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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____ OCT 31 2011	10/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN NURSING CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to follow the care plan to monitor dialysis access sites for two of two residents (Resident #10 and Resident #105) receiving hemodialysis. The findings include: 1. Resident #10 was admitted to the facility on 7/20/01 and re-admitted on 8/4/11 with cumulative diagnoses that included End Stage Renal Disease, Pancreatic Disorder and Anemia. The resident was receiving Hemodialysis three times a week. The resident was assessed as being severely cognitively impaired on the most recent Quarterly Minimum Data Set (MDS) Assessment dated 8/16/11. A review of the resident ' s most recent care plan included the following: "assess shunt site, monitor for warmness, drainage, redness to site." Review of the nursing notes for (Medicare charting) for months of August, September and October 2011 did not reveal any documentation of assessment of the dialysis assess site. A review of the Medication Administration Record	F 282	F282 **STANDARD DISCLAIMER:** **This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).** **For Resident #10 and Resident #105, their dialysis access sites are being monitored as ordered by the physician and in accordance with their individual care plans.** **For those resident's having the potential to be affected by the same alleged deficient practice(s), a physician's order was in place on 10-13-2011 to assess the dialysis access site following dialysis and all licensed nurses have been educated to document the assessment on the Medication Administration Record.** **The Clinical Coordinator and/or Director of Nursing will monitor the Medication Administration Record no less than weekly to determine compliance.** **Any discrepancies noted on the Medication Administration Record by the Clinical Coordinator and/or Director of Nursing shall be presented to the Quality Assurance Committee monthly for three months, then quarterly thereafter to ensure compliance.**	10-13-2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lori Dayvor, RN	Administrator	10-27-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 282	Continued From page 1 and Treatment Record did not reveal any documentation of assessment of the resident's dialysis assess site following dialysis. During an interview with Nurse #3 on 10/12/11 at 12:05PM she stated that she did not check the dialysis access site when the resident returns from dialysis unless the dialysis center calls and says there is a problem. She stated that this resident returns on the van and gets in her wheelchair and rolls herself down for lunch and then goes outside to smoke. During an interview with Director of Nursing on 10/12/11 at 12:10PM she stated that the facility does not have any protocol for dialysis as far as checking sites and doing vitals. The Director of Nursing stated that the dialysis center does this and if there is a problem then they let us know or they send the resident to the hospital. She stated that she was sure the nursing staff check the sites but this is not documented anywhere. During an interview with Minimum Data Set Coordinator on 10/12/11 at 1:25PM she stated that the facility does not have a specific protocol for dialysis. She stated that the care plan should have been more specific in stating that if the resident complains of pain or discomfort to assess the dialysis shunt site. She stated that "we really depend on the dialysis center to check the shunt site." During an interview with Administrator on 10/12/11 at 12:45PM she stated that if the care plan reads to assess the site then it would be expected to be done or the care plan needs to be updated to read to be done at dialysis.	F 282		

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F 282	Continued From page 2 During an interview with the Facility Manager at the dialysis center on 10/12/11 at 2:30PM she stated that the majority of the residents return to facility with a dressing over the access site. She stated that the nursing staff should be checking these sites to monitor for any bleeding or problems. During an interview with the Administrator on 10/13/11 at 1:00PM she stated that there is now a Physician's Order in place to check the dialysis site following dialysis and the assessment will be documented on the Medication Administration Record. 2. Resident #105 was admitted to the facility on 2/3/11 with cumulative diagnosis that included End Stage Renal Disease. The resident was receiving Hemodialysis three times a week. The resident was assessed on the latest Quarterly Minimum Data (MDS) Assessment as being cognitively intact. A review of the care plan dated 3/14/11 and updated quarterly included the following: "assess shunt site, monitor for redness, warmth, drainage." Review of the Nursing notes showed no documentation of assessment of the shunt site. A review of the Medication Administration Record and Treatment Record did not reveal any documentation of assessment of the resident's dialysis assess site following dialysis. During an interview with Nurse #3 on 10/12/11 at 12:05PM she stated that she did not check the	F 282		

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F 282	Continued From page 3 dialysis access site when the resident returns unless the dialysis center calls and says there is a problem. During an interview with Director of Nursing on 10/12/11 at 12:10PM it was stated that the facility does not have any protocol for dialysis as far as checking sites and doing vitals. The Director of Nursing stated that the dialysis center does this and if there is a problem then they let us know or they send the resident to the hospital. She stated that she was sure the nursing staff check the sites but this assessment is not documented anywhere. During an interview with Minimum Data Set Coordinator on 10/12/11 at 1:25PM she stated that the facility does not have a specific protocol for dialysis. She stated that the care plan should have been more specific in stating that if the resident complains of pain or discomfort to assess the dialysis shunt site. She stated that "we really depend on the dialysis center to check the shunt site." During an interview with Administrator on 10/12/11 at 12:45PM she stated that if the care plan reads to assess the site then it would be expected to be done or the care plan needs to be updated to read to be done at dialysis. During an interview with the Facility Manager at the dialysis center on 10/12/11 at 2:30PM she stated that the majority of the residents return to facilities with a dressing over the access site. She stated that the nursing staff should be checking these sites to monitor for any bleeding or problems.	F 282		

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F 282	Continued From page 4 During an interview with resident on 10/12/11 at 3:20PM she stated the no one checks her access site after dialysis. She states that she does return with a dressing and she takes it off when she feels like the dressing is dry. During an interview with the Administrator on 10/13/11 at 1:00PM she stated that there is now a Physician's Order in place to check the dialysis site following dialysis and the assessment will be documented on the Medication Administration Record.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, dialysis center interviews and record review, the facility failed to monitor the dialysis access site for 2 of 2 residents receiving hemodialysis. (Resident #10 and Resident #105). The findings include: 1. Resident #10 was admitted to the facility on 7/20/01 and re-admitted on 8/4/11 with cumulative diagnoses that included End Stage	F 309		

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F 309	Continued From page 5 Renal Disease, Pancreatic Disorder and Anemia. The resident was receiving Hemodialysis three times a week. The resident was assessed as being severely cognitively impaired on the most recent Quarterly Minimum Data Set (MDS) Assessment dated 8/16/11. A review of the resident's most recent care plan included the following: "assess shunt site, monitor for warmness, drainage, redness to site." Review of the nursing notes for (Medicare charting) for months of August, September and October 2011 did not reveal any documentation of assessment of the dialysis assess site. A review of the Medication Administration Record and Treatment Record did not reveal any documentation of assessment of the resident's dialysis assess site following dialysis. During an interview with Nurse #3 on 10/12/11 at 12:05PM she stated that she did not check the dialysis access site when the resident returns from dialysis unless the dialysis center calls and says there is a problem. She stated that this resident returns on the van and gets in her wheelchair and rolls herself down for lunch and then goes outside to smoke. During an interview with Director of Nursing on 10/12/11 at 12:10PM she stated that the facility does not have any protocol for dialysis as far as checking sites and doing vitals. The Director of Nursing stated that the dialysis center does this and if there is a problem then they let us know or they send the resident to the hospital. She stated that she was sure the nursing staff check the	F 309	**F309** **STANDARD DISCLAIMER:** **This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).** **For Resident #10 and Resident #105, their dialysis access sites are being monitored as ordered by the physician and in accordance with their individual care plans.** **For those resident's having the potential to be affected by the same alleged deficient practice(s), a physician's order was in place on 10-13-2011 to assess the dialysis access site following dialysis and all licensed nurses have been educated to document the assessment on the Medication Administration Record.** **The Clinical Coordinator and/or Director of Nursing will monitor the Medication Administration Record no less than weekly to determine compliance.** **Any discrepancies noted on the Medication Administration Record by the Clinical Coordinator and/or Director of Nursing shall be presented to the Quality Assurance Committee monthly for three months, then quarterly thereafter to ensure compliance.**	10-13-2011

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F 309	Continued From page 6 sites but this is not documented anywhere. During an interview with Minimum Data Set Coordinator on 10/12/11 at 1:25PM she stated that the facility does not have a specific protocol for dialysis. She stated that the care plan should have been more specific in stating that if the resident complains of pain or discomfort to assess the dialysis shunt site. She stated that "we really depend on the dialysis center to check the shunt site." During an interview with Administrator on 10/12/11 at 12:45PM she stated that if the care plan reads to assess the site then it would be expected to be done or the care plan needs to be updated to read to be done at dialysis. During an interview with the Facility Manager at the dialysis center on 10/12/11 at 2:30PM she stated that the majority of the residents return to facility with a dressing over the access site. She stated that the nursing staff should be checking these sites to monitor for any bleeding or problems. During an interview with the Administrator on 10/13/11 at 1:00PM she stated that there is now a Physician's Order in place to check the dialysis site following dialysis and the assessment will be documented on the Medication Administration Record. 2. Resident #105 was admitted to the facility on 2/3/11 with cumulative diagnosis that included End Stage Renal Disease. The resident was receiving Hemodialysis three times a week. The resident was assessed on the latest Quarterly	F 309		

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F 309	Continued From page 7 Minimum Data (MDS) Assessment as being cognitively intact. A review of the care plan dated 3/14/11 and updated quarterly included the following: "assess shunt site, monitor for redness, warmth, drainage." Review of the Nursing notes showed no documentation of assessment of the shunt site. A review of the Medication Administration Record and Treatment Record did not reveal any documentation of assessment of the resident's dialysis assess site following dialysis. During an interview with Nurse #3 on 10/12/11 at 12:05PM she stated that she did not check the dialysis access site when the resident returns unless the dialysis center calls and says there is a problem. During an interview with Director of Nursing on 10/12/11 at 12:10PM it was stated that the facility does not have any protocol for dialysis as far as checking sites and doing vitals. The Director of Nursing stated that the dialysis center does this and if there is a problem then they let us know or they send the resident to the hospital. She stated that she was sure the nursing staff check the sites but this assessment is not documented anywhere. During an interview with Minimum Data Set Coordinator on 10/12/11 at 1:25PM she stated that the facility does not have a specific protocol for dialysis. She stated that the care plan should have been more specific in stating that if the resident complains of pain or discomfort to	F 309		

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F 309	Continued From page 8 assess the dialysis shunt site. She stated that "we really depend on the dialysis center to check the shunt site." During an interview with Administrator on 10/12/11 at 12:45PM she stated that if the care plan reads to assess the site then it would be expected to be done or the care plan needs to be updated to read to be done at dialysis. During an interview with the Facility Manager at the dialysis center on 10/12/11 at 2:30PM she stated that the majority of the residents return to facilities with a dressing over the access site. She stated that the nursing staff should be checking these sites to monitor for any bleeding or problems. During an interview with resident on 10/12/11 at 3:20PM she stated the no one checks her access site after dialysis. She states that she does return with a dressing and she takes it off when she feels like the dressing is dry. During an interview with the Administrator on 10/13/11 at 1:00PM she stated that there is now a Physician's Order in place to check the dialysis site following dialysis and the assessment will be documented on the Medication Administration Record.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329		

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F 329	Continued From page 9 indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interviews and medical record review, the facility failed to monitor the resident's listed allergy of NSAIDS for 1 of 10 residents (Resident #37) reviewed for unnecessary medications and failed to monitor 1 of 10 residents (Resident #107) receiving hypnotics. The findings include: 1. Resident #37 was admitted to the facility on 4/1/04 and readmitted on 7/14/10 with diagnoses of dementia, cerbrovascular accident (stroke), chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and osteoarthrosis.	F 329		

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F 329	Continued From page 10 A review of the Lexi-Comp ' s Drug Reference Geriatric Dosage Handbook 12th edition, revealed Aspirin ' s pharmacologic category is a salicylate. Referenced under Contraindications, " Hypersensitivity to salicylates, other NSAIDS, or any component of the formulation. " A review of the allergy sticker on the front of the resident's medical chart revealed Resident #37 had an allergy to NSAIDS (nonsteroid anti-inflammatory drugs) A review of the resident's Physician's Orders for October 2011 revealed she was ordered on 7/14/10 Aspirin 325 mg (an NSAID) 1 tablet by mouth once daily. A review of the Medication Administration Record (MAR) for the month of October 2011 revealed on the allergies section the resident had listed NSAIDS. Listed on the MAR was Aspirin 325 mg tablet take 1 tablet by mouth once daily. Documentation revealed the resident received the Aspirin October 1st thru 12th, 2011. A review of the facility consultant pharmacist chart review revealed there was no documentation concerning the resident being on Aspirin with an NSAID allergy. During an interview on 10/12/11 at 1:40 PM, Nurse #1 stated her process for giving medications was she would look on the MAR and on the front of the chart and would not give a medication the resident had an allergy to. She stated she did not know why the Aspirin was continued without someone addressing Resident	F 329	**F329** **STANDARD DISCLAIMER:** **This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).** **A physician's order was received on 10/12/2011 to remove the "NSAID ALLERGY" from chart of resident #37. A physician's order dated 11-10-2008 was found in the thinned chart of resident #37 that read "D/C ASA Allergy". A copy of this order was presented to the surveyor on 10/12/2011.** **For those residents having the potential to be affected by the same alleged deficient practice(s), all licensed nurses have received education on the importance of checking the Medication Administration Record for any allergies prior to medication administration and to report any discrepancies found to the physician and pharmacy. The Consultant Pharmacist will review the Medication Administration Records monthly for any allergy discrepancies. Any discrepancies noted will be brought to the attention of the physician and the pharmacy.** **The Consultant Pharmacist will monitor the communications to the physician no less than monthly to determine compliance. Any discrepancies identified by the Consultant Pharmacist will be presented to the Quality Assurance Committee monthly for three months, then quarterly thereafter to ensure compliance.**	10-13-2011

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F 329	Continued From page 11 #37 had an allergy to NSAIDS. Nurse #1 further stated the resident had been getting the Aspirin for a while and she did not think she was allergic to the NSAID. Nurse #1 stated the pharmacy should have been alerted when they printed the MAR with any medication a resident was noted as having an allergy to. During an interview on 10/12/11 at 1:10 PM, the Director of Nursing (DON) stated she had called the facility pharmacist and he said he did not know why the resident was receiving Aspirin when she had an allergy to NSAIDS. She stated she had called the pharmacy consultant and he did not know why he missed the resident was receiving Aspirin and had an NSAIDS allergy. The DON further stated the nurses should not have given the Aspirin, a known NSAID, without getting clarification from the physician. The DON further stated she had called the physician and he stated the resident was not allergic to Aspirin and to continue to give her the Aspirin and remove the allergy from her medical record. During an interview on 10/12/11 at 3:45 PM, the facility pharmacist stated the resident had been taking the Aspirin and had not had any reaction, but the MAR should have reflected her true allergies. The allergy to an NSAID should have been clarified by the nurses before they gave the Aspirin. The pharmacy consultant, while monitoring her medications, should have seen she was receiving Aspirin and had an allergy to NSAIDS. The pharmacy consultant should have notified the facility of the allergy and made a recommendation to discontinue the allergy if she was not having any adverse consequences.	F 329		

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F 329	Continued From page 12 2. Resident #107 was originally admitted to the facility on 8/12/11, with diagnoses including Decubitus Ulcer, (Pressure Sore on skin), Neurogenic Bladder, Severe Arthritis and Insomnia. According to the most recent Quarterly Minimum Data Set (MDS) dated 9/23/11, Resident #107's memory was intact and he required total assistance in all areas of activities of daily living. Review of the Medication Administration Record (MAR) revealed when Resident #107 was admitted to the facility on 8/12/11, he started receiving Trazodone 50 mgs. at bedtime for insomnia (lack of sleep). On 8/13/11 Resident #107 also started receiving Ambien 5 mgs. as needed at bedtime for insomnia. According to the Medication Administration Record (MAR), on 9/6/11, Ambien 5mgs. was changed from as needed to Ambien 5mgs. every night at bedtime. Review of the doctor's standing orders dated 9/1/11 through 9/30/11 revealed Resident #107 received Trazodone 50 milligrams and Ambien 5 milligrams at bedtime for insomnia. Review of a Pharmacist's note dated 8/25/11 read in part, "Hopefully can (symbol for change) Trazodone back to prn (as needed) insomnia, by 9/11." Review of another Pharmacist's note dated 9/19/11 read in part, "Req. (request) (symbol for change) Trazodone to prn (as needed) insomnia." Review of a document, dated 9/20/11 and titled, "Consultant Pharmacist Communication to Physician," read in part, "As a reminder, this	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING _____ B. WING _____	10/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN NURSING CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 13 patient has been on Trazodone 50 milligrams q hs (bedtime) (8pm) for insomnia since admission 1 month ago. Consider a switch to q hs (bedtime) prn (as needed) insomnia" "(Attempts at GDR (Gradual Dose Reduction) of sedative/hypnotic meds. is required per the guidelines.)" During an interview on 10/12/11 at 2:10PM, the Director of Nursing (DON) stated the Pharmacist should have sent a note, written on 9/19/11, to the doctor, and he (Pharmacist) probably gave the note to her on 9/21/11. The Director of Nursing explained that the Pharmacist could make a recommendation but it was up to the doctor's discretion to make changes. She stated sometimes it might take up to a month for the doctor to sign the recommendation. During an interview on 10/13/11 at 10:50AM the Pharmacist revealed he would like the consultant recommendation back from the doctor as soon as possible and he wished it could be returned quickly. He revealed getting the recommendation signed and returned from the doctor was a difficult process. He revealed sometimes it could take up to two months to get a response from the doctor. The Pharmacist stated if it was an urgent matter he would call the doctor himself. He revealed he wanted to change Trazodone to, as needed, because Resident #107 was also getting Ambien which was another medication for sleep. The Pharmacist revealed Resident #107 had only been in the facility for a short period of time. He stated he wanted the resident to be on Trazodone instead of Ambien, but the main focus was to have the resident take one sleep medication instead of two.	F 329	**F329** **STANDARD DISCLAIMER:** **This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).** **The "Consultant Pharmacist Communication to the Physician" form for resident #107 was signed by the physician on 10/12/2011 to allow the Trazodone to be given as needed.** **For those residents having the potential to be affected by the same alleged deficient practice(s), the Consultant Pharmacist will review the communications to the physician monthly to ensure they are returned to the facility in a timely manner. The physician will be notified by phone for communications not returned to the facility within thirty days.** **The Consultant Pharmacist will monitor the communications to the physician no less than monthly to determine compliance. Any discrepancies identified by the Consultant Pharmacist will be presented to the Quality Assurance Committee monthly for three months, then quarterly thereafter to ensure compliance.**	10-13-2011

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	345210	A. BUILDING _____ B. WING _____	10/13/2011

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F 329	Continued From page 14 During another interview on 10/13/11 at 10:20AM, the Director of Nursing revealed if she did not have the consultant Pharmacist's recommendations back by the end of the month, she would call the doctor's office to check on the status. She stated that if there was no response from the doctor from three weeks to a month, they would send the doctor another copy of the Pharmacist's recommendation. During an interview on 10/14/11 at 10:55AM, the Administrator revealed they did not have a protocol for the length of time to get the consultant recommendation signed and returned. She stated the Pharmacist consultant report was just a recommendation and it was up to the doctor to accept the recommendation.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be 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. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the pharnmacy consultant failed to report a possible drug allergy to the facility for 1 (Res. #37) of 10 res. reviewed for unnecessary medications and	F 428		

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F 428	Continued From page 15 the facility failed to act on a pharmacy recommendation for 1 (Res. #107) of 10 residents reviewed. The findings include: 1. Resident #37 was admitted to the facility on 4/1/04 and readmitted on 7/14/10 with diagnoses of dementia, cerbrovascular accident (stroke), chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF) and osteoarthrosis. A review of the Lexi-Comp ' s Drug Reference Geriatric dosage handbook 12th edition revealed Aspirin ' s pharmacologic category is a salicylate. Referenced under contraindications, " Hypersensitivity to salicylates, other NSAIDS, or any component of the formulation. " A review of the allergy sticker on the front of the resident's medical chart revealed Resident #37 had an allergy to NSAIDS (nonsteroid anti-inflammatory drugs) A review of the resident's Physician's Orders for October 2011 revealed she was ordered on 7/14/10 Aspirin 325 mg (an NSAID) 1 tablet by mouth once daily. A review of the Medication Administration Record (MAR) for the month of October 2011 revealed on the allergies section the resident had listed NSAIDS. Listed on the MAR was Aspirin 325 mg tablet take 1 tablet by mouth once daily. Documentation revealed the resident received the Aspirin October 1st thru 12th, 2011.	F 428	**F428** **STANDARD DISCLAIMER:** **This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).** **A physician's order was received on 10/12/2011 to remove the "NSAID ALLERGY" from chart of resident #37. A physician's order dated 11-10-2008 was found in the thinned chart of resident #37 that read "D/C ASA Allergy". A copy of this order was presented to the surveyor on 10/12/2011.** **For those residents having the potential to be affected by the same alleged deficient practice(s), all licensed nurses have received education on the importance of checking the Medication Administration Record for any allergies prior to medication administration and to report any discrepancies found to the physician and pharmacy. The Consultant Pharmacist will review the Medication Administration Records monthly for any allergy discrepancies. Any discrepancies noted will be brought to the attention of the physician and the pharmacy.** **The Consultant Pharmacist will monitor the communications to the physician no less than monthly to determine compliance. Any discrepancies identified by the Consultant Pharmacist will be presented to the Quality Assurance Committee monthly for three months, then quarterly thereafter to ensure compliance.**	10-13-2011

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F 428	Continued From page 16 A review of the facility consultant pharmacist chart review revealed there was no documentation concerning the resident being on Aspirin with an NSAID allergy. During an interview on 10/12/11 at 1:10 PM, the Director of Nursing (DON) stated she had called the pharmacy consultant and he did not know why he missed the resident was receiving Aspirin and had an NSAIDS allergy. During an interview on 10/12/11 at 3:45 PM, the facility pharmacist stated the resident had been taking the Aspirin and had not had any reaction, but the MAR should have reflected her true allergies. The pharmacy consultant, while monitoring her medications, should have seen she was receiving Aspirin and had an allergy to NSAIDS. The pharmacy consultant should have notified the facility of the allergy and made a recommendation to discontinue the allergy if she was not having any adverse consequences. During an interview on 10/13/11 at 10:02 AM the facility pharmacist consultant stated Aspirin is classified as an NSAID, but is chemically different than an NSAID. He stated usually people are not allergic to aspirin and he did not feel the resident had a true allergy to the Aspirin. He stated when he looked at a resident's chart and saw an allergy to an NSAID he would go and ask the person what kind of reaction they had. He would clarify if it was a true allergy or not. The pharmacy consultant then stated he would advise the facility the allergy was not a real allergy and remove the allergy from the chart. He further stated he had not talked to the resident and had not clarified the NSAIDS allergy for this resident.	F 428		

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F 428	Continued From page 17 2. Resident #107 was originally admitted to the facility on 8/12/11, with diagnoses including Decubitus Ulcer, (Pressure Sore on skin), Neurogenic Bladder, Severe Arthritis and Insomnia. According to the most recent Quarterly Minimum Data Set (MDS) dated 9/23/11, Resident #107's memory was intact and he required total assistance in all areas of activities of daily living. Review of the Medication Administration Record (MAR) revealed when Resident #107 was admitted to the facility on 8/12/11, he started receiving Trazodone 50 mgs. at bedtime for insomnia (lack of sleep). On 8/13/11 Resident #107 also started receiving Ambien 5 mgs. as needed at bedtime for insomnia. According to the Medication Administration Record (MAR), on 9/6/11, Ambien 5mgs. was changed from as needed to Ambien 5mgs. every night at bedtime. Review of the doctor's standing orders dated 9/1/11 through 9/30/11 revealed Resident #107 received Trazodone 50 milligrams and Ambien 5 milligrams at bedtime for insomnia. Review of a Pharmacist's note dated 8/25/11 read in part, "Hopefully can (symbol for change) Trazodone back to prn (as needed) insomnia, by 9/11." Review of another Pharmacist's note dated 9/19/11 read in part, "Req. (request) (symbol for	F 428	**F428** **STANDARD DISCLAIMER:** **This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).** **The "Consultant Pharmacist Communication to the Physician" form for resident #107 was signed by the physician on 10/12/2011 to allow the Trazodone to be given as needed.** **For those residents having the potential to be affected by the same alleged deficient practice(s), the Consultant Pharmacist will review the communications to the physician monthly to ensure they are returned to the facility in a timely manner. The physician will be notified by phone for communications not returned to the facility within thirty days.** **The Consultant Pharmacist will monitor the communications to the physician no less than monthly to determine compliance. Any discrepancies identified by the Consultant Pharmacist will be presented to the Quality Assurance Committee monthly for three months, then quarterly thereafter to ensure compliance.**	10-13-2011

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F 428	Continued From page 18 change) Trazodone to prn (as needed) insomnia." Review of a document, dated 9/20/11 and titled, "Consultant Pharmacist Communication to Physician," read in part, "As a reminder, this patient has been on Trazodone 50 milligrams q hs (bedtime) (8pm) for insomnia since admission 1 month ago. Consider a switch to q hs (bedtime) prn (as needed) insomnia" "(Attempts at GDR (Gradual Dose Reduction) of sedative/hypnotic meds. is required per the guidelines.)" During an interview on 10/12/11 at 2:10PM, the Director of Nursing (DON) stated the Pharmacist should have sent a note, written on 9/19/11, to the doctor, and he (Pharmacist) probably gave the note to her on 9/21/11. The Director of Nursing explained that the Pharmacist could make a recommendation but it was up to the doctor's discretion to make changes. She stated sometimes it might take up to a month for the doctor to sign the recommendation. During an interview on 10/13/11 at 10:50AM the Pharmacist revealed he would like the consultant recommendation back from the doctor as soon as possible and he wished it could be returned quickly. He revealed getting the recommendation signed and returned from the doctor was a difficult process. He revealed sometimes it could take up to two months to get a response from the doctor. The Pharmacist stated if it was an urgent matter he would call the doctor himself. He revealed he wanted to change Trazodone to, as needed, because Resident #107 was also getting Ambien which was another medication for sleep. The Pharmacist revealed Resident #107 had only been in the facility for a short period of time. He	F 428		

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F 428	Continued From page 19 stated he wanted the resident to be on Trazodone instead of Ambien, but the main focus was to have the resident take one sleep medication instead of two. During another interview on 10/13/11 at 10:20AM, the Director of Nursing revealed if she did not have the consultant Pharmacist's recommendations back by the end of the month, she would call the doctor's office to check on the status. She stated that if there was no response from the doctor from three weeks to a month, they would send the doctor another copy of the Pharmacist's recommendation. During an interview on 10/14/11 at 10:55AM, the Administrator revealed they did not have a protocol for the length of time to get the consultant recommendation signed and returned. She stated the Pharmacist consultant report was just a recommendation and it was up to the doctor to accept the recommendation.	F 428		

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

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	346210	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETHTOWN NURSING CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

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K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: A. Based on observation on 11/09/2011 the five (5) year internal inspection had not been conducted on the sprinkler piping. 42 CFR 483.70 (a)	K 062	**STANDARD DISCLAIMER:** This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). **K 062** The five year internal inspection of the sprinkler piping will be completed by December 24, 2011. The Maintenance Director will ensure that the automatic sprinkler system will be continuously maintained in reliable operating condition and will be inspected and tested periodically in accordance with NFPA 13, NFPA 25, 9.7.5.The Administrator will monitor for compliance.	12/24/11
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: A. Based on observation on 11/09/2011 the kitchen hood had not been inspected in the allowed time frame. 42 CFR 483.70 (a)	K 069	**K 069** The kitchen hood was inspected on November 14, 2011 by Simplex Grinnell. The Maintenance Director will ensure that the kitchen hood will be inspected in accordance with 9.2.3, 19.3.2.6, NFPA 96. The Administrator will monitor for compliance. The Plan of Correction for this alleged deficient practice(s) has been incorporated into the facility's most recent Quality Assurance Committee meeting minutes and shall be evaluated no less than quarterly for effectiveness on a continuing basis.	11/14/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Tom Danner, RN	Administrator	11/23/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

CD

PRINTED: 11/13/2011
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING 02 - BUILDING 02 B. WING _____	11/09/2011

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K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1, 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 11/09/2011 the door to the Activity Room requires more than one (1) motion of the hand to exit the room. 42 CFR 483.70 (a)	K 038	STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). K 038 The door knob to the activity room has been replaced with a one hand motion knob. The Maintenance Director will monitor door knobs during his annual door inspection to ensure all doors have the correct hand motion knobs and all are working properly. The Administrator will monitor for compliance.	11/11/11
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: A. Based on observation on 11/09/2011 the exit discharge for the 200 and the 400 corridors did not have the required lighting. CFR 483.70 (a)	K 045	K 045 The required lighting has been installed at the exit discharge of the 200 and the 400 hall corridors. The Maintenance Director will monitor required lighting during monthly rounds to ensure they are working properly. The Administrator will monitor for compliance.	11/16/11
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	K 062 The five year internal inspection of the sprinkler piping will be completed by December 24, 2011. The Maintenance Director will ensure that the automatic sprinkler system will be continuously maintained in reliable operating condition and will be inspected and tested periodically in accordance with NFPA 13, NFPA 25, 9.7.5.The Administrator will monitor for compliance. The Plan of Correction for this alleged deficient practice(s) has been incorporated into the facility's most recent Quality Assurance Committee meeting minutes and shall be evaluated no less than quarterly for effectiveness on a continuing basis.	12/24/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	11/23/11

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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	345210	A. BUILDING 02 - BUILDING 02 B. WING _____	11/09/2011

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K 062	Continued From page 1 This STANDARD is not met as evidenced by: A. Based on observation on 11/09/2011 the five (5) year internal inspection had not been conducted on the sprinkler piping. 42 CFR 483.70 (a)	K 062		

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ELIZABETHTOWN NURSING CENTER	208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4:6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: A. Based on observation on 11/09/2011 the five (5) year internal inspection had not been conducted on the sprinkler piping. 42 CFR 483.70 (a)	K 062	STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). K 062 The five year internal inspection of the sprinkler piping will be completed by December 24, 2011. The Maintenance Director will ensure that the automatic sprinkler system will be continuously maintained in reliable operating condition and will be inspected and tested periodically in accordance with NFPA 13, NFPA 25, 9.7.5.The Administrator will monitor for compliance.	12/24/11
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: A. Based on observation on 11/09/2011 the kitchen hood had not been inspected in the allowed time frame. 42 CFR 483.70 (a)	K 069	K 069 The kitchen hood was inspected on November 14, 2011 by Simplex Grinnell. The Maintenance Director will ensure that the kitchen hood will be inspected in accordance with 9.2.3. 19.3.2.6, NFPA 96. The Administrator will monitor for compliance. The Plan of Correction for this alleged deficient practice(s) has been incorporated into the facility's most recent Quality Assurance Committee meeting minutes and shall be evaluated no less than quarterly for effectiveness on a continuing basis.	11/14/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jan Danner, RN
TITLE: Administrator
(X6) DATE: 11/23/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345210	A. BUILDING 02 - BUILDING 02 B. WING _____	11/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 11/09/2011 the door to the Activity Room requires more than one (1) motion of the hand to exit the room. 42 CFR 483.70 (a)	K 038	STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). K 038 The door knob to the activity room has been replaced with a one hand motion knob. The Maintenance Director will monitor door knobs during his annual door inspection to ensure all doors have the correct hand motion knobs and all are working properly. The Administrator will monitor for compliance.	11/11/11
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: A. Based on observation on 11/09/2011 the exit discharge for the 200 and the 400 corridors did not have the required lighting. CFR 483.70 (a)	K 045	K 045 The required lighting has been installed at the exit discharge of the 200 and the 400 hall corridors. The Maintenance Director will monitor required lighting during monthly rounds to ensure they are working properly. The Administrator will monitor for compliance.	11/6/11
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	K 062 The five year internal inspection of the sprinkler piping will be completed by December 24, 2011. The Maintenance Director will ensure that the automatic sprinkler system will be continuously maintained in reliable operating condition and will be inspected and tested periodically in accordance with NFPA 13, NFPA 25, 9.7.5.The Administrator will monitor for compliance. The Plan of Correction for this alleged deficient practice(s) has been incorporated into the facility's most recent Quality Assurance Committee meeting minutes and shall be evaluated no less than quarterly for effectiveness on a continuing basis.	12/24/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	11-23-11

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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	345210	A. BUILDING 02 - BUILDING 02 B. WING _____	11/09/2011

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K 062	Continued From page 1 This STANDARD is not met as evidenced by: A. Based on observation on 11/09/2011 the five (5) year internal inspection had not been conducted on the sprinkler piping. 42 CFR 483.70 (a)	K 062		