 of 7 dining observations.</p> <p>Findings included:</p> <p>Review of facility records revealed that a dignity in-service was conducted in December 2014 and included resident rights, abuse reporting, and dignity concerns including topics around providing feeding assistance.</p> <p>On 3/23/2015 at 1:06 PM, NA# 1 was observed telling a resident that he could not enter the dining room on the West 1 hall because the "feeders" were in the dining room being fed.</p> <p>On 3/23/2015 at 1:10 PM, NA # 1 was observed telling another resident that she also could not enter the dining room on the West 1 hall because there was no room yet due to staff feeding the "feeders".</p> <p>On 3/24/2015 at 6:15 PM, NA #2 was in Resident #125's room, at her bedside, assisting her with her dinner meal and stated that resident was able</p>	F 241	<p>South Village Health and Rehab requests to have this Plan of Correction serve as our written allegation of compliance. Our alleged date of compliance is 04/10/15. Preparation and/or execution of this plan of correction does not constitute admission to or agreement with either the existence of, or scope and severity of any cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed to ensure continuing compliance with Federal and State regulatory law. Corrective Action for those resident(s) found to have been affected: NA #1 was not identified and NA #2 was in-serviced by the Social Worker on 3/28/15 regarding maintaining residents' dignity when interacting with them in a manner to enhance their self-esteem and self-worth. The in-service included terms related to the language of culture change. Corrective Action for those resident(s) having the potential to be affected: The Social Worker was in-serviced by the Administrator on 3/26/15 regarding maintaining residents' dignity when interacting with them in a manner to enhance their self-esteem and self-worth.</p>	4/10/15	

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

TITLE

(X6) DATE

Electronically Signed

04/10/2015

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 241	Continued From page 1 to feed herself, but she used to be a "feeder". On 3/26/2015 at 3:10 PM, the facility social worker stated that she conducted an in-service in December 2014 in which she discussed all areas concerning dignity including resident rights, abuse, feeding, and keeping residents clean. She reported that while discussing feeding, she discussed making sure to sit with the "feeders" instead of standing over them and being patient with them and providing assistance as needed, allowing the "feeders" to do as much as they could on their own. When asked if residents were supposed to be referred to as "feeders", the social worker stated she understood that residents should not be referred to as feeders and would not expect staff members to refer to them as such. She stated that she would do an in-service immediately to make sure all staff was aware. On 3/26/15 at 3:45 PM, the facility administrator stated that she would not expect staff to call residents "feeders".	F 241	The in-service included terms related to the language of culture change. All facility staff regardless of position or title were in-serviced by the Social Worker on dignity to include staff interaction with residents in a manner to enhance their self-esteem and self-worth to include speaking to residents respectfully on 03/26/15. The in-service included terms related to the language of culture change. Systemic Change: Staff interaction with residents in a manner to enhance their self-esteem and self-worth to include speaking to residents respectfully including terms related to the language of culture change was added to the staff orientation agenda and the Social Worker will rein-service at least annually. Monitoring: The Social Worker will randomly conduct dignity audits/quizzes to include use of respectful resident labels with all departments weekly x 2 months. The Social Worker will present the results of those audits to the Quality Assurance Performance Improvement (QAPI) Committee monthly for review and recommendations for two months. All corrective action will be completed on or before 04/10/15.		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater.	F 332		4/10/15	

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F 332	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interview, the facility failed to maintain a medication error rate less than 5%. Two errors were detected in 30 opportunities for error, resulting in a 6.67% medication error rate on 1 of 4 Residents (Resident #28)</p> <p>Findings included:</p> <p>Record Review of Resident #28 revealed an admission date of 07/01/11 with diagnoses of hypertension (high blood pressure), diabetes mellitus, hyperlipidemia (high cholesterol) and cerebrovascular accident with hemiparesis (stroke).</p> <p>Review of the Medication Administration Record (MAR) and medical record for Resident #28 revealed physician orders to receive Lantus insulin 50 units subcutaneously twice a day and Humalog Insulin 15 units subcutaneously three times a day with meals.</p> <p>Observation of Nurse #1 during medication administration pass on 03/24/15 at 4:49 PM revealed that neither the ordered Lantus Insulin nor the Humalog Insulin were administered to Resident #28 .</p> <p>During staff interview with Nurse #1 on 03/24/15 at 5:20 PM the nurse stated, "I missed that order, I will track him down now and give it to him."</p>	F 332	<p>Corrective Action for those resident(s) found to have been affected: Nurse # 1 was retrained on the facility Medication Administration policy to include rechecking MAR to ensure all medications are administered and documented on 03/31/15 by the Assistant Director of Nursing. Nurse #1 completed a Med Pass Observation utilizing a Medication Administration Audit Tool by the Assistant Director of Nursing on 04/01/15.</p> <p>Corrective Action for those resident(s) having the potential to be affected: All other licensed staff/med aides were in-serviced by the Assistant Director of Nursing on 03/30/15 regarding the facility Medication Administration policy to include rechecking MAR to ensure all medications are administered and documented. Licensed Nurses have completed a Med Pass Observation by the Assistant Director of Nursing or Pharmacy Consultant utilizing the Medication Administration Audit Tool.</p> <p>Systemic Change: All new hire licensed staff/med aides will receive the in-service regarding the facility Medication Administration Policy and will be observed utilizing the Medication Pass Audit Tool during orientation. A Med Pass Observation by the Assistant Director of Nursing or Pharmacy Consultant utilizing the Medication Administration Audit Tool will be completed annually on all licensed nurses/med aides.</p> <p>Monitoring: The Director of Nursing/Assistant Director</p>		

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F 332	Continued From page 3	F 332	of Nursing or Pharmacy Consultant will complete random Medication Pass Audits one time per week per shift for three months. The Director of Nursing will present the results of those audits to the QAPI committee monthly for review and recommendations for three months. All corrective action will be completed on or before 04/10/15.		
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, service representative interview, and staff interview the facility failed to use effective strips to judge whether the sanitizing solution feeding into the dish machine was at the strength required by the manufacturer. The facility also failed to use good sanitation practices during the preparation of foods as evidenced by failure to sanitize food preparation surfaces before placing cooking utensils on them, failure to sanitize dirty and dusty lids of canned goods before opening them with a can opener, and failure to discard cooked chicken which was	F 371	Corrective Action for those resident(s) found to have been affected: The Dish Machine Service Representative was contacted by the Certified Dietary Manager (CDM) and he checked the dish machine on 3/26/15 to ensure the sanitizer dispenser was working properly. The dish machine service representative determined the test strips were not adequately testing sanitizer due to storing on top of the dish machine, the strips were replaced at that time and are now	4/10/15	

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F 371	<p>Continued From page 4</p> <p>contaminated by an oven mit. The facility also failed to discard abraded coffee mugs and de-stain coffee mugs which were discolored dark brown inside. Findings included:</p> <p>1. Between 9:18 AM and 9:32 AM on 03/25/15 six racks of kitchenware were run through the low-temperature dish machine. Very small drops of sanitizing solution were observed being dispensed when the sanitizer was activated during the final rinse cycle.</p> <p>At 9:32 AM on 03/25/15 a strip used to check the strength of the sanitizing solution feeding into the low temperature dish machine registered only 0 -10 parts per million (PPM) of hypochlorite. At this time the dietary manager (DM) stated the dietary employee running the dish machine may should have primed the sanitizer dispenser more before running breakfast kitchenware through the dish machine. The employee running the dish machine stated the last time he tested the dish machine sanitizer with a strip was around 7:00 AM on 03/25/15, and at that time the strip registered 100 PPM hypochlorite.</p> <p>At 9:38 AM on 03/25/15 a strip was used to check the strength of the sanitizing solution feeding into the dish machine after multiple attempts to prime the sanitizing dispenser, but the strip still registered 0 - 10 PPM hypochlorite.</p> <p>Between 9:47 AM and 9:57 AM on 03/25/15 the facility ran kitchenware through the dish machine while strips used during each cycle registered 50 PPM hypochlorite.</p> <p>At 3:57 PM on 03/25/15 the DM stated the dietary staff had been in-serviced to use a testing strip in</p>	F 371	<p>being stored in a plastic storage container away from the dish machine to avoid moisture. The facility Maintenance Director replaced dish machine tubing and primed machine on 03/27/15.</p> <p>The AM cook sanitized the food preparation work table on 3/25/15 after the deficient sanitary practice was brought to her attention by the surveyor. The can of diced pimentos was discarded on 3/25/15 by the AM cook after the dirty lid was brought to her attention by the surveyor. The section of contaminated chicken was discarded and the contaminated oven mitt was removed from service for washing by the AM cook on 3/25/15 after it was brought to her attention by the surveyor. The abraded coffee mugs were removed from service by the CDM on 3/25/15 after they were brought to her attention by the surveyor. Replacement coffee mugs were ordered by the CDM on 3/23/15 and were placed into service after they arrived on 4/2/15 The AM cook was in-serviced by the CDM regarding proper sanitation practices on 3/25/15.</p> <p>Corrective Action for those resident(s) having the potential to be affected: All dietary staff were in-serviced on the facility 1) Sanitation; 2) Food Preparation and Service and 3) Refrigerators and Freezer policies by the Dietary Manager on 03/25/15. The training included 1) sanitizing table top and food prep services after removing boxes or other materials from the surface; 2) cleaning can lids of dust/debris before proceeding to the can opener; 3) discarding any food that may</p>		

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F 371	<p>Continued From page 5</p> <p>the dish machine sanitizer as kitchenware first began being run through at each meal and between each meal cart thereafter. She reported she had not been made aware of any prior problems with the dish machine sanitizer, and commented a service representative replaced tubing on the dish machine two or three weeks ago.</p> <p>At 9:45 AM on 03/26/15 the dish machine service representative stated he thought the strips the facility were using were compromised, and might not be reading correctly. He stated it was probably not the best practice to store the bottle of strips on the top of the dish machine where the heat and moisture could affect reliability of readings.</p> <p>2. a. At 9:28 AM on 03/25/15 the AM cook placed a box containing frozen diced chicken on the food preparation table. She did not sanitize the work table after removing the box.</p> <p>At 9:40 AM on 03/25/15 the AM cook placed a box containing frozen meatballs on the food preparation table. She did not sanitize the work table after removing the box.</p> <p>At 9:48 AM on 03/25/15 the cook placed a scoop on the food preparation table where the boxes had been sitting.</p> <p>At 9:54 AM on 03/25/15 the cook picked up the scoop from the preparation table and was going into a box to retrieve rice before surveyor intervention.</p> <p>At 3:50 PM on 03/25/15 the PM cook stated between food preparation tasks she washed and</p>	F 371	<p>come in contact with any materials (to include oven mitts); 4) process for de-staining mugs/glasses/plates/utensils and discarding any kitchenware that cannot be de-stained; and 5) the facility policy for Dishwashing Machine Use and ware washing to include checking and recording sanitizing solution strength prior to washing. All new hires will receive the in-service during orientation.</p> <p>Systemic Change: The dietary aide will record sanitizer strength prior to each operation of the dishwasher utilizing the Dishwashing Temperature/Sanitizer Record. Kitchen ware will be inspected daily for damage prior to use, and damaged kitchen ware will be given to the CDM for reorder. All new hires will receive the in-service during orientation.</p> <p>Monitoring: The Dietary Manager will conduct random Sanitation Round Audits and kitchen ware inspections 3 x weekly for 3 months. Results will be forwarded to the QAPI committee for review and recommendations monthly x 3 month</p>		

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F 371	<p>Continued From page 6</p> <p>then sanitized the food preparation table. She reported she utilized a quaternary sanitizing solution kept in a red bucket. She commented boxes which were sat on food preparation surfaces would contaminate them because those boxes had been in trucks and storage areas. According to the PM cook, food preparation surfaces were supposed to be sanitized as soon as boxes were removed from them.</p> <p>At 3:57 PM on 03/25/15 the dietary manager (DM) stated dietary staff washed and sanitized tables between food preparation tasks. She reported boxes were not supposed to be set on food preparation tables, but if by chance they were, the tables were to be sanitized as soon as the boxes were removed.</p> <p>2. b. At 9:57 AM on 03/25/15 a can of diced pimentos was observed on a cart wheeled into the food preparation area. The can lid was dusty and had small bits of food debris on it.</p> <p>At 10:31 AM on 03/25/15 the AM cook opened the can of diced pimentos without wiping off the lid first. The lid became covered in liquid from inside the can, and the lid sank down into the food product. The cook commented she was going to add the pimentos to her cooked squash.</p> <p>At 3:50 PM on 03/25/15 the PM cook stated dietary staff were in-serviced to wash off the lids of canned goods before opening them.</p> <p>At 3:57 PM on 03/25/15 the dietary manager (DM) stated dietary staff were trained to wipe off the lids of canned goods with quaternary sanitizer before opening them with a can opener.</p>	F 371			

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F 371	<p>Continued From page 7</p> <p>2. c. At 10:12 AM on 03/25/15 the AM cook was removing a large baking pan of baked chicken from the stove using a set of oven mits. The pan slipped, and the cook placed one mit under the pan and another mit on chicken in the pan to keep the food from hitting the floor. The oven mit which made contact with the chicken was covered with juice and crushed cereal coating.</p> <p>At 10:22 AM on 03/25/15 the AM cook was using tongs to remove baked chicken from three baking pans and placing the chicken in a large tray pan. The cook placed tongs on a piece of chicken which came into contact with the oven mit. After surveyor intervention, the section of contaminated chicken on the baking pan was disposed of.</p> <p>At 3:50 PM on 03/25/15 the PM cook stated she threw away any food which came into contact with contaminated surfaces. She reported she would consider oven mits to be contaminated.</p> <p>At 3:57 PM on 03/25/15 the dietary manager (DM) stated dietary staff were trained to throw away contaminated foods. She reported food would be contaminated if it made contact with oven mits.</p> <p>3. During inspection of kitchenware, beginning at 11:32 AM on 03/25/15, 14 of 32 coffee mugs were compromised, either being abraded inside or having a build of dark brown matter inside. At this time the dietary manager (DM) stated she had new mugs on order.</p> <p>At 3:50 PM on 03/25/15 the PM cook stated damaged kitchenware was to be placed in the DM's office so she could count it, re-order, and discard the damaged pieces. She reported</p>	F 371			

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F 371	Continued From page 8 stained kitchenware was scrubbed out using a scrub pad three times weekly. At 3:57 PM on 03/25/15 the DM sated the dietary staff was supposed to give her chipped, cracked, abraded kitchenware so she could take it out of stock and re-order replacements. She reported some kitchenware was de-stained in a bleach solution weekly.	F 371			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (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	F 441		4/10/15	

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F 441	<p>Continued From page 9</p> <p>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 interviews, the facility failed to follow standard precautions during the administration of eye drops for 1 of 1 residents (#39).</p> <p>Findings Included:</p> <p>Review of the facility's policy and procedure for administering eye drops dated January 2014 revealed in the "Steps in the Procedure" section to "put on gloves" and to "gently dry eye lid with tissue if dripping occurs (Note: Use only one tissue per wipe)."</p> <p>A review of the medical record on 03/25/15 revealed Resident #39 was admitted on 02/05/08 with diagnoses that included acute myocardial infarction (heart attack), cerebrovascular accident (stroke), chronic obstructive pulmonary disease, and diabetes mellitis.</p> <p>An observation was conducted on 03/25/15 at 10:22 AM of Medical Assistant #1 during a medication administration pass on South Hall. Medical Assistant #1 administered 1 drop of Patanol 0.1% (used to treat seasonal allergic</p>	F 441	<p>Corrective Action for those resident(s) found to have been affected: Med Aide # 1 was retrained on the facility policy for installation of eye drops to include wearing of gloves and use of one tissue per wipe on 03/25/15 by the Assistant Director of Nursing. She was observed for proper technique of the installation of eye drops utilizing an Eye Drop Administration Audit Tool by for the Assistant Director of Nursing on 04/01/15.</p> <p>Corrective Action for those resident(s) having the potential to be affected: All other licensed staff/med aides were in-serviced by the Assistant Director of Nursing on 03/25/15 regarding the facility policy for installation of eye drops and infection control practice in medication administration to include wearing of gloves and use of one tissue per wipe. Licensed Nurses and Medication Aides have been observed by the Assistant Director of Nursing or Pharmacy Consultant for the proper technique of installation of eye drops utilizing the Eye Drop Administration Tool. All new hire</p>		

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NAME OF PROVIDER OR SUPPLIER SOUTH VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2221 WEST RALEIGH BOULEVARD ROCKY MOUNT, NC 27803		
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F 441	<p>Continued From page 10</p> <p>conjunctivitis) eye drops into each of Resident #39's eyes without applying gloves. After the administration of the eye drops Medical Assistant #1 used 1 tissue to wipe both of Resident #39's eyes.</p> <p>An interview on 03/25/15 at 11:06 AM with Medical Assistant #1 revealed that she was not aware of the facility policy or facility procedure regarding the administration of eye drops.</p> <p>An interview on 03/25/15 at 12:30 PM with the Director of Nursing (DON) revealed that there was a policy and procedure in place for administering eye drops. The DON stated that the Medical Assistant should have followed the policy and procedure.</p>	F 441	<p>licensed staff/med aides will receive the in-service and will be observed for proper technique to include wearing of gloves and use of one tissue per wipe during orientation</p> <p>Systemic Change: All new hire licensed staff/med aides will receive the in-service regarding infection control practice in medication administration and will be observed for proper technique to include wearing of gloves and use of one tissue per wipe during orientation and will be observed at least annually thereafter.</p> <p>Monitoring: The Director of Nursing/Assistant Director of Nursing or Pharmacy Consultant will complete random Installation of Eye Drops and Infection Control Practice in Medication Administration Audits one time per week per shift for three months. The Director of Nursing will present the results of those audits to the QAPI Committee monthly for review and recommendations for three months. All corrective action will be completed on or before 04/10/15.</p>		