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

PRINTED: 11/15/2012
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345510 | A. BUILDING _____ B. WING _____ | 11/01/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TARBORO NURSING CENTER | 911 WESTERN BOULEVARD TARBORO, NC 27886 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 274 SS=D | 483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE<br><br>A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, record reviews and staff interviews the facility failed to complete a significant change assessment for 1 (Resident #88) of 1 sampled residents, who had unplanned weight loss of 8% in the last month, developed a new stage 2 pressure ulcer and had demonstrated increased sadness.<br><br>Findings include:<br><br>Resident #88 was re admitted to the facility on 2/27/2011. Diagnoses for Resident #88 included End Stage Renal Failure, Diabetes, Hypertension, Peripheral Vascular Disease, and Cervical Spinal Stenosis.<br><br>Record review of Resident #88 ' s weight history was documented by the Dietary Manager and | F 274 | *Submission of the response to the Statement of Deficiencies by the undersigned does not constitute an admission that the deficiencies existed, that they were cited correctly, or that any correction is required.*<br><br>**F274 COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE**<br><br>Criteria #1 A Significant Change Minimum Data Set with an ARD date of 11/06/2012 was completed for resident # 88.<br><br>Criteria #2 All residents have the potential to be affected by this deficient practice, therefore, an audit will be conducted to identify any resident with a significant change in physical and or mental condition requiring a Comprehensive Assessment/ Significant Change MDS.<br><br>Criteria #3 In-service provided by DON to MDS assessment nurses related to the criteria for completing Comprehensive Assessment/Significant Change MDS. | 11/13/12<br><br>11/19/12<br><br>11/19/12 |

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

ADMINISTRATOR 11-21-12

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 346510 | A. BUILDING _____ B. WING _____ | 11/01/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TARBORO NURSING CENTER | 311 WESTERN BOULEVARD TARBORO, NC 27886 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 274 | Continued From page 1<br>revealed Resident #88 weighed 208 pounds in March 2012 and weighed 196.4 pounds in June 2012. The Resident's weight was recorded as 191.6 pounds in August 2012.<br><br>A quarterly Minimum Data Set (MDS) dated 7/13/12 revealed Resident # 88 was cognitively intact and able to make his own decisions. The MDS indicated Resident #88 needed extensive assistance with bathing, toileting, transfers, and hygiene. In addition, the MDS indicated Resident #88 required limited assistance with eating. The MDS indicated resident #88 had signs and symptoms of depression and had no signs of a poor appetite. The MDS also indicated resident #88 had no pressure ulcers.<br><br>Record review revealed a Registered Dietician (RD) note of 9/14/12 indicated Resident #88 ' s weight was 189.7 pounds. The note indicated the resident had lost 7.9 pounds, 4% of his body weight in 30 days. The note indicated the RD recommended liberalizing the resident's diet to a regular pureed consistency.<br><br>On 9/20/12 an RD note indicated a Fiberoptic Endoscopic Examination of Swallowing (FEES) procedure (a test to evaluate the ability to swallow) was ordered and a nutritional supplement was started. The note indicated the supplement was started three times a day for Resident #88 to aid with energy needs.<br><br>A physician's note dated 9/23/12 revealed the physician was asked to see resident #88 by the SW. The note indicated resident #88 had become more tearful and despondent due to his multiple medical problems. The note indicated | F 274 | Criteria #4 Significant Change Monitoring Tool implemented to ensure compliance. Monitoring tool to be completed by the DON or designee 1 x week x 1 month and then monthly x 2 months. Significant Change Monitoring Tool incorporated into facility monthly QA to evaluate effectiveness and ensure compliance. | 11/19/12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345510 | A. BUILDING _____ B. WING _____ | 11/01/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TARBORO NURSING CENTER | 911 WESTERN BOULEVARD TARBORO, NC 27886 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 274 | Continued From page 2 | F 274 | | |

resident #88 was more depressed and anxious because of his declining condition.

On 9/27/12 the RD notes revealed Resident #88 had expected weight loss due to a decrease in his oral intake. The note also indicated the resident had a significant decrease in his body weight from the previous week. The note indicated Resident #88 ' s body weight was 174.6 pounds.

A facility wound assessment form, dated 10/1/12, indicated Resident #88 had a new stage 2 pressure ulcer on his sacral area. The form indicated the pressure ulcer measured 0.5 centimeters (cm) in length, 0.3 cm. in width, and no depth to the pressure ulcer. The note indicated the pressure ulcer had 100% granulation tissue in the wound bed and the wound edges were well defined. The note indicated Resident #88 ' s pressure ulcer was to be treated with barrier cream after each incontinent episode and he was encouraged to take rest periods in bed throughout the day.

On 10/2/12 the Dietary Manager notes indicated Resident #88's current body weight was 174.6 pounds. The notes also indicated the resident lost 8% of his body weight in one month and 16% of his body weight in 6 months. The note also indicated Resident #88 had an open area on his sacrum.

A quarterly MDS, dated 10/2/12, revealed Resident #88 was cognitively intact and able to make his needs known. The mood section of the MDS indicated the resident had signs and symptoms of depression which included a poor

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345510 | A. BUILDING _____ B. WING _____ | 11/01/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TARBORO NURSING CENTER | 911 WESTERN BOULEVARD TARBORO, NC 27886 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 274 | Continued From page 3 | F 274 | | |

appetite and little pleasure of doing things and indicated the resident's moods had worsened from the previous assessment. The MDS also documented Resident #88 rejected care 1 to 3 days during the assessment period. The MDS documented the resident required extensive assistance for all activities of daily living including bathing, toileting, dressing, and transfers, and required limited assistance with eating. The MDS documented the resident had a stage 2 pressure ulcer which was found on 10/1/2012 and received treatments to the pressure ulcer. The swallowing and nutrition section of the MDS indicated Resident #88 had no signs and symptoms of a possible swallowing disorder and received a mechanically altered diet. The MDS documented the resident's weight at the time of the assessment was 156 pounds and the resident had lost 5% in the last month, or 10% or more of his body weight in last 6 months. The MDS indicated Resident #88 had mouth and facial pain, discomfort or difficulty chewing.

Record review revealed on 10/3/12, the Social Worker (SW) indicated Resident #88 had little interest in doing things, had a poor appetite, and trouble sleeping several times over the past 2 weeks.

Record review revealed on 10/11/12 the RD indicated resident #88 ' s weight was 156.3 and a gastrostomy tube was discussed with the resident due to his poor intake and difficulty swallowing.

Record review revealed an RD note on 10/18/12, the resident had a significant weight loss and a weight of 144.5 pounds.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345510 | A. BUILDING _____ B. WING _____ | 11/01/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TARBORO NURSING CENTER | 911 WESTERN BOULEVARD TARBORO, NC 27886 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 274 | Continued From page 4<br>Record review revealed a facility wound assessment form, dated 10/23/12, for Resident #88 that indicated a stage 2 sacral wound was under treatment.<br><br>Record review revealed a gastrostomy tube was surgically placed on 10/25/12 to meet his nutritional needs due to difficulty swallowing.<br><br>Record review revealed a physician ' s order, dated 10/31/12, revealed the physician had ordered (brand name of tube feeding formula) via his gastrostomy tube and receive pureed pleasure foods as tolerated. In addition, the record review revealed a nutritional supplement was ordered.<br><br>An observation of the resident ' s wound care on 11/1/12 at 10:35 AM, by the Treatment nurse revealed the resident had 3 stage 2 pressure ulcers. The observation revealed a pressure ulcer was on the sacral area, one was on the left ischial area, and the third area was located on the right ischial area.<br><br>An interview with the Treatment nurse on 11/2/12 at 8:30 AM indicated the stage 2 wound on the resident ' s sacrum was first reported on 10/1/12. Measurements on 10/1/12 of the site revealed the wound was 0.5 cm Length, 0.3 cm Width and no depth. The wound was treated with barrier cream every shift and after each incontinent episode and the resident was encouraged to rest in bed for periods during the day. The treatment was changed on 10/23/12 to: cleanse and apply collagen and change every Thursday.<br><br>An interview was conducted with the RD on | F 274 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345510 | A. BUILDING _____ B. WING _____ | 11/01/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TARBORO NURSING CENTER | 911 WESTERN BOULEVARD TARBORO, NC 27886 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 274 | Continued From page 5<br>11/2/12 at 9:05 AM. The RD indicated the resident had experienced recent weight loss. The RD stated the resident ' s weights reflected on vital sign flow sheet were post dialysis days and there were fluctuations. The RD indicated Resident #88 had significant weight loss, a new pressure ulcer on the sacrum, and a decline in condition.<br><br>An interview with the MDS nurse on 11/2/12 at 2:45 PM revealed there a significant change assessment was not done for Resident #88 when the stage 2 sacral wound was first observed on 10/1/12, and the resident had been identified for significant weight loss by the RD.<br><br>An interview with the DON on 11/2/12 at 4:30 PM revealed her expectation was the significant change assessment would have been completed for Resident #88 because the decline in his condition, which included his significant weight loss, a new stage 2 pressure ulcer, and emergence and worsening of sadness. | F 274 | | |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interviews and record reviews, the facility failed to ensure physician ' s orders were carried out for 1 (Resident #125) of 11 sampled residents with orders for laboratory tests.<br><br>Findings include: | F 281 | **F281 Services Provided Meet Professional Standards.**<br><br>Criteria #1 Resident #125 no longer resides at the facility. Ordered labs were obtained and reported to MD prior to resident discharge to home on 11/09/12. | 11/06/12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 346510 | A. BUILDING _____ B. WING _____ | 11/01/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TARBORO NURSING CENTER | 911 WESTERN BOULEVARD TARBORO, NC 27886 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 281 | Continued From page 6 | F 281 | | |

Resident #125 was admitted to the facility on 10/12/12 with diagnoses to include Peripheral Vascular Disease, Diabetes Mellitus Type 2, Congestive Heart Failure, and hypercholesteremia (elevated cholesterol).

Review of the physician ' s orders revealed the resident received Lasix (diuretic) Zaroxolyn (diuretic), K-Dur (potassium supplement), Zocor (medication used for high cholesterol), and NPH insulin and Humulin R insulin for diabetes.

Review of physician ' s orders dated 10/12/12 revealed orders for a renal panel, complete blood count, lipid/liver panel every 6 months; and HbgA1c (measures the average blood sugar content over a period of 3 months) , B12 level, and thyroid stimulating hormone to start 10/17/12.

Review of a facility " Daily Lab Log " revealed the resident ' s name and the labs to be drawn were listed on the log. The " date drawn " was documented as 10/17/12 with (initials of the nurse who drew the blood). Review of a nurse note dated 10/17/12 at 7:06 AM revealed a note in part as: " 1 tube of blood obtained for labs, veins blew (twice). The resident ' s name did not appear on the Daily Lab Log " for a laboratory test after 10/17/12.

On 11/2/12 at 4:28 PM, a telephone interview was conducted with Nurse #2 who drew the resident ' s blood on 10/17/12. The nurse reported when she was unable to draw all of the samples for the resident, she spun the one tube she obtained and put it in the refrigerator. Nurse #2 reported she

Criteria #2 All residents have the potential to be affected by this deficient practice, therefore, the Director of Nursing, ADON, SDC and Team Leader will conduct a facility wide audit of all MD orders to identify any potential missing labs. Any missing labs will be reported to the physician and will be drawn if indicated. All new admission charts will be reviewed for lab orders and appropriate implementation and follow-up. — 11/26/12

Criteria #3 revised lab log implemented to include resident name, room number, lab to be drawn, date due, date drawn, initials of Phleb, date report received, report to MD, copy on chart and original on chart. Lab logs will be placed at each Nurses station. — 11/21/12

100% of licensed nursing staff will be in-serviced on the new lab procedure to include: implementation of new lab orders, drawing of labs, appropriate documentation, reporting to physician and assurance of results to be on charts. — 11/21/12

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345810 | A. BUILDING _____ B. WING _____ | 11/01/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TARBORO NURSING CENTER | 311 WESTERN BOULEVARD TARBORO, NC 27886 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 281 | Continued From page 7<br>reported she was unable to draw all of the samples to Nurse #1, the charge nurse.<br><br>An interview was conducted with Nurse #1 at 5:30 PM on 11/2/12. The nurse stated she didn't remember Nurse #2 having told her she was not able to collect all of the blood samples.<br><br>An interview was conducted with the Director of Nursing (DON) on 11/2/12 at 4:12 PM. The DON stated she expected the nurses would get another nurse to draw a blood sample if they were not able to obtain the sample. If the second nurse was not able to draw the samples, the DON stated she expected the nurse reported off to team leader and the oncoming nurse so the sample was drawn. The DON stated if a sample was not able to be collected by any of the nurses, she expected the nurses called the doctor. The DON reported there was no tracking system to assure the labs results were received (that would indicate the samples were drawn).<br><br>An interview was conducted with the resident ' s physician on 11/2/12 at 3:50 PM. The physician reported once in a while he found a lab that wasn't done and he now had concerns that the laboratory tests he ordered were not being completed. The physician stated he felt there ought to have been a check off system to indicate the laboratory results were received and the laboratory tests he ordered were accounted for. | F 281 | Criteria #4 Lab Audit tool implemented. The DON, ADON, SDC, RN Weekend Supervisor and Team Leader will monitor the lab logs 5 x week x 1month, weekly x 2 month. The DON will incorporate POC in monthly QA and will report any significant findings from the follow-up to Quality Assurance Committee for three months or as deemed necessary. | 11/21/12 |
| F 431 SS=D | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all | F 431 | F431 DRUG RECORDS LABEL/STORE DRUGS & BIOLOGICALS | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345610 | A. BUILDING _____ B. WING _____ | 11/01/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TARBORO NURSING CENTER | 911 WESTERN BOULEVARD TARBORO, NC 27886 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 431 | Continued From page 8<br>controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.<br><br>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.<br><br>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.<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to discard expired medications from the medication storage room refrigerator and locked narcotic box, and 1 of 5 medication carts (200 East). | F 431 | Criteria #1 The multidose vial of Tuberculin Purified Protein Derivative dated 09/28/12, Novolin R with exp date of 05/2012 and 08/2012, the three vials of unopened Morphine Sulfate with expiration of 10/31/2012 and the Haldol vial with exp date of 10/31/2012 were removed and returned to pharmacy for discarding as indicated.<br><br>Criteria # 2 An audit of all medication carts, treatment carts, medication refrigerators and medication storage rooms will be conducted by Pharmacy Consultant to assure that there are no expired medications and that medications are being pulled from stock and returned to pharmacy as indicated.<br><br>Criteria#3 All Licensed Nurses and Medication Aids will be in-serviced on policy and procedure of returning/discarding expired medications to pharmacy. | 11/02/12<br><br>11/21/12<br><br>11/21/12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 346810 | A. BUILDING _____ B. WING _____ | 11/01/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TARBORO NURSING CENTER | 911 WESTERN BOULEVARD TARBORO, NC 27886 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 431 | Continued From page 9<br><br>Findings include:<br><br>An observation was made of the Medication Storage room on 11/2/12 at 11 AM. Medications stored in the refrigerator revealed a multi-dose vial of Tuberculin Purified Protein Derivative that was dated as opened 9/28/12. Nurse #1 reported the medication was expired and should have been discarded as it was only good for 30 days after opening. There was an unopened vial of Novolin R Insulin with a manufacturer ' s expiration date of 5/2012 and another unopened vial of Novolin R with a manufacturer ' s expiration date of 8/2012. There were 3 unopened single use vials of Morphine Sulfate injectables with a manufacturer ' s expiration date of 10/2012 in the locked narcotic box in the medication room. The 200 East hall medication cart observation revealed a single use vial of Haldol (antipsychotic medication) with a manufacturer ' s expiration date of 10/21/2. Nurse #1 stated all of the nurses were responsible for checking for expiration dates of the medications in the medication storage room and the expired medications should have been discarded.<br><br>During an interview with the Director of Nursing (DON) on 11/2/12 12:10 PM, the DON stated nurses were expected to check the expiration dates on medications before giving them to prevent from using expired medications. The DON stated the vials of medications should have been dated when they were opened and she expected the Pharmacist would find any expired medications in the medication room/refrigerator on the monthly visit. Review of pharmacy | F 431 | Criteria #4 Medication Expiration Audit tool implemented. The DON, ADON & SDC will audit all med carts, treatment carts, narcotic lock boxes, medication refrigerators and medication rooms 3 x weeks for 1 month. Pharmacy Consultant will audit the same areas monthly x 1month. Any variances will be corrected at the time of observation and concerns will be reported in monthly QA. Continued compliance will be monitored through weekly audits | 11/21/12 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345510 | A. BUILDING _____ B. WING _____ | 11/01/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TARBORO NURSING CENTER | 911 WESTERN BOULEVARD TARBORO, NC 27886 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 431 | Continued From page 10<br>recommendations revealed the pharmacist was last in the facility on 10/16/12<br><br>A telephone interview was conducted with the facility Pharmacist (RPh) on 11/2/12 at 2:55 PM. The RPh reported he was last in the facility on 10/16/12 for a monthly review of the residents ' medication regimen. Along with the medication review, he performed medication pass observations with the nurses The RPh reported he conducted a quarterly review of the facility ' s medication stock room; he checked the medication refrigerator for medications that had expired,; and checked the temperature of the refrigerator. The RPh reported he did not do a quarterly review on his last visit in October 2012. The RPh stated he did not look in the locked box with narcotics, but asked about them, and he did not remember any insulin bottles in the refrigerator. The RPH stated he didn't do an extensive review for expired medications unless he was asked to do so. | F 431 | | |

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

FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345510 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 11/29/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TARBORO NURSING CENTER | 911 WESTERN BOULEVARD<br>TARBORO, NC 27886 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>A. Based on observation on 11/29/2012 there were no LSC deficiencies noted. | K 000 | | |

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

ADMIN 12-21-12

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.

OD

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345510 | A. BUILDING 02 - BUILDING 02<br>B. WING | 11/29/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TARBORO NURSING CENTER | 911 WESTERN BOULEVARD<br>TARBORO, NC 27888 |



| (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<br><br>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<br><br>This STANDARD is not met as evidenced by:<br>A. Based on observation and staff interview on 11/29/2012 the dry sprinkler system had not had a five (5) year obstruction test. (documentation was not found)<br>42 CFR 483.70 (a) | K 062 | "Submission of this response to the Statement of Deficiencies by the undersigned does not constitute an admission that the deficiencies existed and/or were correctly cited and/or require correction."<br><br>1. The five year inspection will be completed by outside company on Jan. 8, 2013.<br><br>2. Five year internal sprinkler system inspection will be placed on the preventive maintenance log to validate maintained compliance.<br><br>3. Monthly and annual preventive maintenance logs will be reviewed in QA meetings every month for 3 months and quarterly thereafter to validate compliance. | 01/8/2013<br><br>11/30/12 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Admin. — (X6) DATE: 12-21-12

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345510 | A. BUILDING 03 - BUILDING 03<br>B. WING | 11/29/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TARBORO NURSING CENTER | 911 WESTERN BOULEVARD<br>TARBORO, NC 27886 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 050 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2<br><br>This STANDARD is not met as evidenced by:<br>A. Based on observation on 11/29/2012 the staff interviewed did not know the fire drill procedures nor the location on the pull stations to activate the system.<br>42 CFR 483.70 (a) | K 050 | 1. All staff in-serviced and trained on proper fire safety procedures and how to respond to fire/smoke situations within the facility.<br><br>2. New employee orientation and annual training will be reviewed to ensure that staff receive adequate training.<br><br>3. Monthly fire drills and in-services will be conducted to ensure compliance. | 11/30/12 |
| K 076 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.<br><br>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.<br><br>(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 | K 076 | 1. Oxygen tanks are separated and secured in racks with proper labeling for full and empty.<br><br>2. Staff in-serviced on proper storage of medical gasses.<br><br>3. Maintenance Director or designee will monitor proper storage daily. | 11/30/12 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMIN — (X6) DATE: 12-21-12

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345510 | A. BUILDING 03 - BUILDING 03<br>B. WING _____ | 11/29/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| TARBORO NURSING CENTER | 911 WESTERN BOULEVARD<br>TARBORO, NC 27888 |

| (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 076 | Continued From page 1<br>This STANDARD is not met as evidenced by:<br>A. Based on observation on 11/29/2012 there were full and empty 02 cylinders mixed in the 02 storage room near room 216.<br>42 CFR 483.70 (a) | K 076 | | |