STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345242	A. BUILDING _____ B. WING _____	C 04/13/2011

APR 28 2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT THE ALBEMARLE	200 TRADE STREET TARBORO, NC 27886

(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 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to care plan behaviors for 2 of 15 sampled residents (Residents # 13 & # 50) whose care plans were reviewed. Findings include: 1. Resident # 13 was admitted to the facility on 03/24/11 with cumulative diagnoses of fracture of the left hip with open reduction - internal fixation, anemia, and cerebrovascular disease. On 03/21/11, a hospital physician's progress note listed 11 diagnoses. Anxiety was not one of the	F 279	1) Care Plan for resident #13 will be reviewed for completeness by MDS coordinator to include missing anxiety diagnosis and to include appropriate interventions specific to resident by 4/29/11. Resident #50 has been discharged from the community. 2) We will review all residents receiving antipsychotics/antianxiety medications to ensure care plan reflects correct individualized interventions to provide appropriate care of residents by 5/6/2011. (See F 323 #3 Plan for the in-depth care plan action plan)	5/10/11 per phone conversation CDON on 5/6/11 @ 11:52AM DByant

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Diane Barlow	Executive Director	4/27/2011

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 279	Continued From page 1 diagnosis. A Hospital Consultation Report, dated 03/21/11, indicated Resident # 13 had a past medical history that included anxiety. On 03/24/11, a hand written physician's prescription was received for Ativan (a medication used to treat anxiety) 0.5 milligrams (mg) twice daily as needed for anxiety. The order was transcribed on the facility admission orders as a scheduled medication to be received twice daily. The Nursing Admission Data Collection Assessment, dated 03/24/11, indicated the resident had clear speech and was able to understand and to be understood. Resident # 13 was identified as having a medication regimen that included antipsychotics and antianxiety medication. Mood and behavior were not addressed on the assessment. Skilled nursing progress notes from 03/24/11 through 04/11/11 were reviewed. There was no indication the resident had periods of anxiety. There was no care plan developed for anxiety or the use of the medication. The Initial Activity Progress Note, dated 03/25/11, indicated the resident was pleasant and oriented. The Social Service Data Collection, dated 03/25/11, indicated NO for Depression/Anxiety/Sad. Resident # 13 was identified as having an unsettled relationship. There was no care plan developed for the potential for anxiety associated with that unsettled relationship or the use of the scheduled antianxiety medication.	F 279	3) In-service is planned for 5/5/2011 for nurses to cover appropriate documentation of all PRN medications to include rationale for use and follow up to document effectiveness. In-service noted above will address inconsistencies in documentation related to rationale and effectiveness. MDS/ADON and DON will review monthly each MAR to ensure compliance with standard is being met and will provide counseling to any nurse not meeting standards By 5/9/2011. 4) The monthly review of the MAR will be sent to the QI committee for review and evaluation monthly. The DON is responsible by 5/19/2011 (QI Meetings are held on third Thursday of each month)	

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F 279	Continued From page 2 An interview was held with the Assistant Director of Nursing (ADON) on 04/13/11 at 11:09 AM. She stated if a resident received antianxiety medications, she would expect to see the anxiety and interventions for the anxiety care planned. An interview was held with the Director of Nursing (DON) on 04/13/11 at 11:51 AM. The DON stated the use of psychotropic medications and behaviors, such as anxiety, should be care planned. The DON reviewed the care plan for Resident # 13 and acknowledged her anxiety had not been addressed. An interview was held with the Minimum Data Set Coordinator on 04/13/11 at 3:23 PM. He stated care plans were updated quarterly, weekly when doctor's orders were reviewed or as changes occurred. The coordinator stated anxiety should have been care planned for Resident # 13, adding the omission was an oversight. 2. Resident # 50 was admitted on 01/21/11 with cumulative diagnoses of osteoarthritis with a right total knee replacement and depression. The Hospital Discharge Summary, dated 01/21/11, indicated Alprazolam (the generic name for Xanax which is an antianxiety medication) was a current medication. The Hospital Medication Administration Record (MAR) indicated the resident had received Xanax 0.25 milligrams (mg) twice daily as needed for anxiety. Resident # 50's Admission Minimum Data Set (MDS) Assessment, dated 01/28/11, indicated she was cognitively intact with the ability to be understood and to make herself understood. The	F 279		

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F 279	Continued From page 3 MDS indicated the resident had no signs of delirium, no moods, no psychosis and no behavior symptoms. Active diagnoses did not include anxiety. The MDS did indicate an antianxiety agent had been received by Resident # 50 during the assessment period. There was no care plan developed for the use of the antianxiety agent. February 2011 Physician orders included Xanax 0.25 mg twice daily as needed for anxiety. There was no care plan developed for Resident # 50's anxiety. On 02/09/11 at 6:50 AM, the nurse documented in the Skilled Nursing Progress Note that Resident # 50 was confused and anxious. She was sent to the hospital for evaluation. At 12:30 PM, Resident # 50 returned to the facility. The nurse described her affect as flat with a depressed behavior. At 7:00 PM, a nurse documented the resident was very confused and anxious. The nurse stated the resident was screaming and yelling at the staff. Xanax was given. There was no care plan developed for the anxiety, screaming or yelling. The Skilled Nursing Progress Note, dated 02/11/11 at 8:00 PM, indicated the resident went out with the family for dinner. Xanax was given 1 time. Skilled Nursing Progress Notes, dated 02/13/11 at 8:15 AM, the resident was seen in the hallway asking for help and holding a brief in her hand. At 8:40 AM, the nurse documented increased agitation. Xanax was given at this time per the nurse's note. There was no indication the resident's anxiety had been care planned..	F 279		

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F 279	Continued From page 4 Resident # 50's care plan, dated 02/14/11, did not address interventions to decrease her anxiety. The Skilled Nursing Progress Note, dated 02/15/11 at 4:30 AM indicated the resident was confused and asking where she was. There was no care plan developed to address the resident's confusion and anxiety. At 12:30 PM on 02/1611, the nurse documented the resident was still presenting with periods of confusion and required constant redirection and orientation. The care plan did not indicate confusion, anxiety and frequent redirection had been addressed. Review of the February 2011 MAR indicated Resident # 50 received Xanax once on the 2nd, 3rd, 4th, 6th, 7th, 8th, 11th, 12th, and 13th, twice on the 1st, 5th, 9th and 10th . Six doses were recorded as given on the back of the MAR. Anxiety was listed as the reason with the results listed as effective. Anxiety was not added as a problem on Resident # 50's care plan. An interview was held with the Assistant Director of Nursing (ADON) on 04/13/11 at 11:09 AM. She stated if a resident received antianxiety medications, she would expect to see the anxiety and interventions for the anxiety care planned. An interview was held with the Director of Nursing (DON) on 04/13/11 at 11:51 AM. The DON stated the use of psychotropic medications and behaviors, such as anxiety, should be care planned. The DON reviewed the care plan for Resident # 50 and acknowledged her anxiety had not been addressed.	F 279		

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F 279	Continued From page 5 An interview was held with the Minimum Data Set Coordinator on 04/13/11 at 3:23 PM. He stated care plans were updated quarterly, weekly when doctor's orders were reviewed or as changes occurred. The coordinator stated anxiety should have been care planned for Resident # 50, adding the omission was an oversight.	F 279		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to place interventions in place to help prevent falls from the bed and chair for 1 of 3 sampled residents (Resident #15) with a history of falls. Findings include: Resident #15 was admitted to the facility on 12/09/09. The resident's documented diagnoses included osteoporosis, peripheral vascular disease, Alzheimer's disease, and dementia with psychosis. A Resident Incident Report documented Resident #15 was found on the floor on 08/06/10 at 5:40 PM. The resident told staff she was up cleaning and walking around the room (without asking for staff assistance) prior to her fall. The	F 323	1) Care plan for resident #15 has been reviewed on 4/15 for appropriate care planning documentation. Documentation of resident's failure with personal call alarm has been completed as well as determination that a bedside mat will be ineffective or even harmful because the resident does ambulate at night to the restroom and that the mat might cause harm. Negotiated risk agreement completed with the family 4/26/2011. Pad alarm ~~as~~ has been ordered on 4/26/2011 for resident #15 to provide notification of resident's attempt to get out of wheelchair without assistance. Low bed will continue to be utilized with resident.	

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F 323	Continued From page 6 documented action taken to prevent reoccurrence was advising the resident to ask for assistance when trying to ambulate. A 08/06/10 6:10 PM Progress Note documented Resident #15 was found lying on her left side, complaining of pain to her left hip, shoulder, and side of head. The resident was sent out to the emergency room, and x-rays documented the resident was negative for fractures. A 08/12/10 physician's progress note documented, "...At the time she stated that she (Resident #15) got out of the wheelchair without assistance to clean up her room and she was grimacing and holding her left hip (in reference to the resident's 08/06/10 fall)...." The resident's 12/12/10 Annual Minimum Data Set (MDS) documented her cognition was severely impaired, she exhibited no behaviors, she required extensive assistance from a staff member with transfers and bed mobility, and she had one fall with injury (not a major injury) since her prior assessment. The resident's 12/14/10 Falls Care Area Assessment (CAA) documented, "____ (resident's name) triggers for Falls CAA due to history of fall recently. She was found to have stood up from wheelchair and received a skin tear to her lt. (left) lower leg...It is unclear whether this was an actual fall but she is at risk due to her poor safety awareness and her ability to stand on her own...." A 12/24/10 5:40 AM Progress Note documented Resident #15 was found sitting on the floor beside her bed, and allowed the staff to assist her back	F 323	2) A thorough review of all at risk residents will be completed by 5/8/2011 by MDS coordinator to ensure appropriate devices are in use and that documentation of continued need for each device is noted. 3) All new residents admitted to the community as of 4/30/2011 will have their care plans reviewed in the next weekly risk meeting (held each Tuesday). Current resident care plans will be reviewed quarterly by multidisciplinary care plan team. A schedule to ensure this is met will be developed by the MDS coordinator by 4/30/2011.	

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F 323	Continued From page 7 to bed. A 02/06/11 9:10 PM Progress Note documented Resident #15 was found on the floor on her bottom. A Resident Incident Report documented on 02/06/11 at 9:10 PM Resident #15 was found on the floor by her roommate's bed. The resident stated she was trying to fix her pillow. The documented actions taken to prevent reoccurrence were placing the resident's bed in the low position, keeping the call light within reach, placing a personal alarm on the resident at all times, and putting a mat by the resident's bedside. A care plan in Resident #15's active medical record documented "hx/o (history of) falls with injury; has dx/o (diagnosis of) osteoporosis, confusion" as a problem, but the problem was undated. Interventions to this problem included "Bed in low position with floor mats beside bed-when ____ (resident's name) is in bed and unsupervised" and "Personal alarm at all times". The resident's 03/13/11 Quarterly MDS documented her cognition was severely impaired, she exhibited delusions/other behavioral symptoms directed toward others/rejection of care/daily wandering, required extensive assistance from a staff member with transfers and bed mobility, and had no falls since her prior assessment. The care plan generated by this 03/13/11 MDS assessment identified "Potential for falls r/t (in regard to) poor safety awareness, impulsive behavior" as a problem on 12/14/10. Interventions	F 323	MDS coordinator will review all orders at least 3 x weekly to ensure any new orders are reflected on care plan and appropriate triggers are responded to and that adjustments to the care plan are disseminated to the staff by placing current plan in care plan books at the time of adjustment by 4/25/2011. 4) The weekly review of all new orders will be sent to the QI committee for review and evaluation monthly. The DON is responsible by 5/19/2011 (Monthly QI committee meetings are third Thursday of each month)	

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F 323	Continued From page 8 to this problem included "bed in low position with floor mats beside bed". A 03/18/11 10:00 PM Progress Note documented Resident #15 sat on the floor while trying to get on the bed. A Resident Incident Report documented on 03/18/11 at 1:45 PM, "(Resident #15) was in w/c (wheelchair) in her room--and stated 'I decided to get up but only got this far.' Resident sitting on floor beside her bed." No actions taken to prevent reoccurrence were documented. At 10:39 AM on 04/11/11 Resident #15 was exhibiting paranoid behavior in the television room in the unit. The resident was in her wheelchair, but there was no alarm in use. At 1:53 PM on 04/12/12 Resident #15 was in her room in her wheelchair with the door partially closed. There was no alarm in use. At 5:10 PM on 04/12/12 Resident #15 was in her wheelchair in the hallway of the unit. There was no alarm in use. At 8:10 AM on 04/13/11, when the nurse opened the door to the resident's room, Resident #15 was still in bed. Her bed was in the lowest position, but there were no mats by her bedside. At 10:17 AM on 04/13/11 nursing assistant (NA) #2 stated Resident #15 was very confused, and required at least extensive assistance from staff in all her activities of daily living except eating. She reported the resident resisted care a couple of time a week, and had experienced some falls in the past. She commented Resident #15 tried	F 323		

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F 323	Continued From page 9 to rise out of her chair and bed unassisted some times, most often in the afternoons and evenings. According to NA #2, the resident had no fall interventions in place when in her wheelchair, and the only fall intervention the resident had when in the bed was lowering the bed to the lowest position. The NA reported Resident #15's roommate had mats down beside her bed at night, but mats were not used for Resident #15 herself. At 10:53 AM on 04/13/11 the assistant director of nursing (ADON) stated Resident #15 was at fall risk, probably experiencing at least a couple of falls in the past six to eight months. She commented the resident was confused, resisted care at times, tried to rise out of her chair and bed at times without assistance, and experienced some paranoia and agitation. The ADON reported frequent fall interventions which the facility utilized included personal clip alarms which could be used when residents were in chairs or their beds, lowering beds, mats by the bedsides, and rearrangement of furniture in resident rooms. The ADON stated she would have to look at Resident #15's medical record to remember what fall interventions were in place for this specific resident. At 12:23 PM on 04/13/11 Nurse #5 reported Resident #15 periodically tried to rise from both the bed and the chair during the day and the night. She stated Resident #15's bed was in the low position at night, but she had not seen any mats by the resident's bed. The nurse commented she thought Resident #15 had a personal alarm for a short time, but the facility stopped using it because the resident was taking it off and hiding it. According to Nurse #5,	F 323		

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F 323	Continued From page 10 Resident #15 did not have any fall interventions in place when up in her wheelchair, other than keeping the resident close to the nurse's station where she could be watched as much as possible. At 2:26 PM on 04/13/11 the director of nursing (DON) stated the facility tried to address fall risk using three main interventions which included low beds, bedside mats, and personal alarms. He reported Resident #15 was very confused, but ambulated with restorative. According to the Administrator, he commented he thought Resident #15 had a low bed with mats at night, but did not wear a personal alarm because she had not experienced any falls from her chair (although the resident's 08/12/10 MD progress note, 12/14/10 Falls CAA, and 03/18/11 Resident Incident Report document the resident had possible falls involving unassisted exits from her wheelchair). At 3:35 PM on 04/13/11 the ADON stated the facility was not currently using any pad alarms, but would consider doing so under the right conditions. She explained pad alarms might be ideal for confused residents who frequently removed their personal clip alarms. At 4:47 PM on 04/13/11 NA #3 stated Resident #15 got up from bed and her chair unassisted. She explained the resident frequently experienced sundowning symptoms such as agitation, paranoia, verbal abuse of the staff, and rising up out of the bed and chair unassisted. She reported Resident #15's bed was in the low position, but no bedside mats were used for the resident at night. According to this NA, Resident #15 currently had no fall interventions in place	F 323		

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F 323	Continued From page 11 when in her wheelchair. However, she reported she thought a personal alarm was tried on the resident a couple of months ago, but the resident kept taking it off. At 4:53 PM on 04/13/11 Nurse #4 stated Resident #15 sometimes resisted care, was verbally abusive, and exhibited agitation and paranoia. She reported she thought Resident #15 was supposed to have a personal alarm at all times, and have her bed in the lowest position with floor mats at night.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	1) Resident #13 now has order dated 4/13 for BID scheduled ativan. This will be reviewed for dosage adjustment by pharmacist on May 4th visit as noted above. 2) Pharmacist will review monthly the chart of each resident receiving antipsychotics or antianxiety medication to ensure appropriate documentation supports continued need or to determine if recommendation for dosage adjustment is warranted beginning on 5/4/2011 visit.	

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

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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
F 329	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to justify the use of an antianxiety agent for 1 of 7 sampled residents (Resident # 13) whose medications were reviewed. Findings include: Resident # 13 was admitted to the facility on 03/24/11 with cumulative diagnoses of fracture of the left hip open reduction - internal fixation, history of alcohol abuse, cerebrovascular disease, urinary tract infection and anxiety. On 03/21/11, a hospital physician's progress note listed 11 diagnoses. Anxiety was not one of the diagnosis. A Hospital History and Physical, dated 03/21/11, indicated Resident # 13 had a past medical history included alcohol abuse, but did not include anxiety. A Hospital Consultation Report, dated 03/21/11, indicated Resident # 13 had a past medical history that included anxiety. Present medications did not include Ativan (a medication used to treat anxiety). A hospital physician's progress note, dated 03/23/11, did not indicate the resident was anxious. The Hospital Medication Administration Record (MAR), dated 03/24/11, indicated Resident # 13 had received Ativan 0.5 mg twice daily as needed (PRN) for anxiety.	F 329	3) Nurses in-service will be held on 5/5/2011 to ensure nurses understand need to document both indication for PRN medication as well as its effects and any further care that was required if medication was not effective. 4) The monthly review of the pharmacist report will be presented to the QI committee for review and evaluation monthly. The Pharmacist is responsible 5/19/11 (Next scheduled QI MTG).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345242	A. BUILDING _____ B. WING _____	C 04/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT THE ALBEMARLE	200 TRADE STREET TARBORO, NC 27886

(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 329	Continued From page 13 The Hospital Discharge Summary, dated 03/24/11, did not include anxiety as a diagnosis. The discharge recommendations included an order for Ativan 0.5 milligrams (mg) twice daily for anxiety. On 03/24/11 a hand written physician's prescription was received for Ativan 0.5 mg twice daily PRN for anxiety. Facility admission orders, dated 03/24/11, indicated the resident received Ativan 0.5 mg twice daily scheduled at 9:00 AM and 8:00 PM. The Nursing Admission Data Collection Assessment, dated 03/24/11, indicated the resident had clear speech and was able to understand and to be understood. Resident # 13 was identified as having a medication regimen that included antipsychotics and antianxiety medication. Mood and behavior was not addressed on the assessment. Skilled nursing progress notes from 03/24/11 through 04/11/11 were reviewed. There was no indication the resident had periods of anxiety. Nurse's notes from 03/25/11 through 04/11/11, indicated Resident # 13 was happy and cooperative. There was no indication the resident had experienced periods of increased anxiety. The Initial Activity Progress Note, dated 03/25/11, indicated the resident was pleasant and oriented. The Social Service Data Collection for Resident # 13, dated 03/25/11, indicated NO for the category Depression/Anxiety/Sad.	F 329		

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THE FOUNTAINS AT THE ALBEMARLE	200 TRADE STREET TARBORO, NC 27886

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F 329	Continued From page 14 An observation was made of Resident # 13 on 04/12/11 during a resident interview. The resident presented as alert and oriented. She exhibited no symptoms of anxiety and reported no anxiety. An interview was held with Nurse # 3 on 04/12/11 at 4:57 PM. She stated she had never seen Resident # 13 agitated. The nurse stated on admission, orders are taken from the hospital discharge summary. The nurse that was assigned to the resident was responsible for transcribing admission orders. After the first nurse transcribed the orders, a second nurse checked for accuracy. Nurse # 3 stated that any medication with conflicting or contradictory information would be verified with the prescribing physician or the facility physician. The nurse stated resident behaviors were documented on behavior sheets that are kept in the front of the MAR or in nurse's notes. Behavior sheets are kept on anyone on any type of psychotropic medication. An interview was held with the Rehabilitation Director on 04/13/11 at 8:48 AM. Resident # 13 currently received therapy services. The Rehabilitation Director stated the resident was pleasant and had never been observed to be anxious or nervous. An interview was held with Nursing Assistant (NA) # 1 on 04/13/11 at 8:57 AM. The NA worked with Resident # 13 on the 7 to 3 shift. She stated the resident was not nervous, anxious, fidgety or exhibited any other types of behaviors. An interview was held with the Assistant Director of Nursing (ADON) on 04/13/11 at 11:09 AM.	F 329		

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	345242	A. BUILDING _____ B. WING _____	C 04/13/2011

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THE FOUNTAINS AT THE ALBEMARLE	200 TRADE STREET TARBORO, NC 27886

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F 329	Continued From page 15 The ADON stated the assigned nurse or administrative nurses were responsible for transcribing orders. The discharge summary was used for admission medications. Handwritten prescriptions are received from the physician for controlled medications. The ADON stated if the handwritten prescription and the discharge medication list contained conflicted or contradictory medication information, the staff nurse would be expected to call the discharge physician to clarify the medication order. The nurse would then write a clarification order for the medication. After review of the orders the ADON stated the Ativan order for Resident # 13 should have been clarified. The ADON stated she did not know of Resident # 13 exhibiting any behaviors. She stated the resident receiving Ativan twice daily when it had been ordered PRN meant Resident # 13 had received the Ativan unnecessarily. An interview was held with the Director of Nursing (DON) on 04/13/11 at 11:51 AM. The DON stated nurses were expected to document behaviors in the nurse's notes. The consultant pharmacist was expected to review the psychotropic medications on a monthly basis to make sure each medication was justified. The DON stated all residents on psychotropic medications were seen by the consultant psychiatric services to determine the appropriateness of psychotropic medications. On admission, the administrative nurses or the assigned nurse are responsible for transcribing orders to the MAR. Orders are written by one nurse and then double checked for accuracy by a second nurse. The DON stated medication orders are derived from hospital discharge summaries. If there is a discrepancy in a	F 329		

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	345242	A. BUILDING _____ B. WING _____	C 04/13/2011

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F 329	Continued From page 16 handwritten controlled medication prescription and the discharge summary, the expectation was for the nurse to call the discharging physician for clarification. If contact is not made with the prescribing physician, the DON stated he would defer to the handwritten prescription. The expectation would be for the nurse to write an order of clarification for the medication. The DON reviewed the resident's chart and stated the resident did receive the medication in error. He added the order for the Ativan should have been clarified with the prescribing physician. After review of nurse's notes, the DON stated Resident # 13 did not have any behaviors documented to justify the use of an antianxiety medication. A telephone interview was held with the consultant pharmacist on 04/13/11 at 3:53 PM. He stated when reviewing residents with psychotropic medications, including antianxiety agents, he would expect to see a behavioral care plan and target symptoms. If a PRN medication was given, he stated he would expect to see documentation to define if the anxiety was chronic or had environmental or physical causes. The pharmacist stated if he noted behaviors were not being documented, he would at first speak directly to the staff nurse. If the problem continued, he would document and arrange training with the DON. He stated if a resident was admitted with contradictory orders for a medication he would expect the admitting nurse to clarify the order.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0352	A. BUILDING _____ B. WING _____	04/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT THE ALBEMARLE	200 TRADE STREET TARBORO, NC 27886

(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) COMPLETE DATE
L 314	.2309 CARDIO-PULMONARY RESUSCITATION 0A NCAC 13D .2309 CARDIO-PULMONARY RESUSCITATION (a) Each facility shall develop and implement a Cardio-Pulmonary Resuscitation (CPR) policy. (b) The policy shall be communicated to all residents or their responsible party prior to admission. (c) Upon admission each resident or his or her responsible party must acknowledge in writing having received a copy of the policy. (d) The policy shall designate an outside emergency medical service provider to be immediately notified whenever an emergency occurs. (e) The policy shall designate the level of CPR that is available using terminology defined by the American Heart Association. American Heart Association terminology is as follows: (1) Heartsaver CPR; (2) Heartsaver Automatic External Defibrillator (AED); (3) Basic Life Support (BLS); or (4) Advanced Cardiac Life Support (ACLS). (f) The facility shall maintain staff on duty 24 hours a day trained by someone with valid certification from the American Heart Association or American Red Cross capable of providing CPR at the level stated in the policy. The facility shall maintain a record in the personnel file of each	L 314	1) Each staff member working in skilled nursing unit will be interviewed to determine the status of each associate's BLS/AED certification. DON will develop a tool to ensure that there is appropriate staff scheduled each shift to meet the one associate/shift certification standard. This will be accomplished by 5/6/2011. 2) DON/MDS/ADON will attend training as soon as possible at Heritage hospital to obtain appropriate instructor certification. 3) Quarterly offering of CPR/AED certification will be available to skilled nursing/clinical staff beginning in May. DON will seek outside instructors to accomplish this training until staff can accomplish this goal internally. First class is to be offered on 5/10/2011 @ 3PM.	

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

Exec. Director
TITLE

4/27/2011
(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0352	A. BUILDING _____ B. WING _____	04/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT THE ALBEMARLE	200 TRADE STREET TARBORO, NC 27886

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L 314	Continued From page 1 staff person who has received CPR training. (g) The facility shall have equipment readily available as required to deliver services stated in the policy. (h) The facility shall provide training for staff members who are responsible for providing CPR with regards to the location of resources and measures for self- protection while administering CPR. This Rule is not met as evidenced by: Based on staff interview and record review the facility failed to maintain a record in the personnel file of each staff person who was certified in CPR (cardio-pulmonary resuscitation) and to verify that the facility always kept a CPR-certified staff member in the building each shift. Findings include: At 2:26 PM on 04/13/11 the director of nursing (DON) stated it was the facility's company standard to have one staff member in the building on each shift who was CPR-certified. However, he reported he did not have records of staff CPR status available when scheduling staff to make sure this standard was upheld. The DON commented, because a lot of the facility's staff also worked in acute healthcare settings, it was very probable that the facility was meeting the standard. According to the DON, there had been no questions from staff, residents, or families about the availability of CPR-certified staff in the facility on a 24-hour basis. He reported there had only been questions about the availability of CPR training for staff and the source of payment for	L 314	4) The monthly review of the CPR/AED will be sent to the QI committee for review and evaluation monthly. The DON is responsible by 5/19/11 (Next scheduled QI Mtg).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NH0352	A. BUILDING _____ B. WING _____	04/13/2011

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L 314	Continued From page 2 such training. At 4:10 PM on 04/13/11 the DON supplied the survey team with a copy of the facility's policy on CPR (revised 02/17/10) which documented, "It is the policy of this community that cardiopulmonary resuscitation (CPR) is initiated when there is a recognized cardiac and/or pulmonary arrest." Interpretation and Implementation of the policy documented, "3. All licensed staff are required to obtain basic CPR certification and to be re-certified as per state regulations." At 6:03 PM on 04/13/11 the DON stated even though he could not say for sure that the facility was meeting the company standard of having one staff member in the building on each shift who was CPR-certified, the facility was working on obtaining CPR training for it's staff. He explained the local hospital and local nursing homes met together for the last two months in an attempt to standardize admission and discharge procedures/policies. The DON also reported the hospital agreed to be a source of training for some of the nursing home staff in the area. The DON commented it was his goal for the ADON, MDS (minimum data set) Nurse, and himself to receive training from the hospital to become CPR trainers who could in turn teach CPR training classes for facility staff. The DON stated he understood the importance of meeting the company's standard on CPR, but the facility had not run into a problem where any residents who needed CPR went without it.	L 314		

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

PRINTED: 06/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345242	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE FOUNTAINS AT THE ALBEMARLE	200 TRADE STREET TARBORO, NC 27886

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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 This STANDARD is not met as evidenced by: A. Based on observation on 06/10/2011 the staff interviewed did not know about the master door release switch located near the nurses station. 42 CFR 483.70 (a)	K 038	All current staff for this area will be re-Educated and re-trained on the use and location of the master door release switch located near the nurses' station (emergency release switch) for the skilled nursing area and documented by July 15th 2011. All new staff upon orientation will be in-serviced on the use and location of the master door release switch located near the nurses' station (emergency release switch) for the skilled nursing area and documented Each year we will conduct an annual in-service on the use and location of the master door release switch located near the nurses' station (emergency release switch) for skilled nursing area and document the in-service. Records will be kept and monitored by the DON and HR director to insure everyone knows where and how to use the master door release switch (emergency release switch) for skilled nursing.	7/15/11 on-going started 6/21/11 on-going

RECEIVED
JUN 24 2011
CONSTRUCTION SECTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diane Barbour
TITLE: Executive Director
(X6) DATE: 6/23/2011

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.

CD

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

PRINTED: 06/13/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345242	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/10/2011

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RECEIVED
JUN 23 2011
CONSTRUCTION SECTION

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

Diane Barlow, Executive Director — 6/23/2011

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.