PRINTED: 10/20/2011 FORM APPROVED OMB NO. 0938-0391

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	NG OCT 3 1 2	(X3) DATE SURVEY COMPLETED
		345210	B, WNG_	•	10/13/2011
	OVIDER OR SUPPLIER	TER	Sī	TREET ADDRESS, CITY, STATE, ZIP CODE 208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 282 SS=D	The services provided must be provided by accordance with each care.  This REQUIREMENT by: Based on resident arrecord review, the fact plan to monitor dialyst two residents (Reside receiving hemodialys). The findings include:  1. Resident #10 was 7/20/01 and re-admitt cumulative diagnoses Renal Disease, Panc The resident was rectimes a week. The rebeing severely cognit recent Quarterly Mini Assessment dated 8/ A review of the reside included the following for warmness, draina.  Review of the nursing charting) for months of October 2011 did not of assessment of the	d or arranged by the facility qualified persons in a resident's written plan of a reveal any documentation of a reveal any documentation of a resident's written plan of the facility on the document of the facility on the care plan of the facility of the	F 28	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 I 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 documen 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.	t n d
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE	E	TITLE	(X6) DATE

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345210	B. WING_		10	/13/2011	
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F 282	and Treatment Red documentation of a dialysis assess site During an interview 12:05PM she state dialysis access site from dialysis unless ays there is a proresident returns or wheelchair and rol then goes outside  During an interview 10/12/11 at 12:10F does not have any checking sites and Nursing stated tha and if there is a prothey send the resident she was sure sites but this is not During an interview Coordinator on 10/1 that the facility doe for dialysis. She st have been more spresident complains assess the dialysis "we really depend the shunt site."  During an interview 10/12/11 at 12:45F plan reads to asse expected to be done.	cord did not reveal any assessment of the resident's e following dialysis.  In with Nurse #3 on 10/12/11 at add that she did not check the e when the resident returns as the dialysis center calls and blem. She stated that this the van and gets in her is herself down for lunch and	F 28	2			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>*</sup> A. BU)LDI	TIPLE CONSTRUCTION NG	(X3) DATE S COMPLI	
		345210	B. WNG		10	/13/2011
	ROVIDER OR SUPPLIER	NTER	s	TREET ADDRESS, CITY, STATE, ZIP COL 208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337	)E	
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F 282	the dialysis center of stated that the major facility with a dressi stated that the nursi these sites to monit problems.  During an interview 10/13/11 at 1:00PM Physician's Order in site following dialys documented on the Record.  2. Resident #105 w 2/3/11 with cumulate End Stage Renal Direceiving Hemodialy resident was assess Minimum Data (MD cognitively intact.  A review of the care updated quarterly in "assess shunt site, drainage."  Review of the Nursi documentation of and Treatment Recodocumentation of and dialysis assess site.	with the Facility Manager at an 10/12/11 at 2:30PM she rity of the residents return to an over the access site. She ing staff should be checking or for any bleeding or with the Administrator on she stated that there is now a place to check the dialysis is and the assessment will be Medication Administration was admitted to the facility on ive diagnosis that included isease. The resident was ayis three times a week. The sed on the latest Quarterly S) Assessment as being a plan dated 3/14/11 and accluded the following: monitor for redness, warmth, and notes showed no seessment of the shunt site. It is a seessment of the resident's	F 28			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345210	B. WING		10	/13/2011
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F 282	dialysis access site unless the dialysis problem.  During an interview 10/12/11 at 12:10F does not have any checking sites and Nursing stated that and if there is a prothey send the resid that she was sure sites but this assess anywhere.  During an interview Coordinator on 10/10/10/11 at 12:45F plan reads to asse expected to be dorupdated to read to During an interview the dialysis center stated that the maj facilities with a dre stated that the nurse.	with Director of Nursing on Mit was stated that the facility protocol for dialysis as far as doing vitals. The Director of the dialysis center does this oblem then they let us know or lent to the hospital. She stated the nursing staff check the isment is not documented with Minimum Data Set 12/11 at 1:25PM she stated is not have a specific protocol ated that the care plan should be of pain or discomfort to shunt site. She stated that on the dialysis center to check with Administrator on PM she stated that if the care plan needs to be be done at dialysis.  With the Facility Manager at on 10/12/11 at 2:30PM she ority of the residents return to ssing over the access site. She sing staff should be checking iter for any bleeding or	F 282			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		(X2) MU A. BUILI	ILTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER	345210	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP		13/2011
	HTOWN NURSING CEN	TER		208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337		
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F 282	Continued From pag	e 4	F 2	282		
	3:20PM she stated the site after dialysis. She with a dressing and site feels like the dressing During an interview with 10/13/11 at 1:00PM site following dialysis	with the Administrator on the stated that there is now a place to check the dialysis and the assessment will be				
F 309 SS=D	Record.	Medication Administration  NRE/SERVICES FOR  NG	F 3	309		
	provide the necessar or maintain the highe mental, and psychos	eceive and the facility must y care and services to attain st practicable physical, ocial well-being, in comprehensive assessment				
	by: Based on resident a center interviews and					
	The findings include:					
	7/20/01 and re-admit	admitted to the facility on ted on 8/4/11 with s that included End Stage				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER THTOWN NURSING CEN	rer		208	ET ADDRESS, CITY, STATE, ZIP CODE B MERCER RD BOX 1447 IZABETHTOWN, NC 28337	*********	,
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F 309	The resident was rectimes a week. The rebeing severely cognit recent Quarterly Minit Assessment dated 8/ A review of the reside included the following for warmness, draina Review of the nursing charting) for months of October 2011 did not of assessment of the A review of the Medic and Treatment Record documentation of assessment of assessment of the During an interview with 12:05PM she stated the dialysis access site with from dialysis unless the says there is a problem resident returns on the wheelchair and rolls with then goes outside to During an interview with 10/12/11 at 12:10PM does not have any prochecking sites and do Nursing stated that the and if there is a problem they send the resident resident resident resident resident that the and if there is a problem they send the resident res	reatic Disorder and Anemia. Eving Hemodialysis three sident was assessed as ively impaired on the most mum Data Set (MDS) 16/11.  In this most recent care plan It "assess shunt site, monitor ge, redness to site." In notes for (Medicare of August, September and reveal any documentation dialysis assess site.  In this most recent care plan It is a monitor ge, redness to site." In notes for (Medicare of August, September and reveal any documentation dialysis assess site.  In this assess site.  In this is a monitor ge, redness to site." In notes for (Medicare of August, September and reveal any documentation dialysis assess site.  In this is a monitor ge, redness to site." In notes for (Medicare of August, September and reveal any documentation dialysis assess site.  In this is a monitor ge dialysis assess site.  In this is a monitor ge dialysis center calls and ge dialysis in her ge dialysis in her gerself down for lunch and	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 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 the physician and in accordanc with their individual care plans.  For those resident's having the potential to be affected by the same alleged deficient practice 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 documenthe assessment on the Medicati 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 of Nursing shall be presented to the Quality Assurance Committee monthly three months, then quarterly thereafter to ensure compliance	ord or	10-13-2011

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		345210	B. WIN	iG		10/1:	3/2011
	ROVIDER OR SUPPLIER	TER	1	20	REET ADDRESS, CITY, STATE, ZIP CODE 08 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337		:
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F 309	During an interview w Coordinator on 10/12 that the facility does n for dialysis. She state have been more spec resident complains of assess the dialysis sh "we really depend on the shunt site."  During an interview w 10/12/11 at 12:45PM plan reads to assess expected to be done updated to read to be  During an interview w the dialysis center on stated that the majori facility with a dressing stated that the nursin these sites to monitor problems.  During an interview w 10/13/11 at 1:00PM s Physician's Order in p site following dialysis documented on the M Record.  2. Resident #105 wa 2/3/11 with cumulativ End Stage Renal Dis receiving Hemodialysis receiving Hemodialysis	with Minimum Data Set //11 at 1:25PM she stated not have a specific protocol and that the care plan should cific in stating that if the f pain or discomfort to nunt site. She stated that the dialysis center to check  with Administrator on she stated that if the care the site then it would be or the care plan needs to be a done at dialysis.  with the Facility Manager at 10/12/11 at 2:30PM she ty of the residents return to g over the access site. She g staff should be checking	F	309			

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F 309	cognitively intact.  A review of the care rupdated quarterly incomessess shunt site, modrainage."  Review of the Nursing documentation of associated and Treatment Record documentation of associated and Interview work 12:05PM she stated and all sites access site wounless the dialysis and do Nursing an interview work of the was sure the sites but this assessmanywhere.  During an interview work Coordinator on 10/12 that the facility does refor dialysis. She state have been more specific associated and the sites and the si	olan dated 3/14/11 and luded the following: onitor for redness, warmth, g notes showed no sessment of the shunt site. cation Administration Recorded did not reveal any sessment of the resident's	F 309			

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F 309	"we really depend on the shunt site."  During an interview w 10/12/11 at 12:45PM plan reads to assess expected to be done updated to read to be During an interview with e dialysis center on stated that the majorifacilities with a dressistated that the nursin these sites to monitor problems.  During an interview with a dressing and site after dialysis. Shi with a dressing and site is like the dressing.	with Administrator on she stated that if the care the site then it would be or the care plan needs to be done at dialysis.  With the Facility Manager at 10/12/11 at 2:30PM she ty of the residents return to ng over the access site. She g staff should be checking r for any bleeding or  With resident on 10/12/11 at the no one checks her access the states that she does return the takes it off when she	F	309			
F 329 SS=D	site following dialysis documented on the MRecord. 483.25(I) DRUG RECUNNECESSARY DR	place to check the dialysis and the assessment will be dedication Administration  BIMEN IS FREE FROM  UGS  regimen must be free from An unnecessary drug is any accessive dose (including	F	329			
	duplicate therapy); or	cessive dose (including for excessive duration; or nitoring; or without adequate					

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F 329	adverse consequence should be reduced or combinations of the resident, the facility may be a comprehence of the condition of the resident, the facility may be a conditional therapy is necessary as diagnosed and do record; and residents drugs receive gradual behavioral intervention	or in the presence of es which indicate the dose discontinued; or any easons above.  ensive assessment of a fust ensure that residents nitipsychotic drugs are not ess antipsychotic drug to treat a specific condition cumented in the clinical who use antipsychotic dose reductions, and	F	329			
	by: Based on staff intervireview, the facility faild listed allergy of NSAID (Resident #37) review medications and failed residents (Resident # The findings include:  1. Resident #37 was 4/1/04 and readmitted of dementia, cerbrova	d to monitor 1 of 10  107) receiving hypnotics.  admitted to the facility on 1 on 7/14/10 with diagnoses scular accident (stroke), Ilmonary disease (COPD),		Tree to the control of the control o			

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NAME OF PROVIDER OR SUPPLIER  ELIZABETHTOWN NURSING CE  (X4) ID SUMMARY S	NTER STATEMENT OF DEFICIENCIES	l ID	20	EET ADDRESS, CITY, STATE, ZIP CODE 8 MERCER RD BOX 1447 LIZABETHTOWN, NC 28337 PROVIDER'S PLAN OF CORRE	•	(x5)	
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Geriatric Dosage Harevealed Aspirin 's salicylate. Referent "Hypersensitivity to any component of the Areview of the aller resident's medical chad an allergy to NS anti-inflammatory did Areview of the resident's medical chad an allergy to NS anti-inflammatory did Areview of the resident october 2011 reveatively. A review of the Medical of the allergies section NSAIDS. Listed on tablet take 1 tablet is Documentation reveation october 1st. A review of the facilic chart review revealed documentation cond Aspirin with an NSAID During an interview Nurse #1 stated her medications was shon the front of the comedication the resident of the did not keep the salicylated she salicyl	i-Comp 's Drug Reference andbook 12th edition, pharmacologic category is a need under Contraindications, a salicylates, other NSAIDS, or the formulation. "  Try sticker on the front of the chart revealed Resident #37 SAIDS (nonsteroid rugs)  dent's Physician's Orders for aled she was ordered on mg (an NSAID) 1 tablet by  dication Administration Record the of October 2011 revealed on the resident had listed the MAR was Aspirin 325 mg by mouth once daily. ealed the resident received the thru 12th, 2011.  Stity consultant pharmacist end there was no cerning the resident being on AID allergy.  on 10/12/11 at 1:40 PM,	F	329	STANDARD DISCLAIMER: This Plan of Correction is prepared an necessary requirement for continued participation in the Medicare and Medicaid program(s) and does not, in any manner, constitute an admission 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 physician's order dated 11-10-2008 wf found in the thinned chart of resident #37 that read "D/C ASA Allergy". A cof this order was presented to the surveyor on 10/12/2011.  For those residents having the potent to be affected by the same alleged deficient practice(s), all licensed nurshave received education on the importance of checking the Medication Administration and to report any discrepancies found to physician and pharmacy. The Consultant Pharmacist will review the Medication Administration Records monthly for any allergy discrepancie Any discrepancies noted will be brought to the attention of the physician the pharmacy.  The Consultant Pharmacist will monit the communications to the physician less than monthly to determine compliance. Any discrepancies identified by the Consultant Pharmacist will monit the communications to the Quality Assurance Committee monthly for the months, then quarterly thereafter to ensure compliance.	to  7. A  vas t oppy  tial ses on les od the e s. cian tor	10-13-2011	

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F 329	stated the resident hat for a while and she did to the NSAID. Nurses should have been ale MAR with any medical having an allergy to.  During an interview on Director of Nursing (Entertain the facility pharmacisty known why the resident when she had an alles she had called the phind did not known why he receiving Aspirin and the DON further state have given the Aspiring etting clarification from further stated she had stated the resident was to continue to give he allergy from her medically pharmacist state the MAR should hallergies. The allergy been clarified by the MASPIRIAN ASPIRIAN The pharmamonitoring her medical she was receiving As NSAIDS. The pharman notified the facility of recommendation to displace the should have allergied the facility of recommendation to displace the should have allergied the facility of recommendation to displace the should have allergied the facility of recommendation to displace the should have allergied the facility of recommendation to displace the should have allergied the facility of recommendation to displace the should have allergied the facility of recommendation to displace the should have allergied the facility of recommendation to displace the should have allergied the facility of recommendation to displace the should have allergied the facility of recommendation to displace the should have allergied the facility of recommendation to displace the should have allergied the facility of recommendation to displace the should have allergied the facility of recommendation to displace the should have allergied the sh	NSAIDS. Nurse #1 further and been getting the Aspirin do not think she was allergic with stated the pharmacy and when they printed the ation a resident was noted as in 10/12/11 at 1:10 PM, the DON) stated she had called the and he said he did not was receiving Aspirinary to NSAIDS. She stated armacy consultant and he missed the resident was had an NSAIDS allergy. The DON of called the physician. The DON of called the physician and he as not allergic to Aspirin and the Aspirin and remove the call record.  In 10/12/11 at 3:45 PM, the sted the resident had been and not had any reaction, have reflected her true to an NSAID should have hurses before they gave the	F	329			

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 329	facility on 8/12/11, wider per language in part, "Hopefar and in part, "Hopefar and in part, change) Trazodone back to p 9/11."  Review of a docume "Consultant Pharman in somma in part, change) Trazodone in part, change in pa	s originally admitted to the th diagnoses including essure Sore on skin), Severe Arthritis and to the most recent Quarterly (IDS) dated 9/23/11, mory was intact and he nce in all areas of activities ation Administration Record in Resident #107 was yon 8/12/11, he started 50 mgs. at bedtime for ap). On 8/13/11 Resident eliving Ambien 5 mgs. as or insomnia. According to histration Record (MAR), on a was changed from as mgs. every night at bedtime.	F 329				

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NAME OF PROVIDER OR SUPPLIER  ELIZABETHTOWN NURSING CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			l ID	20	EET ADDRESS, CITY, STATE, ZIP CODE  18 MERCER RD BOX 1447  LIZABETHTOWN, NC 28337  PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREF TAG	- 1	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
F 329	hs (bedtime) (8pm) for 1 month ago. Consider prints of the	Trazodone 50 milligrams quer insomnia since admission er a switch to q hs (bedtime) mnia" "(Attempts at GDR ction) of sedative/hypnotic the guidelines.)"  In 10/12/11 at 2:10PM, the DON) stated the Pharmacist one, written on 9/19/11, to tharmacist) probably gave 1/11. The Director of eat the Pharmacist could tion but it was up to the make changes. She stated ke up to a month for the	F	329	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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345210	B. WNG		10/1	3/2011
NAME OF PROVIDER OR SUPPLIER  ELIZABETHTOWN NURSING CENTER			208	T ADDRESS, CITY, STATE, ZIP CODE MERCER RD BOX 1447 ZABETHTOWN, NC 28337		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 329 F 428 SS=D	the Director of Nursi have the consultant recommendations be she would call the distatus. She stated the from the doctor from they would send the Pharmacist's recommendation of the state of the protocol for the leng consultant recommendation of the Pharmacist of the Pharmacist of the Pharmacist of the She stated the Pharmacist a recommendation of the She State of the She She State of the She She She She She She She She She S	view on 10/13/11 at 10:20AM, ing revealed if she did not Pharmacist's ack by the end of the month, octor's office to check on the lat if there was no response it three weeks to a month, doctor another copy of the mendation.  on 10/14/11 at 10:55AM, the led they did not have a lith of time to get the landation signed and returned. In macist consultant report was it in and it was up to the recommendation.  GIMEN REVIEW, REPORT	F 428			
	by: Based on record re pharnmacy consulta drug allergy to the fa	IT is not met as evidenced view and staff interviews the ant failed to report a possible acility for 1 (Res. #37) of 10 necessary medications and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
74101 04101	JON 11 12 11 10 11		A. BUILDING				
		345210	B. WNG		10/1	3/2011	
	NAME OF PROVIDER OR SUPPLIER  ELIZABETHTOWN NURSING CENTER			EET ADDRESS, CITY, STATE, ZIP CODE D8 MERCER RD BOX 1447 LIZABETHTOWN, NC 28337	1.25		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 428	the facility failed to a recommendation for residents reviewed.  The findings included 1. Resident #37 was 4/1/04 and readmitt of dementia, cerbrochronic obstructive congestive heart fair osteoarthrosis.  A review of the Lex Geriatric dosage has Aspirin 1 s pharmack Referenced under of Hypersensitivity to a any component of the A review of the aller resident's medical of had an allergy to National and the resident's medical of had an allergy to National and the resident's medical of had an allergy to National and the resident's medical of had an allergy to National and the resident's medical of had an allergy to National and the resident's medical of had an allergy to National and the resident's medical of had an allergies section NSAIDS. Listed on tablet take 1 tablet	act on a pharmacy of 1 (Res. #107) of 10  as:  as admitted to the facility on ed on 7/14/10 with diagnoses vascular accident (stroke), pulmonary disease (COPD), lure (CHF) and  accident (stroke), pulmonary disease (COPD), lure (CHF) and  accident edition revealed cologic category is a salicylate. contraindications, " asalicylates, other NSAIDS, or the formulation. "  argy sticker on the front of the chart revealed Resident #37 SAIDS (nonsteroid arugs)  dent's Physician's Orders for aled she was ordered on and my (an NSAID) 1 tablet by  dication Administration Record the of October 2011 revealed on an the resident had listed the MAR was Aspirin 325 mg by mouth once daily, ealed the resident received the	F 428	F428 STANDARD DISCLAIMER: This Plan of Correction is prepared necessary requirement for continue participation in the Medicare and Medicaid program(s) and does not, any manner, constitute an admission 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 # physician's order dated 11-10-2008 found in the thinned chart of resident # 37 that read "D/C ASA Allergy". A of this order was presented to the surveyor on 10/12/2011.  For those residents having the pote to be affected by the same alleged deficient practice(s), all licensed nuhave received education on the importance of checking the Medica Administration Record for any aller prior to medication administration to report any discrepancies found to physician and pharmacy. The Consultant Pharmacist will review the Medication Administration Records monthly for any allergy discrepanciantly discrepancies noted will be brought to the attention of the physicial ess than monthly to determine compliance. Any discrepancies identified by the Consultant Pharmacist will monthe communications to the physicial ess than monthly to determine compliance. Any discrepancies identified by the Consultant Pharmacist will be presented to the Quality Assurance Committee monthly for months, then quarterly thereafter to ensure compliance.	in on to  n 37. A was ent copy ential urses tion gles and to the tihe stes. sician nitor an no	10-13-2011	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345210	B. WING		10,	13/2011
	ROVIDER OR SUPPLIER	TER	24	EET ADDRESS, CITY, STATE, ZIP CODE 08 MERCER RD BOX 1447 LIZABETHTOWN, NC 28337		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	chart review revealed documentation conce Aspirin with an NSAII During an interview of Director of Nursing (If the pharmacy consulty why he missed the reand had an NSAIDS During an interview of facility pharmacist staking the Aspirin and but the MAR should allergies. The pharm monitoring her medicallergies. The pharm monitoring her medicallergies. The pharm monitoring her medicallergies. The pharm monitoring her medicallergies are commendation to owas not having any and the pharmacist conclassified as an NSAID. He sallergic to aspirin and had a true allergy to the looked at a reside to an NSAID he would what kind of reaction it was a true allergy of consultant then state the allergy was not a allergy from the chart	y consultant pharmacist If there was no erning the resident being on D allergy.  In 10/12/11 at 1:10 PM, the DON) stated she had called tant and he did not know esident was receiving Aspirin allergy.  In 10/12/11 at 3:45 PM, the ated the resident had been If had not had any reaction, have reflected her true have consultant, while resident should have seen epirin and had an allergy to have consultant should have the allergy and made a discontinue the allergy if she diverse consequences.  In 10/13/11 at 10:02 AM the insultant stated Aspirin is ID, but is chemically different estated usually people are not if he did not feel the resident the Aspirin. He stated when int's chart and saw an allergy if go and ask the person they had. He would clarify if or not. The pharmacy if he would advise the facility real allergy and remove the if the further stated he had ident and had not clarified the	F 428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			RVEY ED
345210			B. WNG			10/13/2011	
	OVIDER OR SUPPLIER	iter		20	EET ADDRESS, CITY, STATE, ZIP CODE 8 MERCER RD BOX 1447 LIZABETHTOWN, NC 28337		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 428	facility on 8/12/11, w Decubitus Ulcer, (Pr Neurogenic Bladder, Insomnia. According Minimum Data Set (I Resident #107's mer required total assista of daily living.  Review of the Medic (MAR) revealed whe admitted to the facili receiving Trazodone insomnia (lack of sle #107 also started re needed at bedtime f Medication Administ 9/6/11, Ambien 5mg needed to Ambien 5 Review of the doctor 9/1/11 through 9/30/ received Trazodone milligrams at bedtim  Review of a Pharma read in part, "Hopef Trazodone back to p 9/11."  Review of another P	as originally admitted to the rith diagnoses including essure Sore on skin), Severe Arthritis and to the most recent Quarterly MDS) dated 9/23/11, mory was intact and he ance in all areas of activities attion Administration Record on Resident #107 was to 98/12/11, he started to 50 mgs. at bedtime for seep). On 8/13/11 Resident ceiving Ambien 5 mgs. as or insomnia. According to the ration Record (MAR), on s. was changed from as mgs. every night at bedtime.	F	428	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
	oriori readinipait,	riod. (reduced (e)time to					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING		I MANAGE .			
		345210	B. WiN	G		10/1	3/2011	
NAME OF PROVIDER OR SUPPLIER  ELIZABETHTOWN NURSING CENTER				208 N	ADDRESS, CITY, STATE, ZIP CODE MERCER RD BOX 1447 ABETHTOWN, NC 28337			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 428	Review of a documer "Consultant Pharmace Physician," read in ppatient has been on This (bedtime) (8pm) for 1 month ago. Consider professional profes	o prn (as needed) insomnia."  at, dated 9/20/11 and titled, ist Communication to art, "As a reminder, this frazodone 50 milligrams q or insomnia since admission er a switch to q hs (bedtime) mnia" "(Attempts at GDR ction) of sedative/hypnotic the guidelines.)"  In 10/12/11 at 2:10PM, the DON) stated the Pharmacist ote, written on 9/19/11, to harmacist) probably gave 11/11. The Director of at the Pharmacist could tion but it was up to the make changes. She stated ke up to a month for the	F	428				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345210	B. WING		10/1	3/2011	
	OVIDER OR SUPPLIER	TER	20	EET ADDRESS, CITY, STATE, ZIP CODE 08 MERCER RD BOX 1447 LIZABETHTOWN, NC 28337			
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	OULD BE	(X6) COMPLETION DATE	
F 428	instead of Ambien, but have the resident take instead of two.  During another intervithe Director of Nursin have the consultant Frecommendations based would call the dostatus. She stated the from the doctor from the doctor from they would send the Charmacist's recommendations an interview of Administrator revealed protocol for the length consultant recommends the stated the Pharm	resident to be on Trazodone at the main focus was to a one sleep medication  few on 10/13/11 at 10:20AM, grevealed if she did not charmacist's ck by the end of the month, ctor's office to check on the at if there was no response chree weeks to a month, doctor another copy of the lendation.  In 10/14/11 at 10:55AM, the did they did not have a for time to get the dation signed and returned. Lacist consultant report was an and it was up to the	F 428				

RECEIVED 11/23/2011 16:08 DHSR CONSTRUCTION

Nov 23 2011 02:34pm P005/007

FORM APPROVED

OMB NO. 0938-0391

Fax: 919-733-6592 PRINTED: 11/13/2011

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF GORRECTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 B, WING 11/09/2011 348210 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **208 MERCER RD BOX 1447** ELIZABETHTOWN NURSING CENTER ELIZABETHTOWN, NC 28337 PROVIDER'S PLAN OF CORRECTION SUMMARY SYATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X6) COMPLETION DATE ΙD (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX TAG TAG DEFICIENCY) NFPA 101 LIFE SAFETY CODE STANDARD STANDARD DISCLAIMER: K 062 K 062 This Plan of Correction is prepared SS=D as a necessary requirement for Required automatic sprinkler systems are continued participation in the continuously maintained in reliable operating Medicare and Medicald program(s) condition and are inspected and tested and does not, in any manner, 19.7.6, 4:6.12, NFPA 13, NFPA constitute an admission to the periodically. validity of the alleged deficient 25, 9.7.5 practice(s). K 062 12 |24| 11 The five year internal inspection of the sprinkler piping will be completed This STANDARD is not met as evidenced by: by December 24, 2011. A. Based on observation on 11/09/2011 the five (5) year internal inspection had not been The Maintenance Director will conducted on the aprinkler piping. ensure that the automatic sprinkler 42 CFR 483.70 (a) system will be continuously NFPA 101 LIFE SAFETY CODE STANDARD K 069 maintained in reliable operating K 069 condition and will be inspected and SS≔D tested periodically in accordance Cooking facilities are protected in accordance with NFPA 13, NFPA 25, 9.7.5.The with 9.2.3. 19.3.2.6, NFPA 96 Administrator will monitor for compliance. This STANDARD is not met as evidenced by: K 069 n [<del>PH]</del> 11 The kitchen hood was inspected on A. Based on observation on 11/09/2011 the November 14, 2011 by Simplex kitchen hood had not been inspected in the Grinneli. allowed time frame. 42 CFR 483.70 (a) 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. APORATORY DIRECTORS OR PROVIDENSUPPLIER REPRESENTATIVE'S SIGNATURE (X8) DATE

Administrator 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

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Fax:919-733-8592

PAGE Nov 23 2011 02:34pm PUUS/UU/ 03/05

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

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: A BUILDING 02-BUILDING 02 B, WING

DHSR CONSTRUCTION

345210

11/09/2011

#### NAME OF PROVIDER OR SUPPLIER

#### ELIZABETHTOWN NURSING CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337

(X4) ID	Summary Statement of Deficiencies	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6)
PREPIX	(Bach Deficiency Must be preceded by Full	PREFIX		COMPLETION
TAG	Regulatory or LSO Identifying Information)	YAG		DATE

(, , , ,	·		DAY (0)2,10.1)	
K 038 SS=0	)	K 038	STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicald program(s) and does not, in any manner, constitute an admission to the variety of the alleged deficient practice(s).  K 038 The door knot to the activity room has been replaced with a one hand motion knot.	Math
K 045 SS≂D	L :	K 045	The Maintenance Director will monitor door knobs during his annual door inspection to ensure all doors have the correct hand mollon knobs and all are working properly. The Administrator will monitor for compilance.	יוןופאיי
	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 082	K 062 The five year internal inspection of the sprinkler ploing 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	12/24111

K 062 NFPA 101 LIFE SAFETY CODE STANDARD 9S=D Required automatic sprinkler systems are

continuously maintained in reliable operating condition and are inspected and tested 19.7.6, 4.6.12, NFPA 13, NFPA periodically. 25, 9.7,5

LABORATORY DIRECTURE OR PROVIDENSUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

Administrator will monitor for compliance.

practice(s) has been incorporated into the

facility's most recent Quality Assurance

Committee meeting minutes and shall be

The Plan of Correction for this alleged deficient

evaluated no less than quarterly for effectiveness

(X6) DATE

Administrater Any deficiency statement ending who are asteriek (\*) 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 whather or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosuble 14 days following the date these documents are made available to the facility. It deficiencies are cited, an approved plan of correction is requisite to continued

K 062

program participation.

Facility ID: 923160

on a continuing basis.

DHSR CONSTRUCTION

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Fax:919-733-6592

04/05

PAGE 02 Nov 23 2011 02:34pm PUU1/001 PRINTED: 11/13/2011 FORM APPROVED

DEPAR'		APPROVED . 0938-0391					
STATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LDING	E CONSTRUCTION 02 - BUILDING 02	(X8) DATE SURVEY COMPLETED	
345210			B. WI	۸G		11/0	19/2011
NAME OF PROVIDER OR SUPPLIER  ELIZABETHTOWN NURSING CENTER				208	et address, city, state, zip code Mercer rd box 1447 Zabethtown, nc 28337		
. (X4) IO PREFIX TAG	JEACH DEFICIENCY	Tement of deficiencies Must be preceded by full SC identifying information)					COMPLETION DATE
K 062	Continued From pa	ge 1	K	062		• .	
	A. Based on obser	os not met as evidenced by: valion on 11/09/2011 the five pecfion had not been prinkler piping.	de extra manufactura de la composição de l				
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				*			
		•		ryadamilitatiyayinikkimilika qoʻr asa sadasi sir is eneme or e	•		

05/05

MOV 23 2011 UK . 30P10 PRINTED: 11/13/2011

FORM:APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULYIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING 01 - MAIN BUILDING 01 B. WING 11/09/2011 345210 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 208 MERCER RD BOX 1447 ELIZABETHTOWN NURSING CENTER ELIZABETHTOWN, NC 28337 (X3) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY SYATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL IO PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OX4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY STANDARD DISCLAIMER: NFPA 101 LIFE SAFETY CODE STANDARD K 062 ' K 062 This Plan of Correction is prepared SS≒D as a necessary requirement for Required automatic sprinkler systems are continued participation in the continuously maintained in reliable operating Medicare and Medicald program(s) condition and are inspected and tested and does not, in any manner, constitute an admission to the 19.7.6, 4:6.12, NFPA 13, NFPA periodically. validity of the alleged deficient 25, 9.7.5 practice(s). /२ (२५) ग The five year internal inspection of the sprinkler piping will be completed by Dacember 24, 2011. 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 The Maintenence Director will conducted on the sprinkler piping. ensure that the automatic sprinkler 42 CÉR 483.70 (a) system will be continuously K 069 NFPA 101 LIFE SAFETY CODE STANDARD maintained in reliable operating K 069 condition and will be inspected and SSMD tested periodically in accordance Cooking facilities are protected in accordance with NFPA 13, NFPA 25, 9.7,5, The with 9.2.3. 19.3.2.8, NFPA 96 Administrator will monitor for compliance, This STANDARD is not met as evidenced by: K 069 r [19]] II A. Based on observation on 11/09/2011 the The kitchen hood was inspected on November 14, 2011 by Simplex kitchen hood had not been inspected in the Grinnell. allowed lime frame. 42 CFR 483.70 (a) The Maintenance Director Will

LARGHATORY DIRECTORS OR PROVIDENSUPPLIER REPRESENTATIVE'S SIGNATURE

Administrator

confinuing basis.

compliance.

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

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

(X8) CIAYE

Any deficiency statement ending with an actorisk (\*) 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 nuising homes, the findings stated above are disclosable 90 days relicaving the date of survey whether or not a plan of correction is provided. For nuising homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made evellable to the facility. If deficiencies are cited, an approved plan of correction is regulaite to continued pragram participation.

DHSR CONSTRUCTION

RECEIVED 11/23/2011 15:08 Fax:919-733-6592 Nov 23 2011 02:34pm P008/807

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

PRINTED: 11/13/2011 FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING 02 - BUILDING 02	(X3) DATE SURVEY COMPLETED
		345210	B. WING		11/09/2011
	PROVIDER OR SUPPLIER ETHTOWN NURSING	CENTER	s	TREET ADDRESS, CITY, STATE, ZIP CODE 208 MERCER RD BOX 1447 ELIZABETHTOWN, NC 28337	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO GROSS-REFERENCED TO THE APP DEFICIENCY)	ONTO BE CONSTITUTE
K 038 SS=D	Exit access is arrar	FETY CODE STANDARD  aged so that exits are readily  aes in accordance with section	K 03	STANDARD DISCLAIMER: This Plan of Correction is prepared as a necessary requirement for continued partic in the Medicare and Medicald program(s) a does not, in any manner, constitute an adm to the validity of the alleged deficient practic K 038 The door knob to the activity room has bee replaced with a one hand motion knob,	nd ilssion ce(s).
K 045 SS≈D	A. Based on obser to the Activity Roon motion of the hand 42 CFR 483.70 (a) NFPA 101 LIFE SA Illumination of mean discharge, is arrang lighting fixture (bulb darkness. (This do	s not met as evidenced by: vation on 11/09/2011 the door requires more than one (1) to exit the room.  FETY CODE STANDARD  as of egress, including exit ged so that failure of any single will not leave the area in es not refer to emergency ce with section 7.8.) 19.2.8	K 041	The Maintenance Director will monitor door knobs during his annual door inspection to ensure all doors have the correct hand mot knobs and all are working properly. The Administrator will monitor for compliance.	he 11//6/11
K 062 SS=D	A. Based on obser- discharge for the 20 not have the require CFR 483.70 (a) NFPA 101 LIFE SA Required automatic continuously mainta condition and are in	FETY CODE STANDARD sprinkler systems are lined in reliable operating	K 062	K 062 The five year internal inspection of the sprin piping will be completed by December 24, 2 The Maintenance Director will ensure that the automatic sprinkler system will be continuous maintained in reliable operating condition are be inspected and tested periodically in accordance with NFPA 13, NFPA 25, 9.7.5. Administrator will monitor for compliance.  The Plan of Correction for this alleged deficing 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 effective on a continuing basis.	ine isity ind will  The
ABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

Administrator Any deficiency statement endling 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 2

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DHSR CONSTRUCTION

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  A. BUILDING 02 - BUILDING 02  B. WING			(X3) DATE SURVEY COMPLETED 11/09/2011		
		. 345210						
NAME OF PROVIDER OR SUPPLIER  ELIZABETHTOWN NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  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)		PREFIX (EACH CORRECT TAG CROSS-REFEREN		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	ION SHOULD BE COMPLETION THE APPROPRIATE DATE		
K 062	This STANDARD	s not met as evidenced by: vation on 11/09/2011 the five pection had not been	К	)62				
t								