STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation survey of 12/04/2014 Event ID # DB3Q11.	F 000		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews with the resident and staff the facility failed to place the call button was within reach for 1 of 9 residents (Resident #14) capable of using their call button. The findings included: Resident #14 was readmitted to the facility on 10/6/14 with diagnoses including an old stroke with right sided hemiplegia, a new stroke with left sided weakness, a fracture of the left clavicle and cerebrovascular disease. The 30 day Minimum Data Set dated 11/3/14 revealed Resident #14 was moderately cognitively impaired and she was totally dependent for bed mobility, transfers, dressing, toilet use and personal hygiene. Her care plan dated 10/21/14 revealed she required assistance for transferring from one position to another and she was a risk for falls related to a history of falls and impaired balance. Resident #14's care guide was reviewed and it	F 246	This plan of correction is the Center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. F246 1. The call light for resident #14 was placed in the resident's left hand by Nurse #1 at the time of the survey on 12/3/14. Resident #14 Resident Care Guide was updated on 12/4/14 by the MDS nurse to include keep call light in reach of "resident's left hand" at all times.	12/31/14

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

Electronically Signed | 12/18/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 246	Continued From page 1 did not contain any information about the placement of the call button. The care guide was used by the Nursing Assistants as a guide for the care required for the residents and it was available in the computer kiosk where the Nursing Assistants document the care provided to the residents. An observation of Resident #14 on 12/3/14 at 12:25 PM revealed she was sitting in a reclining wheel chair with her left arm in a sling. The reclining wheel chair was 1 foot away from the bed and the call button was observed in the middle of the bed on the resident's left side. During the visit Resident #14 on 12/3/14 at 12:25 PM she stated she was not able to reach her call button. She stated she did not know where it was. On 12/3/14 at 12:30pm, during an interview, Nursing Assistant (NA) #1 stated she was not aware Resident #14 had returned to her room from the 11:00 AM activity she attended. NA #1 stated the resident could not reach her call button located on the bed. During an interview on 12/3/14 at 12:35 PM NA #2 stated she had returned Resident #14 to her room and the call button was on the resident's bed. In an additional interview at 4:10pm NA #2 stated she went out of the resident's room to help someone else and forgot to return to Resident #14's room to put the call button where the resident could reach it. She stated if the button was placed next to the resident's left hand she could use it. On 12/4/14 at 8:45 AM Resident #14 was observed in her bed. Her call button was located on the pillow above her right shoulder. On 12/4/14 at 10:00 AM Resident #14 was observed in her bed. Her call button was located above her right shoulder on the pillow.	F 246	2. A 100% audit was completed of all residents to include resident #14 by the MDS Nurse and Staff Facilitator on 12/4/14 to assure all call lights were in place and in reach of the residents. All identified areas of concern were immediately addressed by the MDS Nurse and Staff Facilitator during the time of the audit. 100% of nursing staff to include NA #1 and NA #2 were re-educated by the Staff Facilitator beginning 12/14/14 to assure all residents have their call light in reach before leaving the resident's room. All newly hired nursing staff will receive the education regarding keeping call lights within reach in orientation by the Staff Facilitator. 3. Call lights within residents' reach to include resident #14 will be monitored to include nights and weekends by the MDS Nurse, Staff Facilitator, treatment nurse or charge nurses daily x 4 weeks, weekly x 4 weeks then monthly x 1 month utilizing a QI Monitoring Resident rounds tool. The DON will review the Resident Rounds monitoring tools weekly x 8 weeks, then monthly x 1 month for concerns. 4. The DON will present the results of the Resident Rounds monitoring tools to the Executive Quality Assurance Committee meetings monthly x 3 months for trends and the need for continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 246	Continued From page 2 On 12/4/14 at 11:06 AM Resident #14 was again observed in her bed. The call button continued to be located on her pillow above her right shoulder. During an interview on 12/4/14 at 11:06 AM Resident #14 stated she could not reach the call button. She stated she was told the call button should be placed under her left hand. She moved her left fingers to demonstrate where the call button was to be placed. She stated she could not move her head to the right to activate the call button located above her right shoulder. During an interview on 12/4/14 at 11:10 AM Nurse #1 stated Resident #14 had a push bulb for her call button. She reported the resident was only able to use her fingers on her left hand so that was where the call button should be placed. She stated Resident #14 had right sided paralysis and left sided weakness and that the resident could not move her head to press the call button/bulb. During an interview on 12/4/14 at 11:50 AM the MDS (minimum data set) nurse stated Resident #14's care guide did not provide any information about the proper location of the resident's call bell. She stated she would update the care guide which was to be used by the nursing assistants as a reference for the resident's needs. She provided an updated print out of the care guide which included "keep call light in reach of resident's hands at all times."	F 246		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the	F 334		12/31/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 334	Continued From page 3 immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following:	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 334	Continued From page 4 (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review, facility policy and staff interview, the facility failed to verify the pneumococcal immunization status for 1 (Resident #61) of 5 residents reviewed for immunizations. The findings include: The facility policy dated 1/2009 entitled, "Immunizations," read in part, "Pneumococcal Immunization" "Residents will be offered the immunization upon admission, unless it is medically contraindicated or the resident has already been immunized." Resident #61 was admitted to the facility on 7/31/14. Diagnoses included cancer, cachexia and dementia. A "Consent/Release Form" was signed by the responsible party on 7/31/14 authorizing the facility to administer the pneumonia vaccine. The	F 334	1. The pneumococcal immunization status for Resident #61 was updated on 12/5/14 by the Medical Records Director after verification by the Medical Records Director on 12/5/14 that the resident had already received the vaccine prior to admission to the facility. 2. A 100% flu and pneumococcal immunization audit was completed for all residents to include resident #61 in the facility by the Medical Records Director on 12/8/14. All missing flu and pneumococcal immunization was updated by the Medical Records Director by 12/16/14. The audit revealed 3 resident had not received vaccine after consent was provided. The pneumococcal vaccine was administered	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 334	Continued From page 5 form included: "Date immunization received, if known" followed by a line on which a date could be written. No date or verbiage was recorded. Physician orders dated 7/31/14 included: "May give pneumococcal vaccine on admission according to acceptable standards of clinical practices or unless medically contraindicated (consent at admission)." Review of Resident #61's immunization record revealed no indication the pneumococcal immunization had been given. Review of the admission Minimum Data Set dated 8/22/14 indicated the resident's pneumococcal vaccination was up to date. During an interview on 12/3/14 at 4:23 PM, the charge nurse explained that on admission, the resident or family were asked if they wanted the resident to have the pneumococcal vaccine or it they already had it. The charge nurse indicated when she admitted new residents, she checked the consent form to verify consent for immunization. If consent was signed, she would administer the pneumococcal vaccine. The charge nurse added that it was an oversight that nothing was recorded regarding the pneumococcal status in the record and that the resident had not received the immunization. During an interview on 12/4/14 at 9:38 AM, the Social Worker stated that on admission, she provided the resident or responsible party (RP) risk/benefit information for both influenza and pneumococcal vaccines. The SW indicated she asked the resident or RP if they were aware if the resident had had either vaccination and if so, when. The SW added if the resident had not had the vaccinations, she would let the charge nurse know both verbally and via a sticky note. On 12/4/14 at 3:52 PM, the Minimum Data Set (MDS) Nurse the resident's responsible party had	F 334	to each of the 3 residents on 12/10/14, 12/12/14, and 12/16/14. The Social Worker receives consents for immunizations on or prior to admission. The nurses will review the consents on the day of admission and administer the immunizations as indicated by the consents. 100% of licensed nurses received re-education on the immunization policy and procedure for all newly admitted residents by the DON and Staff Facilitator beginning 12/4/14. All newly hired licensed staff will receive the education on immunizations in orientation. 3. A monitoring tool was developed on 12/5/14 by the DON to assure all immunization information will be documented accurately and timely for all new admissions. The immunization status of all newly admitted residents will be reviewed by the Medical Records Director weekly x 4 weeks then monthly x 2 months to assure all immunization information was documented accurately and timely utilizing and immunization monitoring tool. All identified areas of concern will be addressed by the charge nurse. The DON will initial and review the immunization monitoring tool weekly x 4 weeks, then monthly x 2 months for trends and concerns. 4. The DON will present the results of the immunization monitoring tool to the Executive Assurance Committee monthly x 3 months to identify trends and the need for continued monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 334	Continued From page 6 told her the resident had the pneumococcal immunization prior to admission. The MDS nurse added that she would not have shared this information with the other nurses.	F 334		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure a substantial snack was offered when the time between service of dinner and breakfast exceeded 14 hours. The findings included: The form titled Resident Meal Service Schedule was provided on 12/1/14. The form revealed the dinner meal was served from 4:40 PM -5:10 PM and the breakfast meal was served from 7:40 AM - 8:00 AM.	F 368	1. The meal delivery schedule has been altered to serve breakfast beginning at 7:15am on a daily basis, lunch will be served beginning at 11:45am, and dinner will begin at 4:45pm on a daily basis beginning on 12/18/14 to ensure there are no more than 14 hours between meals. The facility will continue to provide snacks in the evening to residents who are ordered snacks and to residents that wish	12/31/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 368	Continued From page 7 During an interview on 12/4/14 at 9:45 AM the Dietary Manager stated she was not aware that the time frame from dinner to breakfast was greater than 14 hours. She then acknowledged that the scheduled meal times were 15 hours apart. She stated that the Geriatric Aide provided snacks to residents who were assigned to receive snacks but she was not sure if snacks were offered to all residents. During an interview on 12/4/14 at 4:20 PM the Geriatric Aide stated she just passed out snacks to residents who were assigned to receive snacks but if another resident requested something she would retrieve something after she had conferred with the resident's nurse. She stated she only passed snacks during the day shift and the nursing assistants on the evening shift were responsible for passing the 8:00pm snacks. She stated the diabetic residents received a snack but not every resident was offered a snack. A review of the resident council minutes revealed no discussions related to meal times. During an interview on 12/4/14 at 4:20 PM Resident #38 stated she was frequently hungry before going to bed and that she was not able to sleep if she was hungry. She added the she frequently had a nurse to make her crackers with peanut butter using her personal supply. She stated the resident council had not discussed the length of time between dinner and breakfast. She added that the resident council had not given permission to allow more than 14 hours between those meals.	F 368	to have a snack. 2. A letter of notification of the change in the meal schedule has been sent to the Responsible parties by the Social Worker on 12/16/14. Resident Council Meeting will be held on 12/22/14 notifying them of the changes. The Dietary Manager began an in-service for all dietary staff beginning 12/15/14 on providing the breakfast meal at 7:15am and the dinner meal 4:45pm on a daily basis. All newly hired dietary staff will receive the meal delivery education in orientation by the Dietary Manager. 3. The Dietary Manager developed a Meal Delivery QI Monitoring tool on 12/16/14 to assure that no more than 14 hours between the dinner meal and breakfast has occurred. The Dietary Manager and Kitchen supervisor will monitor breakfast and dinner meal delivery to include meal delivery to resident #66 utilizing the Meal Delivery QI tool daily x 4 weeks, then weekly x 4 weeks then monthly x 1 month to assure that no more than 14 hours have occurred between dinner and breakfast. This audit will include weekends. Snacks will be provided to residents by the Dietary Manager or Kitchen Supervisor for any identified areas of concern. The Administrator will initial and review the Meal Delivery QI tool weekly x 8 weeks then monthly x 1 month for completion and trending. 4. The Dietary Manager will present the results of the Meal Delivery QI monitoring to the Executive Quality Assurance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 368	Continued From page 8	F 368	Committee monthly x 3 months to identify trends and the need for continued monitoring.	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 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 This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to ensure staff properly washed hands after coughing into hands while feeding a resident for 1 of 7 residents (Resident #66) being fed in the dining room. The finding included: On 12/01/14 at 11:40 AM an observation in the dining room revealed various staff members feeding residents. At 11:49 AM the Activities Director was observed to cough into her left hand while feeding Resident #66. At 11:51 AM she was observed to use her left hand to grasp the resident's uncovered tea cup around the top with her fingers and hold the straw between her fingers. She again coughed into her left and then at 11:57 AM she offered the resident a cup of water using the fingers of her left hand placed around the upper rim of the cup. Her fingers were also used to hold the straw steady.	F 371	The Activities Director received an in-service on hand washing after coughing while feeding a resident on 12/1/14 by the Staff Facilitator. A 100% nursing staff in-service and any department manager who assist with feeding was initiated on 12/1/14 by the Staff Facilitator on hand washing practices after coughing while feeding a resident. The nursing department is solely responsible for feeding meals. All newly hired nursing staff will receive the education on hand washing practices after coughing while feeding a resident in orientation by the staff facilitator. A monitoring tool was developed by the DON on 12/9/14 for monitoring meals and	12/31/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 9 On 12/4/14 at 10:09 AM the Activities Director was interviewed. She stated she should cough into her arm and not into her hand. She added if she did cough into her hand she should go and wash her hands, not continue to feed the resident.	F 371	staff hand washing after coughing during the meal. Breakfast, lunch meals and dinner meals will be monitored by the Staff Facilitator or charge nurses daily x 1 week, then 3 times a week x 3 weeks, then weekly x 4 weeks, then monthly x 1 month utilizing a meal monitoring QI audit tool. This audit will include weekends. The Staff Facilitator or charge nurse will immediately address and re-educate the staff member for any identified areas of concerns. The DON will initial and review the meal monitoring QI audit tool weekly x 8 weeks, then monthly x 1 month for completion and trends. The DON will present the results of the Meal Monitoring QI audit tool to the Executive Quality Assurance Committee x 3 months for trends and the need for continued monitoring.	
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 425		12/31/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 425	Continued From page 10 The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, the facility failed to reorder medications for 2 (Resident # 81 and Resident #66) of 6 residents reviewed for receiving medications. The findings included: 1. Resident #81 was admitted to the facility on 11/18/2014, with diagnoses to include anxiety. An interview with Resident #81 on 12/2/2014 at 8:30AM was conducted. The Resident stated she had not received her Xanax, an anti-anxiety medicine, over the weekend and the nurses had told her they were out of the medicine. She stated she felt shaky inside and her hands were shaking. She stated her medicine was restarted this morning. A review of Resident #81's medical record revealed the order for Xanax was dated 11/18/2014, and was prescribed as Xanax 0.5 milligram (mg), 1 tablet by mouth, three times and a day. A request for continuance of therapy prescription was dated 11/30/2014 and was sent to the Physician's office by fax. The form was the sent to the pharmacy by the physician's office on 12/1/2014. The medical administration record (MAR), documented the resident did not receive 3 doses of Xanax on 11/30/2014 and 12/1/2014. An interview was conducted with Nurse #1 on 12/3/2014. Nurse #1 stated she had given the	F 425	1. The medication for Resident #81 was ordered on 12/1/14 by the Medication Nurse. Resident #81 was administered the medication at the ordered time beginning on 12/2/14. The MD notified on 12/3/14 by the Director of Nursing. A medication error report was completed by the Director of Nursing on 12/3/14. The MD was notified on 12/18/14 of the Xalatan eye drops for Resident #66 by the Director of Nursing for the omission of the Xalatan eye drops. 2. A 100% audit of all medications availability of medications comparing to the MARs for all residents to include resident #81 and resident #66 medications including controlled substances and eye drop medications daily for adequate supply beginning 12/10/14 for 1 week, then weekly x 4 weeks, then biweekly x 2 weeks, then monthly x 1 month. The Staff Facilitator will immediately address all identified areas of concern by contacting pharmacy, back up pharmacy or the MD. The DON will review the Medication Cart audit weekly x 8 weeks then monthly x 1 month for completion and trending.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 425	Continued From page 11 resident her Xanax on 12/2/2014. She stated the medicine was ordered on 12/1/2014, and it was received into the facility on 12/2/2014. She stated it was the nurse who passed the medicines responsibility to order the medicine, and she did not know why the nurse who was on duty the week before did not do that. On 12/3/2014 at 4:35 PM, an interview was conducted with the Charge Nurse, who stated it was the responsibility of the floor nurse to reorder medicines. She stated if the nurse on Friday, 11/28/2014, saw that the resident would not have enough medicine to go through the weekend, she should have ordered the medicine at that time. If a medicine was ordered one day, it would be available the next day. She stated that she was made aware that Resident #81 did not receive her medicine on 12/1/2014 when she came to work. She stated that it was her expectation that the nurse who worked on 11/28/2014 would have ordered the medicine and it was not done. An interview was conducted with the Administrator on 12/4/2014 at 1:25PM. The Administrator stated that it was her expectation that residents medicines would be ordered in a timely manner, so they did not run out. The Administrator stated that it was the floor nurse's responsibility to order the medicine, but that any nurse could reorder the medicines. (2) On 12/04/14, a review of Resident #66's Medication Administration Record (MAR) revealed an order for Xalatan 0.005% ophthalmic solution that read" 1 drop (gtt) to each eye every night at bedtime for Glaucoma. "The review of the MAR revealed the eye drops were not	F 425	3. 100% of licensed staff and medication aides received in-service re-education on the procedure for re-ordering medications to include controlled substances and eye drop medications in a timely manner on 12/5/14. All newly hired licensed staff and medication aides will receive the training of re-ordering medications in orientation by the Staff Facilitator. 4. The Staff Facilitator will present the results of the Medication Cart audits to the Executive Quality Assurance Committee monthly x 3 months for trends and the need to continue monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 425	Continued From page 12 administered on November 29th and 30th, 2014. The review of the MAR revealed the reason for not administering the medication was because the facility was out of Xalatan during that time. A Review of the facility's "Pharmaceutical Medical Group Policy and Procedure Manual" revealed that the facility was responsible for re-ordering resident medications with the facility's contracted pharmacy, the facility was to contact the pharmacy via fax or phone and back-up pharmacies' had been designated for emergency medications and medications that the pharmacy could not provide in a timely manner. On 12/04/14 at10:40 am, an interview with Nurse #2 indicated that the facility expected, each medication cart nurse on all shifts to determine if resident medications were getting low. If resident medications were getting low then the nurse was to pull the sticky tab from the box or bottle, put it on a facility re-order form and fax it to the pharmacy. If the re-order form is submitted during the day the facility usually receives the medication between 2 to 3 am of the next day. If the contracted pharmacy is not able to fill the medication order, then the pharmacist would notify the facility and also call one of the two back-up pharmacies to fill the medication order. On 12/04/14 at 11:00 am, an interview was conducted via phone with the facility's Consultant Pharmacist & Regional Clinical Manager. The pharmacist stated "two back-up pharmacies are designated for the facility." The pharmacist indicated that facility procedure for re-ordering medications during the day would include the facility calling or faxing a re-order form to the pharmacy, the order would be filled and the medication would be delivered that evening between 2 to 3 am. The pharmacist revealed that if the pharmacy did not have a medication or a	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	HWY 305 NORTH JACKSON, NC 27845

(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 425	Continued From page 13	F 425		

medication is needed right away or if it is after hours then the pharmacist calls the designated back-up pharmacy to fill the medication order. The pharmacist notifies the facility via phone and the facility may pick-up the medication needed from the back-up pharmacy. The pharmacist indicated that the typical time it takes to refill a medication is usually by the evening that the order is placed and no more than 24hours. The pharmacist stated, "The facility is responsible for making sure medications are checked ahead of time and do not run out."

On 12/04/14 at 12:35 pm an interview with the Administrator indicated that medication cart nurses on each shift were to make sure that when a resident had only a few medication doses left, a pharmacy re-order would be placed to renew the residents medications. Medications should never run out. The pharmaceutical company that the facility has a contract with designated two back-up pharmacies for medication refills as needed.

On 12/04/14 at 2:40 pm, an interview with the charge nurse indicated that the facility expected each medication cart nurse on all shifts to determine if resident medications are getting low. If resident medications are getting low then the nurse is to pull the sticky tab from the box or bottle and put it on a facility re-order form and fax it to the pharmacy. The charge nurse indicated that the residents' individually labeled medication boxes come with a red tag in the bottom of the box that reads, "Low, re-order" when there are 3 doses left in a resident's medication box. The charge nurse indicated that eye drop solutions should be viewed each time they are administered to determine if the solution was low. The nurse is expected to pull re-order stickers off of the pharmacy labeled box or bottle, place it on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345313	A. BUILDING _____ B. WING _____	C 12/04/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTHAMPTON NURSING AND REHABILITATION CENTER	**HWY 305 NORTH JACKSON, NC 27845**

(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 425	Continued From page 14 a re-order form and fax it to the pharmacy. The pharmacy would then fill the order and deliver the medication the same evening between 2-3 a.m. The charge nurse stated, "There is really no reason for a medication to run out if the system is followed." The charge nurse revealed that a written communication clipboard placed at the nurses' desk was primarily used on evening shifts to notify the 7 am charge nurse that a written prescription was needed for a medication. The charge nurse reviews the board each morning and calls the doctor's office for a written prescription.	F 425		