

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

PRINTED: 03/22/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>346358</b>	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____	(X3) DATE SURVEY COMPLETED  <b>03/15/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>LOUISBURG NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 SMOKETREE WAY LOUISBURG, NC 27549</b>	
(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 156 SS=B	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>	F 156	<p><b>F156</b> <b>Standard Disclaimer:</b> This plan of correction is provided as a necessary requirement of 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.</p> <p>Resident #56 has been introduced to the Ombudsman and had personal meeting with the Ombudsman on March 19, 2012.</p> <p>The Ombudsman attended the Resident Council Meeting on March 19, 2012.</p> <p>The Ombudsman's Role and Contact Information is included in the facility admission packet.</p> <p>The Ombudsman Information is posted in the main corridor on Resident Information board.</p> <p>The Resident Council will discuss the Ombudsman's role and contact information at least quarterly with documentation to support discussion/review.</p> <p>The plan of correction for this alleged deficient practice shall be included as an addendum to the facility's most recent Quality Assurance Committee meeting minutes. Additionally, the Administrator, Social Worker and/or Activities Director shall report any episodes of non-compliance with Ombudsman information review identified to Quality Assurance Committee monthly for three months and then quarterly thereafter.</p>	04/01/12

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

*Cheyl Vermulsea RN*

TITLE

*Administrator*

(X6) DATE

*4/2/2012*

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

PRINTED: 03/22/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  03/15/2012
NAME OF PROVIDER OR SUPPLIER  LOUISBURG NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(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 156	<p>Continued From page 1</p> <p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This</p>	F 156			

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

PRINTED: 03/22/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  03/15/2012
NAME OF PROVIDER OR SUPPLIER  LOUISBURG NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27649		
(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 156	<p>Continued From page 2</p> <p>includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews the facility failed to ensure that 1 of 1 sampled resident (resident #56) knew who the ombudsman was and how to contact him/her.</p> <p>Findings included:</p> <p>Resident # 56 was admitted to the facility on July 15, 2011 with multiple diagnoses including respiratory failure, chronic obstructive pulmonary disease and chronic kidney disease.</p> <p>In an interview at 4pm on 3/13/2012 the President of the Resident Council, resident #56, stated he was not aware of who the ombudsman was or what they did or how to contact them. He also indicated that he had never been informed of the ombudsman. He stated again " I don't know who that is and don't know how to reach that person. "</p>	F 156		

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

PRINTED: 03/22/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  03/15/2012
NAME OF PROVIDER OR SUPPLIER  LOUISBURG NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(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 156	Continued From page 3  A Record review of the Resident Council Minutes from August 2011 until February 2012 revealed that resident # 56 attended regularly. The record review also indicated there was no evidence of a discussion about the ombudsman 's job, or how to contact the ombudsman should a complaint or issue arises. The Resident Council meeting were held on August 22,2011, September 19, 2011, October 19, 2011, November 16, 2011, December 14, 2011, January 23, 2012 and February 20, 2012.  In an interview on 3/14/2012 at 9 am the Social Services (SS) Director who regularly attended the monthly Resident Council meetings revealed that resident #56 was reliable. The SS Director indicated that the Ombudsman comes once a year to the facility, but was unsure of what time last year the Ombudsman visited. She stated that information for contacting the Ombudsman was passed out to each resident in the meeting attended by the Ombudsman. The SS Director revealed that information about the Ombudsman had been discussed at the resident council meetings in the past. She was unable to find that information documented after reviewing the August of 2011 through February 2012 Resident Council minutes and meeting notes.  On 3/14/2012 at 11 am an interview with the Administrator revealed that her expectations were for staff to educate the residents about the Ombudsman. The Administrator stated that the information about the ombudsman was posted on the information board. The Administrator revealed that the Ombudsman came annually to the facility. She stated that the residents were	F 156			

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

PRINTED: 03/22/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  03/15/2012
NAME OF PROVIDER OR SUPPLIER  LOUISBURG NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(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 156	Continued From page 4	F 156			
F 250 SS=D	<p>educated about the 'ombudsman at the admission process..</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and staff interview and record review, the facility failed to arrange an appointment for cataract evaluation for 1 of 1 sampled resident (Resident #62). The findings included:</p> <p>Resident #62 was initially admitted to the facility on 8/14/06. Diagnoses included paraplegia and hypertension. Annual Minimum Data Set dated 2/16/12 revealed a brief interview for mental status score of 15, indicating that the resident was cognitively intact, and no vision problems were noted.</p> <p>Record review revealed a Progress Note dated 1/19/12 written by an optometrist. The Note read that Resident #62 had a cataract to his left eye and "may benefit from cataract consultation now".</p> <p>During an interview on 3/12/12 at 3:39 PM, Resident #62 indicated that he needed to see an eye doctor for cataract removal but nothing had been scheduled. He stated when he asked Administrative Assistant #1 (the person</p>	F 250	<p><b>F250 Standard Disclaimer:</b> This plan of correction is provided as a necessary requirement of 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.</p> <p>Resident # 62 is scheduled for cataract follow up per his request on April 4, 2012.</p> <p>The Administrative Nursing assistant has been in-serviced on review and follow up for Physician recommendations/orders.</p> <p>All consult notes are reviewed by DON or designee for review and follow up for identified appointment needs.</p> <p>Weekly appointment schedule is reviewed by Administrative Nursing for potentially unidentified orders and/or follow up.</p> <p>The Director of Nursing, Clinical Coordinator, and/or Administrator shall ensure compliance by auditing completed appointments for appropriate follow up. Any identified discrepancies shall be remediated.</p> <p>The plan of correction for this alleged deficient practice shall be included as an addendum to the facility's most recent Quality Assurance Committee meeting minutes. Additionally, the Administrator, DON and/or Clinical Coordinator shall report any episodes of non-compliance with Physician recommendations/follow-up identified to Quality Assurance Committee monthly for three months and then quarterly thereafter.</p>	04/01/12	

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

PRINTED: 03/22/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  03/15/2012
NAME OF PROVIDER OR SUPPLIER  LOUISBURG NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(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 250	<p>Continued From page 5</p> <p>responsible for scheduling appointments) she told him she would check on it. He heard nothing further.</p> <p>During an interview on 3/15/12 at 10:35 AM, Administrative Assistant #1 indicated that she had taken Resident #62 to his appointment with the optometrist on 1/19/12 and saw the Progress Note. She recalled being told that the resident needed to wait 1 year before re-evaluation. Administrative Assistant #1 also stated that if a physician wanted to make a referral, the physician's office would generate it. She acknowledged that Resident #62 had asked her about a follow-up appointment, and recalled telling him that she had not heard back from the office yet. She acknowledged she did no additional follow-up.</p> <p>During a telephone interview on 3/15/12 at 10:43 AM, a representative at the optometrist's office indicated that on 1/19/12 the optometrist suggested to Resident #62 that he consider having the cataract evaluated by an ophthalmologist. Any further action would have been up to the resident and facility.</p> <p>During an interview on 3/15/12 at 1:21 PM, the administrator acknowledged that the facility had not followed up with the resident regarding his decision on whether or not to pursue a cataract evaluation. The administrator also indicated that if the facility was expecting the optometrist office to notify them of a referral and not heard nothing within 2 weeks, the facility should have contacted the office.</p>	F 250			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371			

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

PRINTED: 03/22/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345358</b>	(X2) MULTIPLE CONSTRUCTION A BUILDING _____ B WING _____		(X3) DATE SURVEY COMPLETED  <b>03/15/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>LOUISBURG NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 SMOKETREE WAY LOUISBURG, NC 27549</b>		
(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 371	<p>Continued From page 6</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain sanitary conditions in the kitchen by not ensuring opened food items were sealed, dated and labeled; and, by not ensuring food service equipment were maintained clean and free from debris.</p> <p>Findings included:</p> <p>1. During the tour of the kitchen on 3/12/12 at 10:48am, observations of the refrigeration units revealed food items that were not sealed, dated or labeled. The walk-in refrigerator contained 1-resealed bag of shredded cheese that was not dated or labeled. The walk-in freezer contained 1-opened, not dated or labeled bag of uncooked, boned red meats; 1-resealed, not dated or labeled bag of uncooked meat patties; and 1-not dated or labeled, ripped bag of uncooked meat pieces. The reach-in refrigerator contained 3-resealed not dated or labeled packages of sliced luncheon meats in a stainless steel pan which contained an adhesive label dated 2/14/12.</p>	F 371	<p><b>F371</b> <b>Standard Disclaimer:</b> This plan of correction is provided as a necessary requirement of 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.</p> <p>All food service equipment has been cleaned and maintained free of debris.</p> <p>All opened food items are sealed, dated and labeled.</p> <p>Dietary Staff has been in-serviced on food sanitation to include the cleaning of food service equipment and the sealing, dating and labeling of opened food items.</p> <p>The Dietary Mgr. and/or designee will monitor for appropriate sanitation of food service equipment and storage of opened food via Dietary End of Shift Check List: AM/PM Shifts.</p> <p>The Administrator and/or designee will perform random audits of food service sanitation and food storage daily using daily cleaning schedule for validation review. Any identified discrepancies shall be reported and remediated immediately.</p> <p>The plan of correction for this alleged deficient practice shall be included as an addendum to the facility's most recent Quality Assurance Committee meeting minutes. Additionally, the Dietary Manager, Administrator and/or designee shall report any episodes of non-compliance with food equipment sanitation and food storage to Quality Assurance Committee monthly for three months and then quarterly thereafter.</p>	04/02/12	

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

PRINTED: 03/22/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  03/15/2012
NAME OF PROVIDER OR SUPPLIER  LOUISBURG NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(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 371	Continued From page 7 The reach-in freezer contained 1-opened, not dated or labeled, plastic sleeve of 4-porous muffins and ice crystals.  After each observation, the Dietary Manager removed the above items from the refrigeration units.  2. During the initial tour of the kitchen on 3/12/12 at 11:08am, the inside of the microwave oven contained dried, yellow, brown debris. The large sugar bin had brown sticky stains around the lip of the top of the bin that was covered by a plastic, sticky lid. Observations of 4 of 6 of the stainless steel meal delivery carts revealed the inside walls of the carts were stained with dried white and brown debris.  During a second observation of the kitchen on 3/15/12 at 12:05pm, 2-meal delivery carts, containing prepared meal trays from the meal serving line, were stained with brown, sticky, and white debris on the inside walls and floors of the carts.  During an interview on 3/12/12 at 12:06pm, the Dietary Manager revealed that the meal delivery carts were cleaned at the end of each day; but, were to be wiped down before the start of each meal service.	F 371			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an	F 431			



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

PRINTED: 03/22/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345358</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/15/2012</b>
NAME OF PROVIDER OR SUPPLIER  <b>LOUISBURG NURSING CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>202 SMOKETREE WAY LOUISBURG, NC 27549</b>		
(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 431	<p>Continued From page 8</p> <p>accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure four expired IV therapy solution bags were removed from possible usage from 1 of 4 medication storage areas.</p> <p>Findings include:</p>	F 431	<p><b>F431</b> <b>Standard Disclaimer:</b> This plan of correction is provided as a necessary requirement of 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.</p> <p>All IV solutions have been reviewed and are current.</p> <p>Licensed Nursing Staff have been in-serviced on monitoring IV solutions for expiration dates.</p> <p>All IV solution expiration dates are noted on delivery sheets by receiving nurse. Delivery sheets denoting IV fluids are maintained for reference by DON.</p> <p>The 11-7 Licensed Nurses will check IV supplies for expiration dates on a weekly basis. The DON will check weekly for expired IV fluids.</p> <p>The Clinical Coordinator, and/or Administrator shall ensure compliance by randomly monitoring for expired IV solutions on a weekly basis x 4 weeks and monthly thereafter to ensure compliance with storage of current IV solutions. Any identified discrepancies shall be remediated.</p> <p>The plan of correction for this alleged deficient practice shall be included as an addendum to the facility's most recent Quality Assurance Committee meeting minutes. Additionally, the Administrator, DON and/or Clinical Coordinator shall report any episodes of non-compliance with storage of current IV solutions identified to Quality Assurance Committee monthly for three months and then quarterly thereafter.</p>	04/01/12	

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

PRINTED: 03/22/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  03/15/2012
NAME OF PROVIDER OR SUPPLIER  LOUISBURG NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(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 431	Continued From page 9  On 03/14/2012 at 9:15 a.m. an observation of the facility's medication storage room was made with the facility's Director of Nursing Services (DON). The following expired items were found on a lower set of shelving mixed in with additional non-expired IV therapy fluids.  Sodium Chloride 0.9% IV 150ml bags: 2 bags - expired 05/2011 1 bag - expired 09/2011  Sodium Chloride 0.9% IV 1000ml bag: 1 bag - expired 02/2012  On 03/14/2012 at 9:30, an interview was conducted with the facility's DON. The DON observed the IV therapy solution bags, indicated they were expired and stated, "The consultant pharmacist went through and checked the medication room last night (03/13/2012) and apparently did not find these expired bags of IV fluids."	F 431			

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

PRINTED: 04/16/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED  04/10/2012
--	--	---	--

NAME OF PROVIDER OR SUPPLIER  LOUISBURG NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKE TREE WAY LOUISBURG, NC 27549
--	--

(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 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	K 038	<b>K038 STANDARD DISCLAIMER:</b> The Plan of Correction for this alleged deficient practice is provided as a necessary requirement of 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).  No residents were specifically identified as having been affected by the alleged deficient practice.	
K 076	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4  This STANDARD is not met as evidenced by: A. Based on observation on 04/10/2012 there were wheel chairs with 02 in use with out a "No Smoking" sign. 42 CFR 483.70 (a)	K 076	The outside storage room door that is just outside of the kitchen on the left requires a single motion of the hand to exit the room.  The outside kitchen storage door is checked daily for appropriate function and exit with one motion of the hand.  The Maintenance Director, Administrator and/or designee shall ensure compliance via daily random audits to evaluate means of full instant egress in case of emergency from the kitchen storage area.  The Maintenance Director shall report any variances identified to the Quality Assurance Committee monthly for three months, then quarterly thereafter.	04/20/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Cheyl Vermilyea, RN</i>	TITLE <i>Administrator</i>	(X6) DATE <i>April 20, 2012</i>
---	-------------------------------	------------------------------------

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

PRINTED: 04/16/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  04/10/2012
NAME OF PROVIDER OR SUPPLIER  LOUISBURG NURSING CENTER			STREET ADDRESS, CITY, STATE ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(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	
			<p><b>K076</b></p> <p><b>STANDARD DISCLAIMER:</b> The Plan of Correction for this alleged deficient practice is provided as a necessary requirement of 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).</p> <p>All residents who use portable O2 cylinders have "NO SMOKING" signs attached to O2 tanks.</p> <p>All O2 tanks are labeled with "NO SMOKING" signs when placed into use.</p> <p>All staff has been in-serviced on the use of "NO SMOKING" signs for O2 tanks attached to wheelchairs or portable carts.</p> <p>The Maintenance Director and/or designee shall ensure compliance by completing random checks of the O2 cylinders for appropriate labeling of "NO SMOKING".</p> <p>The Maintenance Director shall report any variances in O2 cylinder "NO SMOKING" signage to the Quality Assurance Committee monthly for three months, then quarterly thereafter.</p>	04/25/2012	