		AND HUMAN SERVICES		(95)	1881 17 M		APPROVED 0938-0391
STATEMEN	RS FOR MEDICARE T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION	MAY 2 4 2011	(X3) DATE ST	JRVEY
		345249	B. WING _			04/2	8/2011
NAME OF F	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, ST	TATÉ, ZIP CODE		
MOREHI	EAD NURSING CENTE	ER	1 -	05 EAST KINGS HWY DEN, NC 27288			
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F 161 SS=B	1	TY BOND - SECURITY OF S	F 161	1.A new surety bond increasing amount fr	was requested and om \$25,000 to \$	l obtained, 50,000.	5/24/11
	otherwise provide a Secretary, to assure funds of residents d	rchase a surety bond, or ssurance satisfactory to the ethe security of all personal leposited with the facility. IT is not met as evidenced		2.An audit of the curreviewed and the highest the current bond lim	ghest average bal balance of \$22,00	ances were	
	by: Based on record re facility failed to ensu adequate coverage 1 surety bond. The findings include A review of the sure	view and staff interviews the ure that the surety bond had for resident accounts for 1 of		3. When the resident for at least quarterly, the ensure it does not ex If it does exceed the bond amount will be 5-18-2011 to discuss In attendance were; staff, and Hospital for	e fund balance wi ceed the surety by amount, a change requested. A me is the above proced Administrator, Bu	It be noted to ond balance. e in the surety eting was held dure.	1
	January, February, a facilities accounts w the resident account \$34,966.79, February	lent accounts for the month of and March revealed the ere over \$25,000. In January, is balance closed at y account closed at March the facility accounts 01.		4. The results of audit be reviewed by mar monthly to the facil Committee. The conformation and man appropriate. The conformation, DC Pharmacist, member	nagement staff and ity Quality Assur mmittee will revion ke recommendati ommittee member on, Medicaid Diro	d presented ance ew data and ons as ship includes; ectors,	1
	revealed there were but in January there	am, the office manager fewer accounts in December, was an increase in resident manager stated the	· Concentration of the concent	others as needed			
	revealed he was in c	am, the administrator harge of the surety bond. ated the office manager,			•		: :
BORYFORY	DIRECTOR'S OR PROVIDE	RISUPPLIER REPRESENTATIVES SIGNA	ATURE Alas	Imalanto		5	(6) DATE 20 -20

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.

If continuation sheet Page 1 of 57

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES					APPROVED 0938-0391
STATEMEN	RS FOR MEDICARE TOF DEFICIENCIES DE CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		345249	B, WIN	iG		04/28	3/2011
	PROVIDER OR SUPPLIER			20	EET ADDRESS, CITY, STATE, ZIP CODE 05 EAST KINGS HWY DEN, NC 27288 PROVIDER'S PLAN OF CORRECT	TION	(X5)
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F 161	hospital personnel, the resident account aware of the increased ministrator stated resident accounts in each other about the administrator stated increased due to resident accounts. The facility must promanner and in an eenhances each residual recognition of his resident with an increased on observation and staff interview, catheter bag cover residents with an increased each staff interview, catheter bag cover residents with an increased each staff interview, catheter bag cover residents with an increased each staff interview, catheter bag cover residents with an increased each staff interview, catheter bag cover residents with an increased each staff interview, catheter bag cover residents with an increased each staff interview, catheter bag cover resident #19 was one object to the cover of the cove	and himself were monitoring its. The administrator was not se in resident accounts. The self all parties involved in the eeded to communicate to e resident's accounts. The street bond needed to be sident accounts balances. AND RESPECT OF comote care for residents in a nvironment that maintains or dent's dignity and respect in sor her individuality. IT is not met as evidenced ion, record review, resident the facility failed to provide a for one (1) of two (2) sampled dwelling catheter (Resident #	F 1		 The resident identified without a cathet provided a catheter bag cover. The iden resident assessment and care plan were and updates made as necessary. An audit of all residents with catheters to ensure each had appropriate docume the catheter and each resident with a caprovided a cover for the bag. Random being done weekly and promote bags are Appropriate actions to be taken if dignosags not in place, up to and including actions for repeat deficient practices. An in-service was conducted on 5/19/1 covering F241-Dignity and respect of with emphasis on foley catheters and control the therapy staff was provided copies appropriate policy outlining the use of covers. 	reviewed reviewed s was done entation for atheter is audits are le RN in place. ity disciplinary 11 and 5/20/1 individuality lignity bags. of the	

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	H AND HUMAN SERVICES				APPROVED . 0938-0391
CENTERS FOR MEDICARI STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE S COMPLE	
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CEACH DESIGNENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
12/02/2010 stated indwelling catheter Approaches includ policy. On 04/26/2011 at 2 observed in the ha physical therapy st sitting in a wheelch bag hanging under bag was not covered. On 04/26/2011 at 2 assistant stated the bag under her whenot want a privacy. On 04/27/2011 at 3 observed in her roow was inside a privacy. On 04/27/2011 at 3 she had never said bag. She liked the privacy. On 04/28/2011 at 9 (NA) #1 stated Rescatheter since adm to use a privacy bag use the bag as a port Resident #19 liked around and remover #1 stated she had of the privacy.	Proposed and updated Resident #19 had an due to urinary retention. The decident #19 was allway of the facility with aff in attendance. She was nair with the catheter drainage meath the chair. The drainage meath the chair. The drainage red. Proposed and updated was allowed to be a considered and the catheter drainage red. Proposed and proposed the catheter drainage red. Proposed and proposed the catheter elchair and Resident #19 did bag covering her catheter bag. Proposed and updated was allowed the catheter drainage bag was allowed to be a considered was allowed to be a catheter bag and the catheter bag and the catheter bag and the catheter bag and the catheter bag and it from the privacy bag. NA given Resident #19 a bath that a lainage bag was not in the	F 241	4. The results of audit tools, edits be reviewed by management st monthly to the facility Quality Committee. The committee wil information and make recommappropriate. The committee management of Nu Pharmacist, members of the management of the facility Quality Committee will information and make recommand appropriate. The committee management of the management of the facility Quality Committee will information and make recommand appropriate. The committee management of the management of the facility Quality Committee will information and make recommand appropriate. The committee management of the management of the facility Quality Committee will information and make recommand appropriate. The committee management of the management o	aff and presented Assurance Il review data and endations as embership includes; arsing, Medical Dire anagement team and	ctors,

Event ID: 9RLO11

PRINTED, USTIGIZOTI FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B, WING 04/28/2011 345249 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 205 EAST KINGS HWY MOREHEAD NURSING CENTER **EDEN, NC 27288** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 241 Continued From page 3 F 241 On 04/28/2011 at 1:45 PM., Resident #19 stated it was very important to her to "not let everything shine" and she wanted the urinary drainage bag covered. On 04/28/2011 at 5:50 PM., the Director of Nursing stated she expected the urinary drainage bags to be covered in a privacy bag 483.20(c) QUARTERLY ASSESSMENT AT F 276 1. Quarterly assessments for residents # 1, 3, 5, 7, 9, F 276 11, and 26 were completed and transmitted. LEAST EVERY 3 MONTHS SS=C A facility must assess a resident using the 2.An audit of all assessments, by type, was quarterly review instrument specified by the State conducted. Late or incomplete assessments were and approved by CMS not less frequently than completed or corrected as needed and transmitted. once every 3 months. 3.A plan for completion of assessment and a 90 This REQUIREMENT is not met as evidenced day calendar was developed and implemented. The plan and calendar is monitored daily during bv: facility morning meeting. We are actively Based on record review, observations and recruiting for a full time MDS staff member. interviews with facility staff, the facility failed to prepare quarterly assessments in 92 days for 7 of Temporary agency use continues as needed. 24 sampled residents. (Residents #1, #3, #5, #7, #9, #11 and #26). 4. The results of audit tools, edits, monitors will be reviewed by management staff and presented The findings include: monthly to the facility Quality Assurance Committee. The committee will review data and 1. Resident #1 was admitted to the facility on information and make recommendations as 10/24/09. appropriate. The committee membership includes; Administration, DON, Medicaid Directors, Record review revealed that her last MDS Pharmacist, members of the management team and (Minimum Data Set) was an Annual dated

2011.

9/24/10. There was no MDS completed for the month of December, 2010 or the month of March,

On 4/28/11 at 5:00 pm, Nurse #1 revealed there was a shortage of staff and the other nurse was

others as needed

PKINTED. 00/10/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVI		(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTII	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	G		
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	ROVIDER OR SUPPLIER	R	. <u> </u>	20	REET ADDRESS, CITY, STATE, ZIP CODE 05 EAST KINGS HWY EDEN, NC 27288		1
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F 276	out on leave. Nurse her supervisor about The nurse stated the assistance, but MD On 4/28/11 at 5:15 was aware of the Mourse was unaware was on MDS's. The outside assistance.	ge 4 # #1 stated she had informed ut being short staff for MDS's. he facility hired outside S's were still behind. pm, Nurse #2 revealed she IDS's not being caught up. The he of how far behind the staff he nurse stated the facility hired Nurse #2 stated the MDS's hen though there was	F:	276			
	assistance from an	other agency. pm, the Director of Nursing					•
	(DON) revealed the	e facility was aware of the S's before survey team g, but there was not enough		٠			
	2. Resident #3 was 7/30/10.	s admitted to the facility on					
	and was dated 8/10 Quarterly dated 4/1 out - It was blank in	nimum Data Set) was an Initial 0/10. The next MDS was a 9/11; however, it was not filled the computer. The MDS had and date only on the MDS.					
	was a shortage of some on leave. Nurse her supervisor about the nurse stated the nurse stated the nurse stated.	pm, Nurse #1 revealed there staff and the other nurse was #1 stated she had informed ut being short staff for MDS's. he facility hired outside S's were still behind.					
	Lwas aware of the M	pm, Nurse #2 revealed she IDS's not being caught up. The of how far behind the staff					

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES					. 0938-0391
STATEMEN	RS FOR MEDICARE FOR DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		IPLE CONSTRUCTION	(X3) DATE S COMPL	BURVEY ETED
		345249				04/2	28/2011
	ROVIDER OR SUPPLIER	R		2	REET ADDRESS, CITY, STATE, ZIP CODE 205 EAST KINGS HWY EDEN, NC 27288		
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F 276	was on MDS's. The outside assistance, were still behind ev assistance from an On 4/28/11 at 5:25 (DON) revealed the issues with the MD	e nurse stated the facility hired Nurse #2 stated the MDS's en though there was other agency. pm, the Director of Nursing e facility was aware of the S's before survey team n, but there was not enough	F	276			
	The resident's clinical including the Minimal computer files reversible to make the Minimal computer files reversible to make the Minimal Carbon of 10/18/11. Was an annual assiluted 1/14/11. There has 1/14/11 MDS. During an interview #1, who worked in was aware the MDS completing assession had started getting members had been leave. She stated in made aware that the being completed in March 2011. She started they (MDS staff) control with the made aware that the being completed in March 2011. She started they (MDS staff) control with the minimal carbon in the material	cal record was reviewed, um Data Set (MDS). The aled a quarterly MDS was Assessment Reference Date Following the quarterly MDS essment with the ARD of d been no entry following the con 4/28/11 at 3:12 PM, Nurse the MDS office, stated that she staff were behind on ments. She stated that they behind when two MDS staff out for extended medical the Administrator had been to a timely manner as early as stated she had told him that all ont get the assessments ted that the MDS staff used a					

Care Plan list compiled from the Medical Records

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED . 0938-0391
NAME OF PROVIDER OR SUPPLIER MOREHEAD NURSING CENTER SUMMARY STATEMENT OF (EACH DEFICIENCY MUST BE PERFEIX TAG) F 276 Continued From page 6 office to determine who needs assessment completed. She facility had hired help from an help with MDS completion. Thad not been successful in assup overdue MDSs. At 3:55 PM on 4/28/11, Nurse interviewed. She stated that to help the MDS staff catch up assessments. She stated she far behind they were in compless the stated she had talked to concerning overdue MDS assumes the pre-was an issue, but she were the pre-was an issue, but she were interviewed on 4/28/11 and the pre-was an issue, but she were interviewed to the pre-was an issue, but she were interviewed to the pre-was an issue, but she were interviewed to the pre-was an issue, but she were interviewed to the pre-was an issue, but she were interviewed to the pre-was an issue, but she were interviewed to the pre-was an issue, but she were interviewed to the pre-was an issue, but she were interviewed to the pre-was an issue, but she were interviewed to the pre-was an issue, but she were interviewed to the pre-was an issue, but she were interviewed to the pre-was an issue, but she were interviewed to the pre-was an issue, but she were interviewed to the pre-was an issue, but she were interviewed.		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N		IPLE CONSTRUCTION	(X3) DATE SI COMPLE	
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F 276	office to determine assessment completed with MDS combad not been successive overdue MDSs. At 3:55 PM on 4/28 interviewed. She sto help the MDS states seements. She far behind they were she stated she had concerning overdue. The Director of Nurwere interviewed or DON stated that it I there was an issue magnitude of the pitch of	who needed to have an eted. She stated that the slip from an outside agency to upletion. The agency nurse essful in assisting staff to catch of the stated that she had been pulled aff catch up on MDS stated she did not know how e in completing assessments. It talked to the Administrator e MDS assessments of the mad started coming to light that the but she was unaware of the roblem prior to the survey. It talked the MDS staff had let her hind, but she was unaware of the they were until the survey. It is admitted on 4/14/06 and had in 8/31/10. The call record was reviewed, sum Data Set (MDS). The aled an annual MDS was Assessment Reference Date Although a quarterly verdue, no MDS had been puter system.	F	276			
	#1, who worked in	the MDS office, stated that she					

was aware the MDS staff were behind on

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES					0938-0391
STATEMENT	RS FOR MEDICARE FOR DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	irvey Ted
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F 276	completing assess had started getting members had beer leave. She stated made aware that the being completed in March 2011. She stated they (MDS staff) cocaught up. She stated to determine assessment complification facility had hired he help with MDS comhad not been succeup overdue MDSs. At 3:55 PM on 4/28 interviewed. She stated she had concerning overdue. The Director of Nurwere interviewed on DON stated that it there was an issue magnitude of the power and they were be how far behind that they were be how far behind that they were behind that they was facility on 10/1/10.	ments. She stated that they behind when two MDS staff in out for extended medical the Administrator had been as MDS assessments were not a timely manner as early as stated she had told him that ould not get the assessments ated that the MDS staff used a coiled from the Medical Records who needed to have an eted. She stated that the elp from an outside agency to apletion. The agency nurse essful in assisting staff to catch	F	276			

DEPAR ⁻	TMENT OF HEALTH	I AND HUMAN SERVICES					APPROVED . 0938-0391
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F 276	(MDS) was comple	ted on 1/8/11.	F	276			
	MDS was dated 1/8	ent #9's most recent quarterly 8/11. The facility was unable to assessment for April 2011.					
	was a shortage of some on leave. Nurse well from Novembe Nurse #1 stated shout being short s	pm, Nurse #1 revealed there staff and the MDS nurse was #1 had been out on leave as 12010 to February 2011. He had informed her supervisor taff for MDS's. The nurse 12010 red outside assistance, but hind.					
	was aware of the M nurse was unaware was on MDS's. Nur nurse stated the fac Nurse #2 stated the though there was a	pm, Nurse #2 revealed she IDS's not being caught up. The of how far behind the staff se #2 was part-time. The cility hired outside assistance. MDS's were still behind even ssistance from another was not trained on updated					
	(DON) revealed the	pm, the Director of Nursing facility was aware of the S's before survey team g, but there was not enough of the MDS's.			•		
	6. Resident #23 wa 6/16/05. Resident # completed on 12/31	s admitted to the facility on 23 annual MDS was 1/10.					
	A review of Resider Minimum Data Set	nt #23's most recent quarterly (MDS) was dated 12/31/10.					

DEPAR'	TMENT OF HEALTH	AND HUMAN SERVICES			FORM OMB NO.	APPROVED 0938-0391
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	PROVIDER OR SUPPLIER	ER .	2	REET ADDRESS, CITY, STATE, ZIP CODE 105 EAST KINGS HWY EDEN, NC 27288		
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F 276	The facility was una assessment from Months of the North	able to provide a quarterly March 2011. pm, Nurse #1 revealed there staff and the MDS nurse was #1 had been out on leave as #2 2010 to February 2011. #2 had informed her supervisor taff for MDS's. The nurse red outside assistance, but hind. pm, Nurse #2 revealed she IDS's not being caught up. The #2 of how far behind the staff #3 se #2 was part time. The #3 cility hired outside assistance. #4 MDS's were still behind even #4 sistance from another #4 was not trained on updated pm, the Director of Nursing #4 facility was aware of the #5 se before survey team #5, but there was not enough #6 fithe MDS's. #4 admitted to the facility on #11 annual MDS was #10. #4 11's most recent quarterly (MDS) was dated 1/23/11. #4 ble to provide a quarterly	F 276			

DEPART	MENT OF HEALTH	I AND HUMAN SERVICES					0938-0391
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F 276	On 4/28/11 at 5:00 was a shortage of sout on leave. Nurs well from November Nurse #1 stated shabout being short stated the facility his MDS's were still be On 4/28/11 at 5:15 was aware of the Mourse was unaware was on MDS's. Nurse stated the fall Nurse #2 stated the fall Nurse #2 stated the fall though there was a agency. The nurse MDS version 3.0.	pm, Nurse #1 revealed there staff and the MDS nurse was e #1 had been out on leave as er 2010 to February 2011. e had informed her supervisor staff for MDS's. The nurse ired outside assistance, but shind. pm, Nurse #2 revealed she MDS's not being caught up. The e of how far behind the staff rse #2 was part time. The cility hired outside assistance. e MDS's were still behind even assistance from another was not trained on updated	F	276			
F 280 SS=B	(DON) revealed the issues with the MD entered the building time to go over all of 483.20(d)(3), 483.1 PARTICIPATE PLATE The resident has the incompetent or othe incapacitated under participate in plannichanges in care and A comprehensive of within 7 days after comprehensive assister disciplinary teating the standard of the comprehensive assister disciplinary teating the standard of the comprehensive assister disciplinary teating the comprehensive assister di	IO(k)(2) RIGHT TO ANNING CARE-REVISE CP ne right, unless adjudged erwise found to be ir the laws of the State, to ing care and treatment or	F	280			

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES					0938-0391	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTII	PLE CONSTRUCTION	(X3) DATE SU COMPLE	RVEY TED	
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F 280	Continued From page 11 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of			280	The care plans for the residents #12 at developed and updated as appropriate		5/26/n	
	the resident, the re-	e resident, the resident's family or the resident's gal representative; and periodically reviewed to revised by a team of qualified persons after		2.An audit of all resident's care plans was, completed, updating as appropriate.				
	This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to develop an individualized care plan for one(1) of twenty four (24) residents (Resident # 12) and failed to review and revise a care plan for two (2) of twenty-four (24) residents (Resident # 14, Resident #19). Resident #12 had an admission				3. Additional trained staff were contract agency to assist with assessment comprocedure for assessment completion and all appropriate staff instructed. A completion by day was developed for and July. A plan was developed to ide incomplete or late assessments shown by discipline and a time line for comput in place. Recruitment efforts to fil created position including the use of a recruiter continue.	pletion. The was reviewed calendar of May, June, entify all ng tasks letion was 1 a newly		
	care plan but the fa with an individualize Resident #14 was a nursing was discont plan for Resident # updated following had	icility did not follow through ed care plan. Care plan for not revised when restorative tinued on 03/21/2011. Care 19 was not reviewed and iospitalization for left femoral 011 and hospitalization for oral fracture on 04/08/2011.	-		4. The results of audit tools, edits, more be reviewed by management staff an monthly to the facility Quality Assure Committee. The committee will revie information and make recommendate appropriate. The committee members Administration, Director of Nursing, Directors, Pharmacist, members of the management team and others as need	d presented ance ew data and ons as ship includes; Medical		
	03/19/2011. Cumu	as admitted to the facility on lative diagnoses included: left ntia, Diabetes, reflux disease (GERD) and					:	
	A comprehensive r	ninimum data set (MDS) had d by the facility.						

PRINTED. USHTUIZUTT FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 04/28/2011 B, WING_ 345249 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 205 EAST KINGS HWY **EDEN, NC 27288** MOREHEAD NURSING CENTER (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION ID SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX DATE (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PRÉFIX DEFICIENCY) TAG F 280 Continued From page 12 F 280 Admission care plan dated 03/18/2011 stated Resident #12 required limited to extensive assistance with activities of daily living and potential for weight loss related to leaving 25% or more of food uneaten at most meals. Potential for skin breakdown was not addressed on the care plan. On 4/26/2011, observations throughout the day revealed Resident #12 received total care by nursing staff. On 04/27/2011 at 9:10 AM., Nursing assistant (NA) #1 stated Resident #12 required total assistance with all areas of her care. On 4/27/2011 at 10:00 AM., Nurse #3 stated Resident #12 developed an unstageable pressure ulcer on 04/12/2011. Wound care treatment and air boots for both feet were implemented on 04/12/2011. On 04/28/2011 at 3:10 PM., Nurse #1 (MDS nurse) stated the MDS's were behind. Nurse #1 stated the initial care plan is generated after the MDS is completed. She could not generate an initial care plan because she was a licensed practical nurse (LPN). Nurse #1 stated she had been out on leave from November until February, then the full time MDS coordinator (RN) had been out on leave. Nurse #1 stated Resident #12

should have been care planned by now.

On 04/28/2011 at 5:00 PM., the Director of Nursing stated there had been a lot of staffing issues with the MDS department (staff being part-time, MDS co-coordinator (RN) being out on

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES			_	FORM OMB NO.	APPROVED 0938-0391
TATEMEN	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		345249	B. Wi	√G_		04/28	3/2011
	ROVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 105 EAST KINGS HWY		
MOREHI	AD NURSING CENTE			E	PROVIDER'S PLAN OF CORRECT	TION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE
F 280	updating of the care expected the care pupdated episodicall reviewed quarterly. 2. Resident #19 was facility 09/04/2009 as on 04/11/2011. Cuarthritis, congestive fracture 03/12/2011 infection and urinar Significant change dated 02/22/2011 in on short term or lonand was independent equired supervision eating, personal hybridependent with all the hallway. Medical record was available to nursing and updated 12/8/2 Resident #19 was a falls with her last faincluded non-skid sassist with toileting walker for use when Medical record revisustained a left femand was hospitalized Resident #19 was a falls with the last faincluded non-skid sassist with toileting walker for use when Medical record revisustained a left femand was hospitalized Resident #19 was a falls with the last faincluded non-skid sassist with toileting walker for use when Medical record revisustained a left femand was hospitalized Resident #19 was a falls with the last faincluded non-skid sassist with toileting walker for use when Medical record revisustained a left femand was hospitalized Resident #19 was a falls with the last faincluded non-skid sassist with toileting walker for use when Medical record revisustained a left femand was hospitalized Resident #19 was a falls with the last faincluded non-skid sassist with toileting walker for use when Medical record revisustained a left femand was hospitalized Resident #19 was a falls with the last faincluded non-skid sassist with toileting walker for use when Medical record revisustained a left femand was hospitalized Resident #19 was a falls with the last faincluded non-skid sassist with toileting walker for use when Medical record revisus the last faincluded non-skid sassist with the last faincluded non-skid sassi	d regarding care plans (initial, e plans), she stated she plans to be completed, y and, at a minimum, as originally admitted to the and readmitted to the facility mulative diagnoses included: heart failure, left femoral, history of urinary tract y retention. Minimum Data Set (MDS) tated Resident #19 displayed ag term memory impairment ent in decision-making. She in with transfers, dressing, giene and bathing. She was imbulation in her room and in staff was dated 09/06/2009 010. Care Plan stated at risk for falls due to history of 108/24/2010. Approaches hoes/ socks when out of bed, as needed, and provide in ambulating resident. ew revealed Resident #19 total 12/2011 and 03/12/2011-03/15/2011.	F	280			

PRINTED: 05/10/2011 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A, BUILDIN	G			
		345249	B. WING _		04/28/2011		
	ROVIDER OR SUPPLIER	ER.	2	REET ADDRESS, CITY, STATE, ZIP CODE 05 EAST KINGS HWY DEN, NC 27288			
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE I	(X5) COMPLETION DATE	
F 280	Continued From particles of the continued From particles of the could not physical therapy and with them on 04/27. On 04/28/2011 at 2 care plan with risk is reviewed and update included: provide warmbulating residen. On 04/28/2011 at 3 had been out on less February and then (RN) had been out Resident #19 shout plan within fourteer assessment dated why a revised care and placed in the monoporture. On 04/28/2011 at 5 Nursing stated ther issues with the MD part-time, MDS cooleave). When asked updating of the care pupdated episodical reviewed quarterly. 3 Resident #14 was stated there is the care pupdated and placed in the care pupdated episodical reviewed quarterly.	ge 14 :45 PM., Resident #19 stated ed with bathing, dressing, and toileting. Resident #19 of walk by herself, received d walked twenty-two steps //2011. :00 PM., Nurse #1 provided a for falls due to history of falls ted 04/04/2011. Approaches valker for use when t, no weight bearing on left leg. :10 PM., Nurse #1 stated she ave from November until the full time MDS coordinator on leave. Nurse #1 stated Id have had a revised care of days of the significant change 02/22/2011. She did not know plan had not been completed nedical record. :00 PM., the Director of e had been a lot of staffing S department (staff being ordinator (RN) being out on the director of the plans), she stated she olans to be completed, by and, at a minimum,	F 280	DEFICIENCY)			
	06/30/2009. Cumu	lative diagnoses included: and right elbow fracture, and chronic obstructive					

FORM APPROVED OMB NO. 0938-0391

		A MEDICALD CERTIFICATA	(VO) I	a u ti	IPLE CONSTRUCTION	(X3) DATE S	URVEY	
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU			COMPLETED		
		345249	B. WI	NG_		04/2	28/2011	
	PROVIDER OR SUPPLIER	≅R		2	REET ADDRESS, CITY, STATE, ZIP CODE 205 EAST KINGS HWY EDEN, NC 27288	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 280	Annual minimum da stated Resident #14 was independent w required supervision in the hallway, persident Balance was unstead walking. Range of nupper and lower extended the contact guard and the conta	Annual minimum date set dated 02/07/2011 stated Resident #14 was cognitively intact. She was independent with transfers and toileting, required supervision with bed mobility, ambulation in the hallway, personal hygiene and bathing. Balance was unsteady during transitions and walking. Range of motion was limited in both upper and lower extremities. Care plan dated 02/16/2011 indicated Resident #14 had impaired mobility due to weakness. Restorative program was in progress. Approaches included: Restorative ambulation with contact guard assistant and wheeled walker up to 250 feet and assisted range of motion to both lower extremities using two pound weights. On 04/28/2011 at 11:55 AM., Nurse #3 (restorative nurse) stated Resident #14 had		280				
F 281 SS=D	have discontinued replan. On 04/28/2011 at 5: Nursing stated she completed, updated minimum, reviewed plans should be curred 483.20(k)(3)(i) SER PROFESSIONAL STATE services provide	VICES PROVIDED MEET	F 2	81				

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			FORM OMB NO.	09710/2011 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SU COMPLE	TED
		345249	B. WING		04/2	8/2011
	ROVIDER OR SUPPLIER	≣R	s	TREET ADDRESS, CITY, STATE, ZIP COE 205 EAST KINGS HWY EDEN, NC 27288		
(X4) ID PREFIX TAG	(EVOR DEDICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION).	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOOLD RF	(X5) COMPLETION DATE
F 281	This REQUIREMENT by: Based on observatinterviews, the faciliphysician orders to record for 1 of 26 s #25) whose medica and failed to follow weekly weights for (resident #10). Find 1. Resident #25 way 4/20/11 with multiple congestive heart dicoronary artery discresident's clinical recorders dated 4/20/1 (milligram) daily. Is for the treatment of angina. Lexicomp's Drug Intedition, Warnings/F "abrupt withdrawal Reconciliation of medication pass of 8:25AM revealed the pot given. Review	tion, record review and staff ity failed to transcribe the medication administration ampled residents (resident ation orders were reviewed, the physician's order for 1 of 26 sampled residents dings include: as admitted to the facility on le diagnoses including sease, hypertension, and ease. Record review of the ecord revealed physician 11 for Isosorbide 40mg sosorbide is a vasodilator used congestive heart failure and aformation Handbook, 14th precautions, stated in part: may result in angina." edication orders after a preservation on 4/27/11 at the resident's Isosorbide was of the resident's medication rd (MAR) revealed no entry for	F 28	1. The physician orders for residents were not transcribed to the medicine record were corrected. 2. All physician orders were checked transcription. Random audits of pwill be done weekly to identify ar concern. All identified issues will as needed. 3. In-services training was conducted physician order transcription procewill be provided to all newly hire well as any nurses identified as not training. Random audits of physician transcription will be conducted an action taken as needed. 4. The results of audit tools, edits, not be reviewed by management staff monthly to the facility Quality As Committee. The committee will reinformation and make recommence appropriate. The committee mem Administration, DON, Medicaid I Pharmacist, members of the mana others as needed	I for accuracy in hysician orders by areas of be resolved d to review the less. Training d nurses as leeding the lean order d corrective monitors will and presented surance leview data and lations as bership includes; Directors,	
	In an interview on 4 examined the resid	1/27/11 at 9:30AM, Nurse #4 ent's physician order sheet				

and MAR and acknowledged the Isosorbide order was not on the MAR. Nurse #4 stated the order must not have been transcribed to the MAR at admission and had not been given. He stated the

PRINTED: UDITUIZUTT FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 04/28/2011 B, WING _ 345249 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 205 EAST KINGS HWY **EDEN, NC 27288** MOREHEAD NURSING CENTER PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PREFIX DEFICIENCY) TAG F 281 Continued From page 17 F 281 facility printed the physician order sheets and MARS. He stated the admitting nurse would have been responsible for transcribing orders from the physician order sheet to the MAR. Nurse #4 stated he would add the order to the MAR and begin administration of the medication immediately. Inspection of the medication cart revealed the pharmacy had dispensed 15 tablets of Isosorbide on 4/20/11. In an interview on 4/28/11 at 4:09 PM, the Director of Nursing (DON) stated for new admissions, the nurse assigned to that resident reviewed admission orders and entered them into the computer to generate the MAR. She stated the nursing staff administered medications according to the MARS. The DON stated there was not currently a system in place to double-check the MARS for new admissions and added "there will be from now on." The DON stated she expected the staff to transcribe all medication orders accurately to the MARS. The nurse responsible for transcribing the Isosorbide order to the resident's MAR was not available for interview. 2. Resident #10 was originally admitted to the facility on 11/11/05, but was readmitted on 3/21/11 with a diagnosis of Alzheimer Disease. Resident # 10's Minimum Data Set (MDS) was not updated for cognitive status.

The physician 's order in April 2011 for Resident #10 revealed the resident was to be weighed for 4

The resident's Medication Administration Records

weeks upon readmission on 3/21/11.

FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SUI COMPLET	RVEY FED
AND PLAN OF CORRECTION			A. BU B. WI			04/28	3/2011
		345249			EET ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF PROVIDER OR SU		TD		20	05 EAST KINGS HWY		
MOREHEAD NURSING			ID		DEN, NC 27288 PROVIDER'S PLAN OF CORRECT	TION	(X5) COMPLETION
	いいんしきんりつく	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAC	X	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ROPRIATE	DATE
Resident #1 weeks upon #10 was sup 4/11/11, 4/1 weights con Resident's # revealed "w Resident #1 two weights were no oth On 4/28/11 not weigh R revealed the refused to b On 4/28/11 Resident#1 The nurse s Resident#1 revealed if a taken, NA w would atten nurse was s the next shi weigh the re weights we On 4/27/11 provided do weights. The	the mode of would read many posed of 8/11, a npleted of 10's Weight work in were of the weight was to in the work of the weight was to in the work of the weight was to in the work of the weight and the weight was to in the work of the work of the weight was to in the work of the weight was to in the work of the weight was to in the work of the weight	onth of April 2011 revealed d be weighed weekly for 4 hission on 3/21/11." Resident to be weighed on 4/4/11, and 4/25/11. There were no on those days. Care Plan (CP) dated 3/21/11 eekly for 4 weeks." Leight sheet revealed the last on 3/9/11 and 4/16/11. There were no on those days. Leight sheet revealed the last on 3/9/11 and 4/16/11. There were no on those days.		281			

MINIED, USITOREST FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION B, WING 04/28/2011 345249 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 205 EAST KINGS HWY EDEN, NC 27288 MOREHEAD NURSING CENTER PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) PRÉFIX TAG DEFICIENCY) TAG F 281 Continued From page 19 On 4/28/ 11 at 2:30pm, Nurse # 4 revealed Resident #10 never refused care or weights. Nurse# 4 also revealed NA 's never reported Resident #10 refusing care or being weighed. Nurse # 4 worked with Resident #10 on 4/4/11 and was not informed about refusal of care. On 4/28/11 at 5:25pm, the Director of Nursing (DON) revealed residents' should be weighed for 4 weeks upon admission and readmission as documented on the MAR per facilities policy. The DON stated there were spaces on the MAR for staff to sign off after the resident was weighed. The DON stated the weekly weights should be on the MAR so that the nurses could remind the NA's to weigh the resident's on Monday. 5/26/11 1.All professional nurses were given access to the F 286 483.20(d) MAINTAIN 15 MONTHS OF computer application to allow them access to the F 286 RESIDENT ASSESSMENTS MDS. Instructions were provided to all nurses ss=c Via e-mail on 5/20/2011. A facility must maintain all resident assessments

residents.

completed within the previous 15 months in the

This REQUIREMENT is not met as evidenced

Based on record review and staff interview, the

facility failed to ensure fifteen (15) months of the

electronically were accessible to staff.

Minimum Data Set (MDS) which were maintained

During the entrance conference of the survey on 4/26/11 at 8:05, the Nurse #1 stated that all MDS assessments and care plans were in a folder in a filing cabinet at each nursing station for all

resident's active record.

The findings include:

Director of Nurses.

2.An audit of all current nurses access status and

3. A procedure was developed to ensure all existing

nursing staff and new staff receive training on how

to access the appropriate application to allow access

to resident assessments. A list of all the nurses and their access status will be maintained by the

skills level was conducted 4/26/11.

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED 093 <u>8-0391</u>	
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SU COMPLE	IRVEY	
		345249	B. Wil	4G		04/28/2011		
	ROVIDER OR SUPPLIER		. ! -	2	REET ADDRESS, CITY, STATE, ZIP CODE 05 EAST KINGS HWY DEN, NC 27288			
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	iX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	OFD RF	(X5) COMPLETION DATE	
F 286	(DON), and the Inter 3.0 assessments we DON stated that all DON asked a nurse station on the south and access the MD on that hall. The nurse denied access Records Clerk to do who needed access The Medical Record 4/28/11 at 10:47 An upgrade from MDS computer system hupdate, staff access change resulted in access. She stated specific staff that we data. She stated not access the update of the	PM, the Director of Nursing prim DON stated that all MDS ere filed electronically. The nurses had access. The ewho was at the nursing hall to go into the computer S for a resident who resided urse attempted to log in and the DON asked the Medical etermine who had access and	F	286	4. The results of audit tools, edits, mon be reviewed by management staff and monthly to the facility Quality Assur Committee. The committee will revie information and make recommendate appropriate. The committee members Administrator, Director of Nurses, M Directors, Pharmacist, members of the management team and others as needed.	d presented ance we data and ons as thip includes; edical		
F 287 SS=B	5:20 PM that all nui MDS data.	an interview on 4/28/11 at reses now had access to the NG/TRANSMITTING SMENT	F	287				
	completes a reside	Within 7 days after a facility nt's assessment, a facility llowing information for each ty: ssment.						

	HUMAN SERVICES				OMB NO.	0938-0391	
CENTERS FOR MEDICARE & ME	EDICAID SERVICES ROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION ID	ENTIFICATION NOMBER.	A BUI	LDING				
	345249	B. WIN			04/28	3/2011	
NAME OF PROVIDER OR SUPPLIER			STR 20	EET ADDRESS, CITY, STATE, ZIP CODE D 5 EAST KINGS HWY			
MOREHEAD NURSING CENTER	_		E	DEN, NC 27288	TION I	(X5)	
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDEI	RE DRECEDED BY LOFF	ID PREF TAG	1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPR DEFICIENCY)	OFD RE	COMPLETION DATE	
(ii) Annual assessment u (iii) Significant change in (iv) Quarterly review asse (v) A subset of items uporeentry, discharge, and d (vi) Background (face-sh is no admission assessm (2) Transmitting data. Wite completes a resident's as must be capable of trans System information for eithe MDS in a format that record layouts and data or passes standardized edit the State. (3) Transmittal requirement a facility completes a resident's area facility must electronically accurate, and complete I System, including the fol (i) Admission assessment. (iii) Significant change in (iv) Significant correction (v) Significant correction assessment. (vi) Quarterly review. (vii) A subset of items upreentry, discharge, and continual transmission of ME does not have an admission of ME does not have an admission.	pdates. status assessments. essments. on a resident's transfer, leath. eet) information, if there nent. ithin 7 days after a facility ssessment, a facility smitting to the CMS ach resident contained in conforms to standard dictionaries, and that its defined by CMS and ents. Within 14 days after sident's assessment, a y transmit encoded, MDS data to the CMS lowing: nt. status assessment. of prior full assessment. of prior quarterly on a resident's transfer, leath. heet) information, for an OS data on a resident that sion assessment. illity must transmit data in CMS or, for a State which	F	287	 The assessments for residents # 10, 11 completed and transmitted. An audit of assessments of all types we showing resident, type of assessment, completed. Two additional staff from staffing service were retained to assist completion of assessments. A procedure and 90 day calendar systic completion and transmission of assess developed and implemented. Calendar distributed to all Interdisciplinary Teal Members and it will be a standing age for facility morning meeting. We are recruiting for a full time MDS staff mill continue to use temporary agency needed. The results of audit tools, edits, morn be reviewed by management staff and monthly to the facility Quality Assur Committee. The committee will revisit information and make recommendating appropriate. The committee members Administration, Director of Nursing, Directors, Pharmacist, members of the management team and others as need. 	yas completed, and date was a personnel t with tem for sments was ars were am ectively nember and y staff as titors will d presented ance ew data and ions as ship includes; Medical e		

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 04/28/2011 B. WING. 345249 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 205 EAST KINGS HWY EDEN, NC 27288 MOREHEAD NURSING CENTER PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE ID SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PRÉFIX TAG F 287 Continued From page 22 F 287 format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced Based on record review and staff interview, the

(LPN).

facility failed to transmit completed assessments in a timely manner for four (4) of twenty-four (24) residents (Resident #10, Resident #11, Resident

Resident #12 was admitted to the facility on 03/19/2011. Cumulative diagnoses included: left.

Gastroesophageal reflux disease (GERD) and

Medical record was reviewed. A fourteen day comprehensive assessment using the Minimum Data Set (MDS) was not in the medical record.

On 04/26/2011 at 10:55 AM., a request was made to the MDS nurse for the admission assessment for Resident #12. Nurse #1 stated there were no Minimum Data Set assessments done for Resident #12. She stated they knew they were behind with MDS's but they were not sure how far behind. She stated she had been out on medical leave from November 2010 until February 2010. The MDS coordinator was out on leave in February, returned in March 2011 and went out on leave at the end of March 2011. Nurse #1 stated she could not complete the MDS because she was a licensed practical nurse

On 04/27/2011 at 11:00 AM., the Director of

#12, Resident #19). Findings included:

hip fracture, Dementia, Diabetes,

iron deficiency.

DEPAR]	IMENT OF HEALTH	AND HUMAN SERVICES				FORM OMB NO	APPROVED 0938-0391
CENTER	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		LE CONSTRUCTION	(X3) DATE SI COMPLE	URVEY
		345249	B. WIN	IG		04/2	8/2011
	ROVIDER OR SUPPLIER			20	EET ADDRESS, CITY, STATE, ZIP COD 5 EAST KINGS HWY DEN, NC 27288	Ξ	
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HUULU BE	(X5) COMPLETION DATE
F 287	Nursing stated MD transmitted within to On 04/28/2011 at 3 did not have any id behind. She knew to be done for the retwenty-five (25)th On 04/28/2011at 3 stated she worked two twelve hours downward far behind they were needed help. Nurse transmitted 52 record how many MDS's with the worked two twelve hours downward far behind they were needed help. Nurse transmitted 52 record how many MDS's with the worked two twelve hours downward far behind they were needed help. Nurse transmitted 52 record how many MDS's with the worked two twelve had not been compared to the worked two twelve had not been compared to the worked two twelve had not been compared to the worked two twelves as the worked two twelves and the worked twelves and the worked twelves and the worked twelve	S's should be completed and he time frame required. 8:10 PM., Nurse #1 stated she ea how many MDS's were there were some that needed month of March-maybe irty(30) or more. 55 PM., Nurse #2 (MDS RN) part time and averaged one to any per week working with the stated she had not been to any d training with MDS 3.0. She cussed with administration how re with MDS's and that they se #2 stated she had ords today. She did not know were delinquent. as admitted to the facility was hospitalized 2011 for a left femoral fracture 4/08/2011-04/11/2011 for	F 2	287			

On 04/28/2011 at 2:00 PM., significant change

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 04/28/2011 B. WING 345249 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 205 EAST KINGS HWY

EDEN, NC 27288 MOREHEAD NURSING CENTER (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PREFIX TAG F 287 Continued From page 24 F 287 assessment dated 02/22/2011 was completed. Signatures of staff that had completed the assessment areas were as follows: Social worker (sections D,E,J,Q) 03/21/2011, Dietary (section K) 03/21/2011, Activities (section C,F) 03/25/2011, Registered Nurse (section M) 04/08/2011 and Registered Nurse (sections A,B,G,H,I,L,N,O,P,V,X,Z) 04/28/2011. Care Area Assessment summary and Care plan completion was signed 04/28/2011. On 04/28/2011 at 3:10 PM., Nurse #1 stated she did not have any idea how many MDS's were behind. She knew there were some that needed to be done for the month of March-maybe twenty-five (25)-thirty(30) or more. She stated she had been out on medical leave from November 2010 until February 2010. The MDS coordinator was out on leave in February, returned in March 2011 and went out on leave at the end of March 2011. Nurse #1 stated she could not complete the MDS because she was a licensed practical nurse (LPN). On 04/28/2011at 3:55 PM., Nurse #2 (MDS RN) stated she worked part time and averaged one to two twelve hours day per week working with the MDS's. Nurse #2 stated she had not been to any classes or obtained training with MDS 3.0. She stated she had discussed with administration how far behind they were with MDS's and that they needed help. Nurse #2 stated she had transmitted 52 records today. She did not know how many MDS's were delinquent. 3. Resident # 10 's initial admission to the facility was on 11/11/08, but was readmitted on 3/21/11.

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FORM APPROVED OMB NO. 0938-0391

		& MEDICAID SERVICES	(Y2) M	 8 II TIP	PLE CONSTRUCTION	(X3) DATE SU	RVEY
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BU			COMPLET	ED
ANDLIANC						04/29	/2011
		345249	D. WII			1 04/20	2011
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE 05 EAST KINGS HWY		
MOREHE	EAD NURSING CENT	ER			DEN, NC 27288		
		ATEMENT OF DEFICIENCIES	ID	١	PROVIDER'S PLAN OF CORRECT	TION	(X5) COMPLETION
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	<u> </u>						
F 287	Continued From pa	age 25	F	287			
	A review of Reside	nt #10's Minimum Data Set					
	(MDS) revealed the	e resident was discharged on he facility on 3/9/11, and there					
	l was a significant c	hange completed on 3/13/11.					
	Laccording to the R	esident Assessment ersion 3.0, the MDS's on				j	
	215/11 and 3/13/11	were not transmitted (sent to			·		
	Centers of Medica	id and Medicare Services, also					
	known as CMS).						
	On 4/28/11 at 5:00	pm, Nurse #1 revealed there					
	twoc a chortage of	staff and the other nurse was e #1 stated she had informed					
	her supervisor abo	out being short staff for MDS's.					
	The nurse stated t	he facility hired outside					
	assistance, but MI	OS's were still behind. Nurse #1 trying to submit MDS's that					
	were still open.	trying to outsine in a same					1
		Nurso #2 revealed she					
	l was responsible fo	pm, Nurse #2 revealed she or completing the MDS 's.					
	Murca #2 revealed	she was aware of the widgs					
	not being caught u	p. The nurse stated the MDS eave. The nurse revealed she					
	was not trained on	MDS 3.0 version. The nurse					
	royaled she relied	d on the MDS nurse out on					
	leave for assistant	ce. Nurse #2 revealed the MDS one since the end of last year.					
	The nurse stated t	he MIDS hurse was coming					
	hack but was not	sure when. The nurse revealed					
	the MDS nurse wa	s the person trained to version. The nurse was					
	lunaware of how fa	ir behind the staff was on					
	MDS's The nurse	revealed the MDS's in the					
	I recently cent to Ci	the word "transmitted," was MS. The nurse stated staff					
	I would receive a co	infirmation from Within 24 nours					
	of being transmitte	ed with an acceptance or denial.					- 65 55

FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTIPLE CONSTRUCTION DING		COMPLETED		
		345249	. B. WING	G	04/2	8/2011		
NAME OF PROVIDER OR SUPPLIER MOREHEAD NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP 205 EAST KINGS HWY EDEN, NC 27288	CODE				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
	A review of Reside recent quarterly Mindated 1/23/11. The quarterly MDS to C Medicare Services to the Resident Assiversion 3.0. The quarterly MDS to C Medicare Services to the Resident Assiversion 3.0. The quarterly MDS as shortage of so out on leave. Nurse her supervisor about on leave. Nurse her supervisor about The nurse stated the assistance, but MD revealed staff was twere still open. On 4/28/11 at 5:15 was responsible for Nurse #2 revealed short on leave not trained on the revealed she relied leave for assistance nurse had been gor The nurse stated the back, but was not sithe MDS nurse was complete MDS 3.0 vunaware of how far MDS's. The nurse relied may be the MDS of the MDS's. The nurse relied may be the MDS of the MDS's. The nurse relied may be the MDS of the MDS's. The nurse relied may be the MDS of the MDS's. The nurse relied may be the MDS's may be th	as admitted to the facility on the #11's revealed the most nimum Data Set (MDS) was facility transmitted the enters of Medicaid and (CMS) on 2/22/11, according sessment Instrument (RAI) larterly MDS was transmitted after MDS, was completed. pm, Nurse #1 revealed there staff and the other nurse was a #1 stated she had informed at being short staff for MDS's. It is facility hired outside S's were still behind. Nurse #1 rrying to submit MDS's that the nurse stated the MDS ave. The nurse revealed she MDS 3.0 version. The nurse on the MDS nurse out on the MDS nurse out on the MDS nurse was coming are when. The nurse revealed the MDS nurse was coming are when. The nurse was behind the staff was on evealed the MDS's in the	F 28	37				
		ne word "transmitted," was						

NEDART	MENT OF HEALTH	AND HUMAN SERVICES				FORM A	APPROVED 0938-0391_
CENTER	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		LE CONSTRUCTION	(X3) DATE SU COMPLE	RVEY
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		345249	1	1G		04/28	3/2011
NAME OF P	ROVIDER OR SUPPLIER			20	EET ADDRESS, CITY, STATE, ZIP CODE 5 EAST KINGS HWY		
MOREHE	AD NURSING CENT	ER		E	PROVIDER'S PLAN OF CORRECT	TION	(X5)
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F 287 F 319 SS=D	would receive a co of being transmitte	IS. The nurse stated staff nfirmation from within 24 hours d with an acceptance or denial.		287 319	Facility social workers interviewed reasswers given did not indicate depresent However, because this has been an is	ssion.	र्जीकिशी।
	resident, the facility who displays ment	prehensive assessment of a must ensure that a resident all or psychosocial adjustment appropriate treatment and the assessed problem.			resident, the resident and her respons have agreed to a psychiatric evaluation Appointment is being set up with Trie in Greensboro, NC. Chaplain comes to periodically as well.	rible party on. ad Psychiatric	
	by: Based on observa and staff interview	NT is not met as evidenced ation, record review, resident s, the facility failed to provide ices to manage a resident's f 24 sampled residents			2:Any resident who displays mental or padjustment difficulties will receive aptreatment and services per policy.	osychological propriate	:
	(Resident #5). Resident #5 was a 2/17/09 with cumu	idmitted to the facility on lative diagnoses that included ler, Diabetes Mellitus, Renal zed Pain, and Osteoarthritis.		į	3. Facility social worker will monitor for difficulties via periodic assessments appropriate findings to physicians, reparty and interdisciplinary team for in Chaplain services as well as psychiat are available should a resident require	and report sponsible ntervention. ric services	
	7:35 PM, Residented had asked the resident then indicated the resident then indicated the resident the resident the resident the resident the resident the resident discussed.	our of the facility on 4/25/11 at the #5 stated that a staff member ident if the resident "felt that er off dead" and the response of the staff member. The stated that the conversation is at that time. There were #5's cheeks as this was			4. The results of audit tools, edits, mon be reviewed by management staff and monthly to the facility Quality Assur Committee. The committee will revie information and make recommendati appropriate. The committee members Administrator, Director of Nursing, I Directors, Pharmacist, members of the management team and others as need.	d presented ance w data and ons as ship includes; Medical	
	The facility policy Adjustment" with	titled "Mental/Psychological a review date of 2-07 revealed					1 22.55

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PRINTED: 05/10/2011 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B, WING_ 04/28/2011 345249 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 205 EAST KINGS HWY MOREHEAD NURSING CENTER **EDEN, NC 27288** (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE PREFIX (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG F 319 Continued From page 28 that "The social worker will assess the resident and assist in the development of a plan to help the resident adjust to life changes. A psychologist is available to assess the resident and make recommendations to the physician for treatment." A review of the annual Minimum Data Set (MDS) dated 1/14/11 revealed that Resident #5 responded "yes" on the Mood Interview for "Thoughts that you would be better off dead, or of hurting yourself in some way" with a frequency of "7-11 days (half or more of the days)." A review of the resident's clinical record revealed that on 1/31/11 the Social Worker charted the resident "answered yes to statement interview statement 'thoughts you would be better off dead' with symptom frequency of 2 which is 7-11 out of 14 days. Resident is not at risk for self harm as she is totally dependent upon others for mobility and other ADLs (activities of daily living)." No other notes could be found regarding referral or follow up to this statement.

A review of the Care Plan for Resident #5 dated 1/28/11 listed "At times feels down and depressed. Provide reminders of chaplain services." under the diagnosis listed as "diversional activity deficit."

Nurse Aide (NA) #2 stated during an interview on 4/28/11 at 10:26 AM that Resident #5 appeared to be depressed and had told NA #5 that she wished she wasn't alive. NA #2 stated she had reported this to the nurse for the resident.

NA #3 was interviewed on 4/28/11 at 11:04 AM.

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CENTER	RS FOR MEDICARI	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) N	ULTIPI	LE CONSTRUCTION	(X3) DATE SUF	RVEY ED
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	ROVIDER OR SUPPLIER			20	EET ADDRESS, CITY, STATE, ZIP CODE 5 EAST KINGS HWY DEN, NC 27288		
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F 319	depressed and hawould rather not be attempted to make her know she was others. On 4/28/11 at 11: Resident #5 stayed bed. She stated to cope with all the The Social Worker Resident #5 on 4/4 that during the last resident had indicated. The Social referral had been	esident #5 appeared to be ad heard the resident say she alive. NA #3 stated she are Resident #5 feel better and let important to the NA and 14 AM, Nurse #5 stated that ad to herself, rarely got out of that it was hard for Resident #5 at had happened to her. Per was interviewed regarding 128/11 at 11:23 AM. She stated at MDS assessment, the stated she would just as soon be 14 Worker stated she thought a made for this resident.	F	319			
F 325 SS=D	been made. On 4/28/11 at 4:4 (DON) stated that resident answere that they would have thoughts of self harderral would have 483.25(i) MAINTAUNLESS UNAVORBASED on a residence assessment, the resident - (1) Maintains acceptates such as harder the such as harder	O PM, the Director of Nursing tit was her expectation that any d yes to the question of feeling ave been better off dead or had arm an appropriate professional ve been made.		325	1.Resident # 12's weight was obtain weights are being done for eight weight monitored closely by interditeam. This resident has been evalumanager and registered dietician. on an appetite stimulant, special difference plan has been updated as	reeks and are sciplinary nated by dietary The resident is let and suppleme	5/26/11

PRINTED: 05/10/2011 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 04/28/2011 B. WING 345249 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 205 EAST KINGS HWY EDEN, NC 27288 MOREHEAD NURSING CENTER PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PRÉFIX TAG F 325 Continued From page 30 F 325 2.All residents were weighed and weights were demonstrates that this is not possible; and reviewed by Dietary Manager and Director of (2) Receives a therapeutic diet when there is a Nurses. All residents with significant weight loss Are being monitored. Their physician, their nutritional problem. family/responsible party, registered dietician, and interdisciplinary team were all notified and interventions put into place. This REQUIREMENT is not met as evidenced 3. The policy and procedure for obtaining weights by: Based on record review and staff interview, the was revised. Restorative certified nursing facility failed to monitor weights for one (1) of assistants are now responsible for obtaining twenty-four (24) residents (Resident #12). all weights and these weights are reviewed weekly by Dietary Manger and director of Resident #12 had significant weight loss in a one

1. Resident #12 was admitted to the facility on 03/19/2011. Cumulative diagnoses included: left hip fracture, Dementia, Diabetes, Gastroesophageal reflux disease (GERD) and iron deficiency.

month period. Findings included:

Medical record was reviewed. A fourteen day comprehensive assessment using the Minimum Data Set (MDS) was not in the medical record.

Care plan (no date for problem onset) stated Resident #12 was at risk for weight loss related to leaving twenty five (25) per cent or more of food uneaten at most meals. Goals included maintenance of current weight. Approaches included: Regular diet with pureed texture, Dietary manager/ Dietician to evaluate current resident nutritional status, weigh and record as ordered or as deemed appropriate and monitor weights and promptly report significant weight loss or developing trend of continued weight loss.

Physician admission orders for 03/19/2011 were

4. The results of audit tools, edits, monitors will be reviewed by management staff and presented monthly to the facility Quality Assurance Committee. The committee will review data and information and make recommendations as appropriate. The committee membership includes; Administration, Director of Nursing, Medical Directors, Pharmacist, members of the management team and others as needed.

		LAND HUMAN SERVICES					FORM OMB NO.	APPROVI . 0938- <u>03</u>	ED .91_
CENTER	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		CONSTRUCTION		(X3) DATE SI COMPLE	URVEY	
AND PLAN O	FCORRECTION		1,				04/28/2011		
		345249		STREE	T ADDRESS, CITY, S	STATE, ZIP CODE			
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F 325	reviewed. Orders for four weeks on	were noted for weekly weights admits and readmits.	F	325	·				
	reviewed for Marc 03/19/2011, Resid at 132 pounds. Nuntil 04/11/2011 w 115 pounds.	istration Records (MAR) were h 2011 and April 2011. On lent #12 had a weight recorded o further weights were recorded when weight was recorded at							
	admission weight 133.2 pounds. W stated weight on (as reviewed and revealed an recorded on 03/19/2011 at eight chart summary sheet 04/11/2011 was 115.00 pounds.					- 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
	o3/19/2011, 03/25 and 04/15/2011 dependent of any food offere three servings of Occasionally will receives less that tube feeding."	essments for nutrition dated 5/2011, 04/04/2011, 04/08/2011 locumented nutrition as "late. Rarely eats a complete ly eats only about one half (1/2) ed. Protein intake includes only meat or dairy products per day. take a dietary supplement or n optimal amount of liquid diet or							
	Resident #12 had pounds. Meal pe to seventy-five pe added twice daily								
	stated if weight le would send a no When weights a	It 4:00 PM., the Dietary manager oss occurred, nursing personnel te to her as well as the Dietician. re obtained and there is a five ling staff would automatically dent. The Dietary manager							27 251
1	10110.3.				171 - 1D1 042260		continuation sl	neet Page	3Z 01 3

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		PLE CONSTRUCTION	COMPLETED				
		345249	B. WIN	IG		04/28	3/2011			
NAME OF PROVIDER OR SUPPLIER MOREHEAD NURSING CENTER					STREET ADDRESS, CITY, STATE, ZIP CODE 205 EAST KINGS HWY EDEN, NC 27288					
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F 325	Resident #12 and v 03/14/2011. She s anything from nurs weight loss and did Dietician being notiloss. On 04/26/2011 at 4 had documented the did not check the p stated, normally, she weight or the last nurse drastic weight chare either way, the resistated she did not protocol regarding if there was a big weight constitution.	If the hospital weight for weight was 124 pounds on tated she had not received ing staff about Resident #12's I not have a record of the ified of Resident #12's weight weight on 04/11/2011 but brevious weight. Nurse #7 ne would check the previous month's weight. If there was a nege of four or five pounds dent would be reweighed. She know if the facility had a policy/weight changes and what to do weight change.		325						
	she would be cons she had not receive Resident #12. On 04/27/2011 at 8 weights are obtained new admissions are weight loss or decris faxed and the fathought this occurre weight gain or loss on the MAR. Nurs Resident #12 and sthe MAR. She woweight on 03/21/20 admitted on 03/19/have been obtained.	of PM., the Dietician stated ulted for any dietary issues and ed anything in her folder for a stated anything in her folder for a stated anything in her folder for a stated weekly for four weeks on all and readmissions. If there is a reased appetite, the physician mily is notified. She stated she and if there was a five pound. The weights were recorded a stated it was printed wrong on all and thave obtained the last because Resident #12 was 2011 and the weight should don 03/26/2011. She did not id not change the MAR or					•			

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DEPAIL	S FOR MEDICARE	& MEDICAID SERVICES	1		TO COLUMN TO NOT THE TOTAL OF T	(X3) DATE S	URVEY	
CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLI	COMPLETED		
ID PLAN O	PLAN OF CORRECTION		1			04/28/2011		
		345249	<u> </u>		REET ADDRESS, CITY, STATE, ZIP CODE		·	
NAME OF PROVIDER OR SUPPLIER				205 EAST KINGS HWY EDEN, NC 27288				
MOREHE	AD NURSING CENT			L	THOUGHT DIE BLAM OF CORR	ECTION	(X5) COMPLETION	
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F 325	Continued From page 33 document why the weight was not obtained on 03/21/2011.		F	325	5			
	observed eating brands and staff. Nursing staff. Nursing staff. Nursing staff. Nursing staff. She usually fed Related Resident #12 atevate very little at the meal, NA #1 staff. (milliters) of fluid a cent of her breakfa							
	Nursing was aske policy. She stated a weight policy or weights to be done of the weights were observed staff to conext seven days. #12's weights for the weight of 115 expected a compliment of the weight in case of was another weight change was from physician and fam							
F 329	Nursing stated an loss or gain would the facility month! there was not a facility that the facility	3:20 PM., the Director of y weights that had a five pound I require a reweight as noted on y weight sheet. She stated acility protocol to follow for nother than the reweight. REGIMEN IS FREE FROM DRUGS		F 32	29	·		

PRINTED: NOTIVIZATI FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 04/28/2011 B. WING 345249 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 205 EAST KINGS HWY **EDEN. NC 27288** MOREHEAD NURSING CENTER PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PRÉFIX TAG 5/26/1) 1. Residents #5, 11, 15, 24, and 14 taking antipsychotics and raglan, had AIMS tests done F 329 Continued From page 34 and they were filed in their medical record for F 329 resident # 14 was reviewed by the consulting Each resident's drug regimen must be free from pharmacist. Information was provided and a unnecessary drugs. An unnecessary drug is any request was sent to the physician for justification drug when used in excessive dose (including for duplicate therapies or discontinuation of the duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of 2.An audit was done of all resident's medication adverse consequences which indicate the dose regimens to determine those residents taking should be reduced or discontinued; or any antipsychotics and reglan. AIMS tests were done combinations of the reasons above. on all the appropriate residents and were filed on their charts. All residents will have monthly Based on a comprehensive assessment of a medication reviews done with an additional focus resident, the facility must ensure that residents duplicate therapies. who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition 3. The admissions nurse will identify residents being as diagnosed and documented in the clinical admitted or re-admitted that require AIMs test. The record; and residents who use antipsychotic test will be done, filed on the resident's charts and the Director of Nurses notified for tracking drugs receive gradual dose reductions, and purposes. All nurses have been in-serviced to behavioral interventions, unless clinically monitor all drug regimens for possible duplicate contraindicated, in an effort to discontinue these therapies for follow up, in addition to the monthly reviews by the consulting pharmacist. Follow up to drugs. be made with physicians as appropriate. 4. The results of audit tools, edits, monitors will be reviewed by management staff and presented monthly to the facility Quality Assurance This REQUIREMENT is not met as evidenced Committee. The committee will review data and information and make recommendations as Based on record review, pharmacist interview, appropriate. The committee membership includes; and staff interviews, the facility failed to monitor 5 Administration, DON, Medicaid Directors, of 5 sampled residents requiring monitoring for Pharmacist, members of the management team abnormal involuntary movements (residents #5, and others as needed. #11, #15, #24, #14), and failed to ensure residents were free from duplicate therapy for 1

of 4 sampled residents receiving sedatives

(resident #14). Findings include:

PRINTED: US/TUIZUTT FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A, BUILDING AND PLAN OF CORRECTION 04/28/2011 345249 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 205 EAST KINGS HWY EDEN, NC 27288 MOREHEAD NURSING CENTER (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE 1D SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PREFIX TAG F 329 Continued From page 35 F 329 1. The Facility's Pharmacy Policy, undated, read in part: "In addition, the following labs and monitoring criteria will be ordered for residents in the MNC (Morehead Nursing Center) when the resident is receiving the specified drug in the specified therapeutic class. Antipsychotics -DISCUS or AIMS q (every) 6 months...Reglan -DISCUS or AIMS q 6 months." DISCUS (Dyskinesia Identification System Condensed User Scale) and AIMS (Abnormal Involuntary Movement Scale) tests are clinician-rated scales used to monitor the presence and/or severity of abnormal involuntary movements associated with the use of medications. Resident #5 was admitted to the facility on 1/7/09 with multiple diagnoses including dysphagia, abnormal involuntary movements, and Parkinson's disease. Record review of the resident's clinical record revealed physician orders dated 4/26/09 for Reglan (metoclopramide) 5mg (milligram) qid (four times daily). Metoclopramide is a gastrointestinal agent used for delayed gastric emptying and gastro-esophageal reflux disease (GERD). Lexicomp's Drug Information Handbook, 14th edition, Warnings/Precautions for metoclopramide, stated in part: "has been associated with extrapyramidal symptoms. Use caution in the elderly and with Parkinson's

disease; may have increased risk of tardive dyskinesia." Adverse Reactions included in part:

Parkinsonian-like symptoms, tardive dyskinesia.

acute dystonic reactions, akathisia,

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	COMPLETED		
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BU					
		345249	B. WI				/2011	
	ROVIDER OR SUPPLIER	ER		20	REET ADDRESS, CITY, STATE, ZIP CODE 05 EAST KINGS HWY DEN, NC 27288			
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F 329	Review of the residence documentation of the facility documentation of the previous year. In an interview on a (director of nursing pharmacist monitor AIMS tests and manursing. She state had been assigned the past. The DON done and put in a relocate them. She shanged and the ninadvertently been was for the AIMS to	lent's clinical record revealed	F	329				
	in part: "In addition monitoring criteria the MNC (Morehea resident is receivin	harmacy Policy, undated, read n, the following labs and will be ordered for residents in ad Nursing Center) when the g the specified drug in the tic class. Antipsychotics - q 6 monthsReglan - DISCUS is."						
	scales used to mo	Stests are clinician-rated nitor the presence and/or al involuntary movements e use of medications.						
	14 <i>171</i> 06 and readm	admitted to the facility on hitted 7/31/10 with multiple g GERD. Record review of				ontinuation sheet	Page 37 of 57	
		Event ID: 9RI Of:	1	Fa	acility ID: 943360 If co	munuation sneet	Lago or or or	

PRINTED: US/TUIZUTT FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 04/28/2011 B. WING 345249 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 205 EAST KINGS HWY EDEN, NC 27288 MOREHEAD NURSING CENTER (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PRÉFIX TAG F 329 Continued From page 37 F 329 the resident's clinical record revealed physician orders dated 7/31/10 for Reglan (metoclopramide) 5mg ac (before meals) and hs (at bedtime). Metoclopramide is a gastrointestinal agent used for delayed gastric emptying and gastro-esophageal reflux disease. Lexicomp's Drug Information Handbook, 14th edition, Warnings/Precautions for metoclopramide, stated in part: "has been associated with extrapyramidal symptoms. Use caution in the elderly; may have increased risk of tardive dyskinesia." Adverse Reactions included in part: acute dystonic reactions, akathisia, Parkinsonian-like symptoms, tardive dyskinesia. Review of the resident's clinical record revealed no documentation of AIMS testing. Review of the facility's AIMS log book revealed no documentation of AIMS results within the previous year. In an interview on 4/28/111 at 4:09PM, the DON stated the consultant pharmacist monitored the medications requiring AIMS tests and made recommendations to nursing. She stated the 7PM - 7AM supervisor had been assigned to complete the AIMS tests in the past. The DON stated the AIMS tests were done and put in a notebook but she couldn't locate them. She

available.

stated her office had been changed and the notebook may have inadvertently been boxed up. Her expectation was for the AIMS tests to be completed per facility policy, filed, and readily

3. The Facility's Pharmacy Policy, undated, read

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	ERS FOR MEDICARE & MEDICAID SERVICES ENT OF DEFICIENCIES N OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN O	F CORRECTION		B. WIN	1G		04/2	8/2011	
	ROVIDER OR SUPPLIER	345249		20	EET ADDRESS, CITY, STATE, ZIP CODE 15 EAST KINGS HWY			
MOREHE	AD NURSING CENT	ER		E	PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION SHOULD BE		(X5) COMPLETION	
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F 329	monitoring criteria the MNC (Moreher resident is receivir specified therapeu DISCUS or AIMS or AIMS or AIMS q 6 month of a month of	n, the following labs and will be ordered for residents in ad Nursing Center) when the lag the specified drug in the lag that lag that lag the lag that lag tha		329				

PRINTED: 05/10/2011 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 04/28/2011 B. WING 345249 STREET ADDRESS, CITY, STATE, ZIP CODE 205 EAST KINGS HWY NAME OF PROVIDER OR SUPPLIER EDEN, NC 27288 MOREHEAD NURSING CENTER (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES m DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PRÉFIX TAG F 329 Continued From page 39 F 329 In an interview on 4/28/111 at 4:09PM, the DON stated the consultant pharmacist monitored the medications requiring AIMS tests and made recommendations to nursing. She stated the 7PM - 7AM supervisor had been assigned to complete the AIMS tests in the past. The DON stated the AIMS tests were done and put in a notebook but she couldn't locate them. She stated her office had been changed and the notebook may have inadvertently been boxed up. Her expectation was for the AIMS tests to be completed per facility policy, filed, and readily available. 4. The Facility's Pharmacy Policy, undated, read in part: "In addition, the following labs and monitoring criteria will be ordered for residents in the MNC (Morehead Nursing Center) when the resident is receiving the specified drug in the specified therapeutic class. Antipsychotics -DISCUS or AIMS q 6 months...Reglan - DISCUS or AIMS q 6 months." DISCUS and AIMS tests are clinician-rated scales used to monitor the presence and/or severity of abnormal involuntary movements associated with the use of medications. Resident #24 was admitted to the facility on 7/2/09 with multiple diagnoses including bipolar disorder and schizophrenia. Record review of the resident's clinical record revealed physician orders dated 7/11/10 for Seroquel (quetiapine)

schizophrenia.

50mg hs. Seroquel is an antipsychotic agent used for the treatment of bipolar disorder and

Lexicomp's Drug Information Handbook, 14th

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CTATEMENT	CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUII	LDING		(X3) DATE SURVEY COMPLETED 04/28/2011	
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MOREHE	·		ĮD		PROVIDER'S PLAN OF CORREC	CTION	(X5) COMPLETION
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F 329	edition, Warnings/stated in part: "tar Reactions include Monitoring Paraminvoluntary moven Review of the resing documentation	Precautions for Seroquel, dive dyskinesia." Adverse d: involuntary movements. eters included: abnormal nent scale (AIMS). dent's clinical record revealed		329			
	In an interview on stated the consult medications requirecommendations 7PM - 7AM super complete the AIM stated the AIMS to notebook but she stated her office in notebook may have expectation we completed per fact available.	4/28/111 at 4:09PM, the DON ant pharmacist monitored the ring AIMS tests and made to nursing. She stated the visor had been assigned to S tests in the past. The DON ests were done and put in a couldn't locate them. She had been changed and the ve inadvertently been boxed up. vas for the AIMS tests to be billity policy, filed, and readily					
	in part: "In addition monitoring criteria the MNC (Morehe resident is received."	Pharmacy Policy, undated, read on, the following labs and a will be ordered for residents in ead Nursing Center) when the ng the specified drug in the utic class. Antipsychotics - q 6 monthsReglan - DISCUS ths."					
	DISCUS and AIM	S tests are clinician-rated onitor the presence and/or					

PRINTED: U5/TU/ZUTT FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 04/28/2011 345249 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 205 EAST KINGS HWY **EDEN. NC 27288** MOREHEAD NURSING CENTER (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE lD SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) 1D REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG PRÉFIX TAG F 329 Continued From page 41 F 329 severity of abnormal involuntary movements associated with the use of medications. Resident #14 was admitted to the facility on 6/30/09 with multiple diagnoses including gastroparesis, diabetes, and esophageal reflux. Record review of the resident's clinical record revealed physician orders dated 3/25/11 which read "restart Reglan 5mg qhs." Reglan (metoclopramide) is a gastrointestinal agent used for delayed gastric emptying, diabetic gastroparesis, and GERD. Lexicomp's Drug Information Handbook, 14th edition, Warnings/Precautions for metoclopramide, stated in part: "has been associated with extrapyramidal symptoms. Use caution in the elderly; may have increased risk of tardive dyskinesia." Adverse Reactions included in part: acute dystonic reactions, akathisia, Parkinsonian-like symptoms, tardive dyskinesia. Review of the resident's clinical record revealed no documentation of AIMS testing. Review of the facility's AIMS log book revealed no documentation of AIMS results within the previous year. In an interview on 4/28/111 at 4:09PM, the DON stated the consultant pharmacist monitored the

medications requiring AIMS tests and made recommendations to nursing. She stated the 7PM - 7AM supervisor had been assigned to complete the AIMS tests in the past. The DON stated the AIMS test was done and put in a notebook but she couldn't locate it. She stated

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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ATCMENT	OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	LDING	ECONSTRUCTION	COMPLE	28/2011
AME OF PI	ROVIDER OR SUPPLIER	345249	B. Wil	STREE	ET ADDRESS, CITY, STATE, ZIP COD EAST KINGS HWY		20/2011
NOREHE	AD NURSING CENT	ER		. ED	EN, NC 27288 PROVIDER'S PLAN OF COR	RECTION	(X5) COMPLETION
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F 329	expectation was ro completed per fact available.	ently been boxed up. Helen the AIMS tests to be will be allowed the state of the tests to be the state of the test	F	329			
	6/30/09 with multile insomnia. Record reveal and a second reveal a	was admitted to the facility on ple diagnoses including I review of the resident's ealed physician orders dated in (zolpidem) 5mg qhs (every for sleep, and orders dated eron (mirtazepine) 7.5mg qhs bien is a sedative indicated for atment of insomnia. Remeron ant with a non-FDA (Federal on) approved indication for					
	edition, Warnings in part: "use cau' other sedative dr	Information Handbook, 14th s/Precautions for Ambien, stated tion in the elderly. Effects with ugs may be potentiated."					
	administration re and Remeron ha 11/26/10.	the resident's medication cord (MAR) revealed Ambien d been given nightly since					
	dated 1/28/11, 3/ documentation of medications for i						
	progress notes of	f the consultant pharmacist's dated 12/10/10, 1/18/11, 2/28/11 ealed no documentation of the two medications for insomnia.	,				

FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 04/28/2011 B. WING __ 345249 STREET ADDRESS, CITY, STATE, ZIP CODE 205 EAST KINGS HWY NAME OF PROVIDER OR SUPPLIER EDEN, NC 27288 MOREHEAD NURSING CENTER (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES ID DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PRÉFIX TAG F 329 Continued From page 43 F 329 In an interview on 4/28/11 at 12:04PM, the Consultant Pharmacist stated the resident's Remeron had been changed from as needed to scheduled on 11/26/10, and the Ambien had been continued. She stated there would be no clinical reason for both medications to be given concurrently. In a telephone interview on 4/28/11 at 3:05PM, the resident's nurse on second shift (Nurse #9) stated she was aware that Remeron and Ambien were both indicated for sleep. She stated the Ambien was not working well for the resident and Remeron was added. Nurse #9 stated the Remeron was usually given at 9PM and the Ambien at 11PM. In an interview on 4/28/11 at 4:09PM, the Director of Nursing stated the consultant pharmacist identified duplicate therapy during the monthly drug regimen reviews. The DON stated she would expect the pharmacist to have requested an evaluation from the physician to consider discontinuing one of the sedative medications for resident #14. She stated she would expect to have documentation in the resident's chart if the physcian wanted to continue both medications. F 428 1. Routine drug regimen reviews were completed on 5/26)11 483.60(c) DRUG REGIMEN REVIEW, REPORT residents #3, 4, 5, 8, 11, 23, 24. A review of F 428 duplicate drug therapy was completed on resident IRREGULAR, ACT ON SS=E #14, physician was provided information and The drug regimen of each resident must be response requested. reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of

nursing, and these reports must be acted upon.

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					FORM A	APPROVED 0938-0391
DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES (VA) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
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ND PLAN OF	CORRECTION	IDENTIFICATION ROLLS	1	NO	04/2	8/2011
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		FR		EDEN NC 27288	a appearion	(X5) COMPLETION
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F 428		Continued From page 44		2.All residents were screened in a monthly drug regimen had Medication regimen review won all active residents.	n May 2011 to ensur been completed. Vill be done monthly	e ,
	by: Based on record and staff interview the consultant phregimen reviews sampled resident #23, #24), and far pharmacist identisampled resident #14). Findings in 1. The Facility's Consultant Pharmacist in the consultant review as soon a resident to the Mand at least more	Pharmacy Policy, Duties of the macist, undated, read in part: pharmacist shall conduct the as possible after admission of a INC (Morehead Nursing Center) on the content of		3. The Hospital Pharmacy Direct regulations and procedures for review and the role of the conwith to the consulting pharma. Nurses will monitor the monregimen reviews to ensure consumer of the reviewed by management monthly to the facility Qual Committee. The committee information and make reconsuppropriate. The committee Administrator, Director of Directors, Pharmacist, men management team and other consultations.	or monthly regiment insulting pharmacist acist. The Director of the medication impliance. Hits, monitors will at staff and presented ity Assurance will review data amount and acions as a membership including Medicaid abers of the	of 1
	7/30/10 with mu insufficiency, hy atrial fibrillation. Record review of Notes revealed regimen review 2010, or December 1.00 per	of the Interdisciplinary Progress no documentation of a drug for October 2010, November aber 2010.				
	Consultant Pha	on 4/28/11 at 11:01AM, the rmacist stated she didn't have a r her visits to the facility and was ed 7 to 8 days per month to rug regimen reviews. She		W. ID 042360	If continuation	sheet Page 45 c

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CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES		T(V2) N	HI TI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
CTATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU	LDIN	G		
		345249	B. WI	//G_		04/28	3/2011
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TAG	REGULATORY						
F 428	indicated all drug r documented in the Notes in the reside computer. The ph complete the revie sometimes went lot it was her understagrace period for colling an interview on of Nursing (DON) pharmacist condumentally. She state recommendations physician and the her expectation was to complete the remonthly basis.	egimen reviews were Interdisciplinary Progress ents' charts and in her armacist stated she tried to ws every 30 days but onger than monthly. She stated anding there was a 10 day ompleting the reviews. 4/28/11 at 4:09PM, the Director stated the consultant cted drug regimen reviews ed the pharmacist's were faxed to the attending nursing staff. The DON stated as for the consultant pharmacist views for all residents on a		428			
	Consultant Pharm "The consultant plant review as soon as resident to the MN and at least mont! Resident #4 was a 4/25/05 and reading diagnoses including pulmonary diseas cerebrovascular at Record review of Notes revealed no regimen review for 2010.	admitted to the facility on mitted 2/16/11 with multiple ng diabetes, chronic obstructive i.e, hypertension, accident, and atrial fibrillation. the Interdisciplinary Progress o documentation of a drug or November 2010 or March					
	In an interview or	14/28/11 at 11:01AM, the					et Page, 46 of 57

PRINTED: 05/10/2011 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

CENTED	S FOR MEDICARE	& MEDICAID SERVICES	Local M	19 TIPI	E CONSTRUCTION	(X3) DATE S	ETED
OTATEMENIT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	f			00,	
AND PLAN OF	CORRECTION	IDENTIFICATION NOME IN	1" "	LDING		041	28/2011
		345249	B. WI				2012011
	ROVIDER OR SUPPLIER		<u>. l</u>	205	ET ADDRESS, CITY, STATE, ZIP CODE 5 EAST KINGS HWY 0EN, NC 27288		(X5)
		VENEZIE DE DEFICIENCIES	ID PREF		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	HOULD BE PPROPRIATE	(X5) COMPLETION DATE
(X4) ID PREFIX TAG	(EACH DEFICIENC REGULATORY OR	ATEMENT OF DELICION OF THE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TAC	3	DEFICIENCY)		
F 428	Consultant Pharm set schedule for hormally allowed complete the drug indicated all drug documented in the Notes in the residual computer. The promplete the revision sometimes went it was her undersignace period for the set of the s	page 46 nacist stated she didn't have a her visits to the facility and was 7 to 8 days per month to g regimen reviews. She regimen reviews were le Interdisciplinary Progress lents' charts and in her harmacist stated she tried to lews every 30 days but longer than monthly. She stated standing there was a 10 day completing the reviews. In 4/28/11 at 4:09PM, the DON least the she stated the	11	428			
	regimen reviews pharmacist's recattending physic DON stated her consultant pharmall residents on 3. The Facility's	ommendations were faxed to the ian and the nursing staff. The expectation was for the nacist to complete the reviews for a monthly basis. Pharmacy Policy, Duties of the parts undated read in part:	1				
	"The consultant review as soon resident to the M and at least mo	as possible after admission of a MNC (Morehead Nursing Center)	-				
	with multiple did chronic kidney of and history of n	s admitted to the facility on 1/7/09 agnoses including diabetes, disease, coronary artery disease, nyocardial infarction.					
	Notes revealed	of the Interdisciplinary Progress no documentation of a drug for June 2010, July 2010, 10, or January 2011.			Facility ID: 943360	If continuation	sheet Page 47 of

PRINTED: 05/10/2011 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 04/28/2011 B. WING 345249 STREET ADDRESS, CITY, STATE, ZIP CODE 205 EAST KINGS HWY NAME OF PROVIDER OR SUPPLIER EDEN, NC 27288 MOREHEAD NURSING CENTER (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE Ю SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PRÉFIX TAG F 428 Continued From page 47 F 428 In an interview on 4/28/11 at 11:01AM, the Consultant Pharmacist stated she didn't have a set schedule for her visits to the facility and was normally allowed 7 to 8 days per month to complete the drug regimen reviews. She indicated all drug regimen reviews were documented in the Interdisciplinary Progress Notes in the residents' charts and in her computer. The pharmacist stated she tried to complete the reviews every 30 days but sometimes went longer than monthly. She stated it was her understanding there was a 10 day grace period for completing the reviews. In an interview on 4/28/11 at 4:09PM, the DON stated the consultant pharmacist conducted drug regimen reviews monthly. She stated the pharmacist's recommendations were faxed to the attending physician and the nursing staff. The DON stated her expectation was for the consultant pharmacist to complete the reviews for all residents on a monthly basis. 4. The Facility's Pharmacy Policy, Duties of the Consultant Pharmacist, undated, read in part: "The consultant pharmacist shall conduct the review as soon as possible after admission of a resident to the MNC (Morehead Nursing Center) and at least monthly." Resident #8 was admitted to the facility on 8/27/09 and readmitted on 11/17/11 with multiple diagnoses including diabetes, hypertension,

dementia, and depressive disorder.

Record review of the Interdisciplinary Progress Notes revealed no documentation of a drug

DEPAF	RTMENT OF HEALTI	HAND HUMAN SERVICES E & MEDICAID SERVICES LOAD PROVIDER/SUPPLIER/CLIA			T AQUETRICTION	FORM A	05/10/2011 APPROVED 0938-0391 JRVEY
	RS FOR MEDICARI IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUI	LDING	E CONSTRUCTION	04/28/2011	
	PROVIDER OR SUPPLIER		<u> </u>	STRE	EET ADDRESS, CITY, STATE, ZIP CODE 5 EAST KINGS HWY DEN, NC 27288	ECTION	(X5) COMPLETION
(X4) IE PREFI TAG	T SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREI TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE PROPRIATE	DATE
F 42	regimen review for and January 201	or May 2010, September 2010; 1.	F	428		•	
	consultant Phariset schedule for normally allowed complete the druindicated all druindicated in the resistant computer. The complete the resistant was a sometimes were som	n 4/28/11 at 11:01AM, the macist stated she didn't have a her visits to the facility and was 7 to 8 days per month to 19 regimen reviews. She 19 regimen reviews were 19 the Interdisciplinary Progress 19 dents' charts and in her 19 pharmacist stated she tried to 19 views every 30 days but 19 tonger than monthly. She stated 19 standing there was a 10 day 19 completing the reviews.				·	
1	١	LANDIA the DON			}		1

In an interview on 4/28/11 at 4:09PM, the DON stated the consultant pharmacist conducted drug regimen reviews monthly. She stated the pharmacist's recommendations were faxed to the attending physician and the nursing staff. The DON stated her expectation was for the consultant pharmacist to complete the reviews for all residents on a monthly basis.

5. The Facility's Pharmacy Policy, Duties of the Consultant Pharmacist, undated, read in part: "The consultant pharmacist shall conduct the review as soon as possible after admission of a resident to the MNC (Morehead Nursing Center) and at least monthly."

Resident #11 was admitted to the facility on 11/7/06 and readmitted on 7/31/10 with multiple diagnoses including diabetes, hypertension, dementia, coronary artery disease, and history of myocardial infarction.

Event ID: 9RLO11

Facility ID: 943360

If continuation sheet Page 49 of 57

DEPARTMENT OF HEALTH AND HUMAN SERVICES

OMB NO. 0938-0391 (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 04/28/2011 B. WING _ 345249 STREET ADDRESS, CITY, STATE, ZIP CODE 205 EAST KINGS HWY NAME OF PROVIDER OR SUPPLIER EDEN, NC 27288 MOREHEAD NURSING CENTER PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES DATE -ID CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PRÉFIX TAG F 428 Continued From page 49 Record review of the Interdisciplinary Progress Notes revealed no documentation of a drug regimen review for September 2010 and January 2011. In an interview on 4/28/11 at 11:01AM, the Consultant Pharmacist stated she didn't have a set schedule for her visits to the facility and was normally allowed 7 to 8 days per month to complete the drug regimen reviews. She indicated all drug regimen reviews were documented in the Interdisciplinary Progress Notes in the residents' charts and in her computer. The pharmacist stated she tried to complete the reviews every 30 days but sometimes went longer than monthly. She stated it was her understanding there was a 10 day grace period for completing the reviews. In an interview on 4/28/11 at 4:09PM, the DON stated the consultant pharmacist conducted drug regimen reviews monthly. She stated the pharmacist's recommendations were faxed to the attending physician and the nursing staff. The DON stated her expectation was for the consultant pharmacist to complete the reviews for all residents on a monthly basis. 6. The Facility's Pharmacy Policy, Duties of the Consultant Pharmacist, undated, read in part: "The consultant pharmacist shall conduct the review as soon as possible after admission of a resident to the MNC (Morehead Nursing Center) and at least monthly. Resident #23 was admitted to the facility on 6/16/05 and readmitted on 1/7/10 with multiple

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1'	PLE CONSTRUCTION	COMPLETED		
AND PLAN C	F CORRECTION	IDENTIFICATION NOWIDER.	A. BUILDING		0.4/0	0/0044	
	4	345249		OTATE ZIR CORE	04/20	8/2011	
	ROVIDER OR SUPPLIER		20	EET ADDRESS, CITY, STATE, ZIP CODE 05 EAST KINGS HWY DEN, NC 27288	*		
MOREHE	AD NURSING CENT		E	DROVINGERS BLAN OF CORRECT	CTION	(X5) COMPLETION	
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F 428	diagnoses includin fibrillation, seizure disease, dementia. Record review of the Notes revealed no regimen review for 2011. In an interview on Consultant Pharma set schedule for he normally allowed 7 complete the drug indicated all drug regimented in the Notes in the reside computer. The phenometimes went to it was her understagrace period for consultant pharmacist's reconsultant pharmacist's reconsultant pharmacist on a regimen reviews in the residents on a regiment review on stated the consultant pharmacist on a regiment review on stated the reviews in the residents on a regiment review on stated the consultant pharmacist on a regiment review on stated the reviews in the residents on a regiment review on a regiment residents on a regiment regiment residents on a regiment regime	g hypertension, atrial disorder, coronary artery and depressive disorder. The Interdisciplinary Progress documentation of a drug September 2010 and January 4/28/11 at 11:01AM, the acist stated she didn't have a ser visits to the facility and was to 8 days per month to regimen reviews. She egimen reviews were Interdisciplinary Progress ents' charts and in her armacist stated she tried to was every 30 days but onger than monthly. She stated anding there was a 10 day ompleting the reviews. 4/28/11 at 4:09PM, the DON and pharmacist conducted drug nonthly. She stated the mmendations were faxed to the n and the nursing staff. The expectation was for the acist to complete the reviews for monthly basis. The possible after admission of a lic (Morehead Nursing Center)	F 428				

EURITED, OOM TOLED FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 04/28/2011 B. WING 345249 STREET ADDRESS, CITY, STATE, ZIP CODE 205 EAST KINGS HWY NAME OF PROVIDER OR SUPPLIER EDEN, NC 27288 MOREHEAD NURSING CENTER PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES DATE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) (X4) ID TAG PRÉFIX TAG F 428 Continued From page 51 F 428 Resident #24 was admitted to the facility on 7/2/09 with multiple diagnoses including diabetes, hypertension, and bipolar disorder. Record review of the Interdisciplinary Progress Notes revealed no documentation of a drug regimen review for October 2010 and March 2011. In an interview on 4/28/11 at 11:01AM, the Consultant Pharmacist stated she didn't have a set schedule for her visits to the facility and was normally allowed 7 to 8 days per month to complete the drug regimen reviews. She indicated all drug regimen reviews were documented in the Interdisciplinary Progress Notes in the residents' charts and in her computer. The pharmacist stated she tried to complete the reviews every 30 days but sometimes went longer than monthly. She stated it was her understanding there was a 10 day grace period for completing the reviews. In an interview on 4/28/11 at 4:09PM, the DON stated the consultant pharmacist conducted drug

regimen reviews monthly. She stated the

all residents on a monthly basis.

pharmacist's recommendations were faxed to the attending physician and the nursing staff. The DON stated her expectation was for the

consultant pharmacist to complete the reviews for

8. Resident #14 was admitted to the facility on 6/30/09 with multiple diagnoses including

insomnia. Record review of the resident's clinical record revealed physician orders dated 8/21/10 for Ambien (zolpidem) 5mg qhs (every night at

EIVINGED. COLOR FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 04/28/2011 B. WING_ 345249 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 205 EAST KINGS HWY **EDEN, NC 27288** MOREHEAD NURSING CENTER PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES ΙD DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG F 428 Continued From page 52 bedtime) for sleep, and orders dated 11/26/10 for Remeron (mirtazepine) 7.5mg qhs for insomnia. Ambien is a sedative indicated for the short-term treatment of insomnia. Remeron is an antidepressant with a non-FDA (Federal Drug Administration) approved indication for sleep. Lexicomp's Drug Information Handbook, 14th edition, Warnings/Precautions for Ambien, stated in part: "use caution in the elderly. Effects with other sedative drugs may be potentiated." Record review of the resident's medication administration record (MAR) revealed Ambien and Remeron had been given nightly since 11/26/10. Record review of the physician's progress notes dated 1/28/11, 3/29/11, and 4/20/11 revealed no documentation of the clinical need for two medications for insomnia. Record review of the consultant pharmacist's progress notes dated 12/10/10, 1/18/11, 2/28/11, and 4/14/11 revealed no documentation of the clinical need for two medications for insomnia. In an interview on 4/28/11 at 12:04PM, the Consultant Pharmacist stated the resident's Remeron had been changed from as needed to scheduled on 11/26/10. She acknowledged the Ambien had also been continued. She stated there would be no clinical reason for both

discontinuance.

medications to be given concurrently. She stated she should have evaluated the Ambien for

In an interview on 4/28/11 at 4:09PM, the DON

OCDADT	MENT OF HEALTH	AND HUMAN SERVICES				FORM OMB NO.	APPROVED 0938-0391
CENTER	ENTERS FOR MEDICARE & MEDICAID SERVICES ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) M		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ND PLAN O	FOUNCOMO	345249	[04/2	8/2011
IAME OF P	ROVIDER OR SUPPLIER	340240	1	STR 20	EET ADDRESS, CITY, STATE, ZIP CODE 05 EAST KINGS HWY		
MOREHE	AD NURSING CENTI	ER	_	E	DEN, NC 27288 PROVIDER'S PLAN OF CORRECT	OTION	(X5)
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F 428	Continued From pa	age 53 int pharmacist identified	F	428			
F 441 SS=D	duplicate therapy of regimen reviews. expect the pharma evaluation from the discontinuing one of resident #14. She have documentation physician wanted to 483.65 INFECTION SPREAD, LINENS	The DON stated she would cist to have requested an ephysician to consider of the sedative medications for stated she would expect to on in the resident's chart if the continue both medications. N CONTROL, PREVENT	F	441			
	Infection Control P	stablish and maintain an rogram designed to provide a comfortable environment and development and transmission ection.					
	Program under what (1) Investigates, coin the facility; (2) Decides what I	stablish an infection control nich it - ontrols, and prevents infections procedures, such as isolation, to an individual resident; and cord of incidents and corrective					
	determines that a prevent the sprea- isolate the resider (2) The facility mu	resident needs isolation to d of infection, the facility must	The second secon				

direct contact will transmit the disease.

(3) The facility must require staff to wash their

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					0938-0391		
STATEMENT	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	irvey Ted		
		345249	B. WII	4G _		04/28	3/2011		
	ROVIDER OR SUPPLIER			2	REET ADDRESS, CITY, STATE, ZIP CODE 05 EAST KINGS HWY				
MOREHE	AD NURSING CENT	≣R		E	DEN, NC 27288	TION	(75)		
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F 441	Continued From pa hands after each di hand washing is ind professional practic	rect resident contact for which dicated by accepted	F	441	Upon notification of improper techniq was instructed in proper sanitation prothe glucometer was sanitized prior to resident use.	on procedure and			
	(c) Linens Personnel must ha transport linens so infection.	ndle, store, process and as to prevent the spread of			2.All nurses were reminded of the prop This will also be reviewed during a st 5/24/11 and 5/31/11. Attendance is n nursing staff.	(1112 tarr	·		
	by: Based on observa interviews, the facility glucometer for 1 of #26) observed recemonitoring. Finding The facility's policy and Cleaning of Me "Cleaning the Exterior the meter must be resident by wiping The Center for Disception Guideling read in part: "Any equipment is share a risk of transmitting blood borne pathog	titled Blood Glucose Testing eter, revised 3/08, read in part: rior of the Meter - The exterior be cleaned between each down with Sani-cloth wipes." ease Control (CDC) and mes for Glucose Monitoring time blood glucose monitoring ed between individuals there is ag viral hepatitis and other gens."			3. In-services were conducted 5/19/11 a to review proper technique with all properties of audit annually in May to update Nurse Corden be reviewed by management staff and monthly to the facility Quality Assur Committee. The committee will review information and make recommendate appropriate. The committee members Administrator, Director of Nurses, M. Pharmacist, members of the management and others as needed.	rofessional are done appetencies. hitors will d presented ance ew data and ions as ship includes; fedical Direct	ors,		
	Safe Injection Prac Patient-to-Patient T Pathogens" read in surfaces such as 9	mended Infection Control and etices to Prevent Fransmission of Bloodborne part: "Environmental lucometers should be gularly and anytime							

FORM APPROVED

FORM APPROVED OMB NO. 0938-0391

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	iultip Ilding	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345249	B. WING			04/28/2011	
	PROVIDER OR SUPPLIER	≣R		20	EET ADDRESS, CITY, STATE, ZIP 5 EAST KINGS HWY DEN, NC 27288	CODE	
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F 441	is suspected. Gluctorindividual patients been used for one patients.	ge 55 blood or body fluids occurs or ometers should be assigned s. If a glucometer that has patient must be reused for device must be cleaned and	F	141			
	tests involve sticking blood sample, which	erstick blood sugar (FSBS) g a resident's finger for a n is then placed on a strip. a glucose meter that reads the					
	3/25/11 with multiple diabetes. Record re	dmitted to the facility on e diagnoses including eview of the resident's clinical hysician order dated 3/25/11 daily).	*				
	nurse #10 preparing sugar for resident #2 glucometer from its test strip into the glu the resident's finger a blood sample by d a drop of blood to the test results, Nurse # Nurse #10 disposed pad, and lancet. Nu glucometer with a 70 and placed the glucocase. Nurse #10 did after use.	to obtain a finger stick blood 26. Nurse #10 removed the carrying case and inserted a cometer. Nurse #10 wiped with an alcohol pad, obtained isposable lancet, and applied te test strip. After reading the 10 removed the test strip. of the used test strip, alcohol rse #10 then cleaned the 1% alcohol disposable wipe meter back into its carrying not disinfect the glucometer		And the second s			
	In an interview on 4/2 stated she had been month and was traine	27/11 at 6:05PM, Nurse #10 working at the facility for one ed how to clean the					

FORM APPROVED OMB NO. 0938-0391

CENTERS FOR WILDIOANL & MILDIOAND OLIVIOLS		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		EFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LDIN	G	COMPLETED	
		345249	B. WII	4G		04/2	8/2011
NAME OF PROVIDER OR SUPPLIER MOREHEAD NURSING CENTER				2	REET ADDRESS, CITY, STATE, ZIP CODE 05 EAST KINGS HWY DEN, NC 27288		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION ĐATE
F 441	glucometer by the f acknowledged she the glucometer afte Nurse #10 stated sl sani-wipes, which co clean and disinfect indicated there were the time. She state sani-wipes, I just for In an interview on 4 of Nursing (DON) st trained in general of facility's educator at train her. The DON trained specifically of glucometer use, cle indicated Nurse #10 the FSBS observation.	loor nurse. Nurse #10 had used alcohol only to clean ir using it for resident #26. he normally used the ontained a disinfectant, to the glucometer. Nurse #10 e no sani-wipes on her cart at d "I should have gotten the rgot, I was nervous." /28/11 at 4:09PM, the Director tated Nurse #10 had been rientation and also by the nd the floor nurse assigned to I stated Nurse #10 had been on the proper procedure for aning, and storage. She D said she was nervous during on. The DON stated she o clean and disinfect	F	141			

•		I AND HUMAN SERVICES		EGEIVED	PRINTED: 06/06/2 FORM APPROV OMB NO. 0938-0
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI	NAME OF WAIN ENTRING 0101	(X3) DATE SURVEY COMPLETED
	•	345249	EN	TRUCTION SECTION	05/26/2011
	PROVIDER OR SUPPLIER EAD NURSING CENTE	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 205 EAST KINGS HWY EDEN, NC 27288	
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K 029 SS=D	1		Κo	29 1.The penetrations in the ceiling of the repaired on 5/27/11.	shop were 5/27/20
				Maintenance personnel will inspect the to locate and repair any penetrations in the second seco	
				Maintenance will inspect one quarter every 3 months to ensure penetrations and repaired. A preventative maintens standing work order will be developed.	s are identified ince (PM)
	A. Based on observe contained gas fired with the room now a sever must be both one ho	e penetrations in the ceiling of ot properly sealed to		4. The results of audit tools, edits, monibe reviewed by management staff and monthly to the facility Quality Assura Committee. The committee will revie information and make recommendation appropriate. The committee members Administration, Director of Nursing, Pharmacist, members of the management others as needed	I presented once w data and ons as ship includes; Medical Directors,
K 046 SS≂D	NFPA 101 LIFE SAF	ETY CODE STANDARD f at least 1½ hour duration is ce with 7.9. 19.2.9.1.	K 04	generator circuit.	- 1/6
1	This STANDARD is : A. Based on observe	not met as evidenced by: ation on 05/26/2011 the v that the lights in the court		2. Maintenance personnel will review to ensure all areas needing emergency circuit will be assessed. 3. The lighting in court yard will be upgenerator power.	Portordio

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION IG 01 - MAIN BUILDING 0101	COMPLETED	
	•	345249 ·	B. Wii	NG_		05/26	/2011
	PROVIDER OR SUPPLIER EAD NURSING CENTE	R	k	2	REET ADDRESS, CITY, STATE, ZIP CODE 05 EAST KINGS HWY DEN, NC 27288	-	
(X4) ID PREFIX TAG	/EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 047 SS=D	Exit and directional accordance with se	signs are displayed in ction 7.10 with continuous ved by the emergency lighting	K	047	K 046 4. The results of audit tools, edits, moni be reviewed by management staff and monthly to the facility Quality Assure Committee. The committee will revie information and make recommendate appropriate. The committee member Administration, Director of Nursing, Pharmacist, members of the manager others as needed	I presented ance ow data and ons as ship includes; Medical Direct	7/6/2011 tors,
K 056	A. Based on observere no Exits directicourt yard. 42 CFR 483.70 (a)	not met as evidenced by: vation on 05/26/2011 there ing as how to egress from the	ΚŒ)56	K 047 1. Illuminated exit signs will be mounte courtyard.	d in the	7/6/2011
SS=D	Installed in accordar for the Installation of provide complete co building. The syster accordance with NF Inspection, Testing,	atic sprinkler system, it is nee with NFPA 13, Standard Sprinkler Systems, to verage for all portions of the n is properly maintained in PA 25, Standard for the and Man Courtee of			Maintenance personnel will assess the for adequacy of exit signs accordance Signs showing exits will be mounted a	with regulation	ate account
	Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5				doors and connected to the emergency power generator. Upon completion, staff and residents will be given an in-service on the exit signs and procedures.		7/6/2011
	This STANDARD is A. Based on observ	not met as evidenced by: ation on05/26/2011 the ne East hall was not covered		***************************************	4. The results of audit tools, edits, monit be reviewed by management staff and monthly to the facility Quality Assura Committee. The committee will revier information and make recommendatio appropriate. The committee members Administration, Director of Nursing, I Pharmacist, members of the managem others as needed	presented nce w data and ns as hip includes; Medical Directo	

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

		E & MEDICAID SERVICES				OMB NO.	<u>09</u> 38-039
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		345249	B. WII	//G		05100	lonaa
	PROVIDER OR SUPPLIER EAD NURSING CENTE	R	I	205 E	ADDRESS, CITY, STATE, ZIP CODE AST KINGS HWY N, NC 27288	05/26	/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
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		Ko	K 0: 61 1.Th	56 he sprinkler contractor will install a s ad in the East hall electrical closet.	sprinkler	7/6/20
				ens	sintenance personnel will inspect fac sure adequate sprinkler coverage.		6/30/20
				loca	ring quarterly sprinkler inspections tractor will be required to review sp ations and coverage to ensure compl h regulations.	rinkler	7/6/201
	 A. Based on observa 	not met as evidenced by: ation on 05/26/2011 the the two dry sprinkler pervised,		mo Cor info app Adr Pha	results of audit tools, edits, monitoreviewed by management staff and pathly to the facility Quality Assurant muttee. The committee will review armation and make recommendation ropriate. The committee membersh ministration, Director of Nursing, Manacist, members of the managements as needed	presented ce data and s as ip includes; edical Director	7/6/201
) une	nkler contractor will install a monit compressed air valve input line to the nain sprinkler riser.	or alarm on se accelerator	7/6/20
			•	2.Spri ensu	nkler contractor will inspect and tes re all valves are monitored as requi	t the system to red by regulation	<i>7/6/</i> 201 1.
				3.The inspx	sprinkler contractor during quarterly ect and test monitored valves and al	/ visits will arm systems.	7/6/201
				be remoned moned m	results of audit tools, edits, monitor eviewed by management staff and puthly to the facility Quality Assurance mittee. The committee will review mation and make recommendations oppriate. The committee membership inistration, Director of Nursing, Memacist, members of the managements as needed	resented e data and as o includes; dical Directors	7/6/201