STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	12/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	600 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES 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. 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. 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. The facility must furnish a written description of legal rights which includes:	F 156	This corrective action plan will serve as Penick Village's allegation of compliance with the requirements of 42 CFR, Part 483, Subpart B for long-term care facilities as of January 7, 2012. Administrator F156 A posting of names, addresses and telephone numbers to pertinent State client advocacy groups was posted on 12/15/11 as soon as it was brought to the facility's attention. An updated posting with names, addresses and telephone numbers to pertinent State client advocacy groups was posted on 1/6/12. Social Worker to review postings monthly basis for the next three months and quarterly for the next nine months for current and accurate information and update as necessary. Any updates will be reviewed with Residents and Families. Results to be reported to Quality Assurance Committee on a quarterly basis over the next 12 months.	12/15/11 1/6/12 1/6/12

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

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

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F 156	Continued From page 1 A description of the manner of protecting personal funds, under paragraph (c) of this section; 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. 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. 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	F 156		

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F 156	Continued From page 2 includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. 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. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews, the facility failed to maintain current state agency contact information. The findings include: On 12/15/11 at 8:45 am, Resident # 55 was interviewed about her Resident Council participation. She stated that she was admitted to the facility during March, 2011 and that she regularly attended their meetings and was an elected officer. She shared that she wasn't sure if she recalled discussion about the state contact information and wasn't sure where it was located. On 12/15/11 at 9:20 am, the Administrative Staff # 5 was interviewed. She stated that as a staff member, she assisted the residents with conducting their monthly meetings. She relayed	F 156		

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F 156	Continued From page 3 that during the meetings, she would discuss with residents important information about resident rights and advocacy contact information, including contacting the state agency. She mentioned that the information was posted in the hallways, near the nurse's stations and outside of her office door. On 12/15/11 at 9:25 am, the state agency contact information was reviewed. It revealed that their posting contained references to the state agency as The Division of Facility Services and it contained phone numbers and addresses to the nursing home licensure and certification branch, as well as the complaint department that were used prior to July, 2007. On 12/15/11 at 9:35 am, the Administrative Staff #6 was alerted to the state posting information. She immediately took down the sign on the bulletin board containing contact information for the state agency and stated that she would change and update the information.	F 156		
F 286 SS=C	483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure that MDS (Minimum Data Set) assessments were readily accessible for 15 (Residents # 62, #52, #12, #6, #25, #7, #37, #34, #3, #32, #26, #50, #64, #2, #44) of 15 sampled	F 286	F286 Resident #62, #52, #12, #6, #25, #7, #37, #34, #3, #32, #26, #50, #64, #2, & #44 current MDS's and CAA were printed and put on resident chart. All residents have potential to be affected by this practice. All current MDS's are being printed and put on the resident charts.	1/12/12 1/12/12

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F 286	Continued From page 4 residents. The findings include: 1. Resident #62 was admitted to the facility on 08/15/11. Review of the resident's chart revealed an admission MDS assessment dated 08/22/11 and a quarterly MDS assessment dated 10/12/11. These assessments contained pages 1-4 and 29-33 of the assessments. On 12/14/11 at 10:55 AM, Administrative staff #1 was interviewed. She stated that she was told to print pages 1-4 and 29-33 and to keep them in the chart (current assessment) and in the file cabinet. She further stated that if you want to see all sections of the MDS assessment, you have to use the computer in her office. Administrative staff #1 further stated that the 2 MDS Nurses were the only staff members who have access to the computer. She stated that MDS assessments were not loaded in the computers at the nurse's stations. 2. Resident #52 was admitted to the facility on 12/06/10. Review of the resident's records revealed a quarterly MDS assessment dated 11/02/11. There were 2 quarterly MDS assessments found in the file cabinet dated 08/09/11 and 05/30/11. These assessments contained pages 1-4 and 29-33 of the assessments. On 12/14/11 at 10:55 AM, Administrative staff #1 was interviewed. She stated that she was told to print pages 1-4 and 29-33 and to keep them in the chart (current assessment) and in the file cabinet. She further stated that if you want to see all sections of the MDS assessment, you have to	F 286	All future MDS's and CAA's will be printed until new software system AOD is implement. AOD software will have MDS's as part of electronic medical record. Medical record consultant to review charts monthly for the next three months and quarterly for the next nine months for MDS presence on resident charts and to report results to Quality Assurance Committee at quarterly meeting for the next 12 months.	1/12/12 1/12/12

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F 286	Continued From page 5 use the computer in her office. Administrative staff #1 further stated that the 2 MDS Nurses were the only staff members who have access to the computer. She stated that MDS assessments were not loaded in the computers at the nurse's stations. 3. Resident #12 was admitted to the facility on 12/18/08. Review of the resident's records revealed an annual MDS assessment dated 10/11/11. In the file cabinet, there were 2 quarterly MDS assessments dated 07/18/11 and 04/26/11 found. These assessments contained pages 1-4 and 29-33 of the assessments. The CAAs (Care Area Assessments) were also not found in the resident's records. On 12/14/11 at 10:55 AM, Administrative staff #1 was interviewed. She stated that she was told to print pages 1-4 and 29-33 and to keep them in the chart (current assessment) and in the file cabinet. She further stated that if you want to see all sections of the MDS assessment including the CAAs, you have to use the computer in her office. Administrative staff #1 further stated that the 2 MDS Nurses were the only staff members who have access to the computer. She stated that MDS assessments were not loaded in the computers at the nurse's stations. 4. Resident #6 was admitted to the facility on 7/25/11. Review of the resident's records revealed an admission Minimum Data Set (MDS) assessment dated 08/01/11. In his chart, there were 1 significant change MDS assessment dated 08/17/11 and 1 quarterly MDS assessment	F 286		

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F 286	Continued From page 6 dated 9/28/11 found. These assessments contained pages 1-4 and 29-33 of the assessments. The CAAs (Care Area Assessments) were also not found in the resident's records. On 12/14/11 at 10:55 AM, Administrative staff #1 was interviewed. She stated that she was told to print pages 1-4 and 29-33 and to keep them in the chart (current assessment) and in the file cabinet. She further stated that if you want to see all sections of the MDS assessment including the CAAs, you have to use the computer in her office. Administrative staff #1 further stated that the 2 MDS Nurses were the only staff members who have access to the computer. She stated that MDS assessments were not loaded in the computers at the nurse's stations. 5. Resident # 25 was admitted to the facility on 7/26/11. Review of the resident's records revealed an admission Minimum Data Set (MDS) assessment dated 08/01/11. In her chart, there were 1 significant change MDS assessment dated 08/17/11 and 1 quarterly MDS assessment dated 09/28/11 found. These assessments contained pages 1-4 and 29-33 of the assessments. The CAA (Care Area Assessments) were also not found in the resident's records. On 12/14/11 at 10:55 AM, Administrative staff #1 was interviewed. She stated that she was told to print pages 1-4 and 29-33 and to keep them in the chart (current assessment) and in the file cabinet. She further stated that if you want to see all sections of the MDS assessment including the CAAs, you have to use the computer in her office.	F 286		

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F 286	Continued From page 7 Administrative staff #1 further stated that the 2 MDS Nurses were the only staff members who have access to the computer. She stated that MDS assessments were not loaded in the computers at the nurse's stations. 6. Resident #7 was admitted to the facility on 3/30/11. Review of the resident's records revealed an admission Minimum Data Set (MDS) assessment dated 04/12/11 and 2 quarterly MDS assessments dated 07/06/11 and 09/27/11 found. These assessments contained pages 1-4 and 29-33 of the assessments. The CAA (Care Area Assessments) were also not found in the resident's records. On 12/14/11 at 10:55 AM, Administrative staff #1 was interviewed. She stated that she was told to print pages 1-4 and 29-33 and to keep them in the chart (current assessment) and in the file cabinet. She further stated that if you want to see all sections of the MDS assessment including the CAAs, you have to use the computer in her office. Administrative staff #1 further stated that the 2 MDS Nurses were the only staff members who have access to the computer. She stated that MDS assessments were not loaded in the computers at the nurse's stations. 7. Resident # 37 was admitted to the facility on 06/29/11. Review of the resident's records revealed an admission Minimum Data Set (MDS) assessment dated 07/06/11 and one quarterly MDS dated 10/03/11 found. These assessments contained pages 1-4 and 29-33 of the assessments. The CAA (Care Area Assessments) were also not found in the	F 286		

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F 286	Continued From page 8 resident's records. On 12/14/11 at 10:55 AM, Administrative staff #1 was interviewed. She stated that she was told to print pages 1-4 and 29-33 and to keep them in the chart (current assessment) and in the file cabinet. She further stated that if you want to see all sections of the MDS assessment including the CAAs, you have to use the computer in her office. Administrative staff #1 further stated that the 2 MDS Nurses were the only staff members who have access to the computer. She stated that MDS assessments were not loaded in the computers at the nurse's stations. 8. Resident # 34 was admitted to the facility on 07/25/11. Review of the resident's records revealed an admission Minimum Data Set (MDS) dated 08/01/11 and 1 quarterly MDS dated 10/26/11 found. These assessments contained pages 1-4 and 29-33 of the assessments. The CAA (Care Area Assessments) were also not found in the resident's records. On 12/14/11 at 10:55 AM, Administrative staff #1 was interviewed. She stated that she was told to print pages 1-4 and 29-33 and to keep them in the chart (current assessment) and in the file cabinet. She further stated that if you want to see all sections of the MDS assessment including the CAAs, you have to use the computer in her office. Administrative staff #1 further stated that the 2 MDS Nurses were the only staff members who have access to the computer. She stated that MDS assessments were not loaded in the computers at the nurse's stations. 9. Resident #3 was admitted to the facility on 8/16/11. Review of the resident's records	F 286		

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F 286	Continued From page 9 revealed a quarterly MDS assessment dated 9/9/11 and a quarterly assessment dated 12/1/11. There was an admission MDS assessments found in the file cabinet dated 8/23/11. These assessments contained pages 1-4 and 29-33 of the assessments. The Care Area Assessments (CAA) were not found in the resident's records. On 12/14/11 at 10:55 AM, Administrative staff #1 was interviewed. She stated that she was told to print pages 1-4 and 29-33 and to keep them in the chart (current assessment) and in the file cabinet. She further stated that if you want to see all sections of the MDS assessment including the CAAs, you have to use the computer in her office. Administrative staff #1 further stated that the 2 MDS Nurses were the only staff members who have access to the computer. She stated that MDS assessments were not loaded in the computers at the nurse's stations. 10. Resident #32 was admitted to the facility on 8/16/08 and readmitted on 9/28/11. Review of the resident's records revealed an annual MDS assessment dated 9/6/11 amd a quarterly MDS assessment dated 11/29/11. There were 3 quarterly MDS assessments found in the file cabinet dated 1/14/11, 3/31/11 and 6/27/11. There was also an annual MDS dated 10/15/10. These assessments contained pages 1-4 and 29-33 of the assessments. The Care Area Assessments (CAA) were not found in the resident's records. On 12/14/11 at 10:55 AM, Administrative staff #1 was interviewed. She stated that she was told to print pages 1-4 and 29-33 and to keep them in the chart (current assessment) and in the file	F 286		

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F 286	Continued From page 10 cabinet. She further stated that if you want to see all sections of the MDS assessment including the CAAs, you have to use the computer in her office. Administrative staff #1 further stated that the 2 MDS Nurses were the only staff members who have access to the computer. She stated that MDS assessments were not loaded in the computers at the nurse's stations. 11. Resident # 26 was admitted to the facility 11/15/2011. A review of the resident's chart revealed an Admission Minimum Data Set (MDS) dated 11/26/11. The assessment contained pages 1-4 and pages 29-33. The Care Area Assessments (CAA) were not found in the resident's records. On 12/14/2011 at 10:55 AM., Administrative staff #1 was interviewed. She stated that she was told to print pages 1-4 and pages 29-33 and to keep them in the chart (current assessment) and in the file cabinet. She further stated that if you wanted to see all the sections of the MDS assessment, you had to use the computer in her office. Administrative staff #1 stated that the two MDS nurses were the only staff members who had access to the computer. She stated that MDS assessments were not loaded in the computers at the nurse's stations. 12. Resident #50 was admitted to the facility 9/30/2010. A review of the resident's chart and medical record revealed a Quarterly MDS dated 5/19/11, an annual MDS dated 8/8/11 and a quarterly MDS dated 11/7/11. The assessments contained pages 1-4 and pages 29-33. On 12/14/2011 at 10:55 AM., Administrative staff	F 286		

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F 286	Continued From page 11 #1 was interviewed. She stated that she was told to print pages 1-4 and pages 29-33 and to keep them in the chart (current assessment) and in the file cabinet. She further stated that if you wanted to see all the sections of the MDS assessment, you had to use the computer in her office. Administrative staff #1 stated that the two MDS nurses were the only staff members who had access to the computer. She stated that MDS assessments were not loaded in the computers at the nurse's stations. 13. Resident #64 was admitted to the facility on 10/13/2011. A review of the resident's chart revealed an Admission MDS dated 10/20/11. The assessment contained pages 1-4 and pages 29-33. The Care Area Assessments (CAA) were not found in the resident's record. On 12/14/2011 at 10:55 AM., Administrative staff #1 was interviewed. She stated that she was told to print pages 1-4 and pages 29-33 and to keep them in the chart (current assessment) and in the file cabinet. She further stated that if you wanted to see all the sections of the MDS assessment, you had to use the computer in her office. Administrative staff #1 stated that the two MDS nurses were the only staff members who had access to the computer. She stated that MDS assessments were not loaded in the computers at the nurse's stations. 14. Resident # 2 was admitted to the facility on 6/14/2011. A review of the resident's chart revealed an Admission MDS dated 6/21/2011 and a Quarterly MDS dated 9/9/11. The assessments contained pages 1-4 and pages 29-33. The Care Area Assessments (CAA) were not found in the	F 286		

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F 286	Continued From page 12 resident's record. On 12/14/2011 at 10:55 AM., Administrative staff #1 was interviewed. She stated that she was told to print pages 1-4 and pages 29-33 and to keep them in the chart (current assessment) and in the file cabinet. She further stated that if you wanted to see all the sections of the MDS assessment, you had to use the computer in her office. Administrative staff #1 stated that the two MDS nurses were the only staff members who had access to the computer. She stated that MDS assessments were not loaded in the computers at the nurse's stations. 15. Resident # 44 was admitted to the facility 5/7/2010. A review of the resident's chart and medical records revealed an annual Minimum Data Set (MDS) dated 2/17/11, a Quarterly assessment dated 5/10/11, a Quarterly assessment dated 8/1/11 and a Quarterly assessment dated 10/25/11. The assessments contained pages 1-4 and pages 29-33. The Care Area Assessments (CAA) were not found in the resident's records. On 12/14/2011 at 10:55 AM., Administrative staff #1 was interviewed. She stated that she was told to print pages 1-4 and pages 29-33 and to keep them in the chart (current assessment) and in the file cabinet. She further stated that if you wanted to see all the sections of the MDS assessment, you had to use the computer in her office. Administrative staff #1 stated that the two MDS nurses were the only staff members who had access to the computer. She stated that MDS assessments were not loaded in the computers at the nurse's stations	F 286		

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F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to monitor the TSH (Thyroid Stimulating Hormone) level for 1 (Resident #62) of 10 sampled residents. The findings include: Resident # 62 was admitted to the facility from the hospital on 08/15/11 with multiple diagnoses	F 329	F329 Resident #62 TSH level was obtained and was in normal limits. Pharmacist checked all resident physician's orders to determine who was taking thyroid hormone preparations. X number of residents were taking thyroid hormone preparations and all had timely TSH results in the chart. TSH level will be recommended by the consultant pharmacist at the time of the first drug regimen review following admission, if not obtained within the past 12 months per accepted clinical standards and within 90 days of initiation of therapy and every 12 months unless otherwise ordered by the physician. Consultant pharmacist will review findings related to thyroid hormone preparations and TSH monitoring monthly for the next three months and quarterly thereafter for the next six months with the Director of Nursing. Results to be shared at quarterly QA meetings for next 12 months.	12/15/11 1/6/12 1/6/12 1/6/12

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F 329	Continued From page 14 including Hypothyroidism. Resident #62 was living in an independent living apartment prior to hospitalization. The quarterly MDS assessment dated 10/12/11 indicated that Resident #62 had memory and decision making problems. Review of the physician's orders for December, 2011 revealed an order for Synthroid 75 mcg (microgram) by mouth daily for Hypothyroidism and to check TSH level every 6 months (February/August). The facility's policy on " Recommended Laboratory Determination " (undated) was reviewed. The policy read in part " Thyroid panel including T-4 and TSH, 90 days after the start of therapy and every 12 months ". Review of the resident's records and the hospital records revealed no report for TSH level. Review of Resident #62's weights revealed that he had lost weights from admission. He weighed 220 lbs (pounds) on 08/22/11, 173 lbs on 09/05/11, 169 lbs on 10/07/11, 166 lbs on 11/07/11 and 165 lbs on 12/07/11. On 12/14/11 at 3:34 PM, administrative nurse #4 was interviewed. Administrative Nurse #1 stated that the facility had no standing orders or policy for labs (laboratory). He further stated that labs were drawn per doctor's order. He also stated that the TSH level for Resident #62 was not due until February, 2012 as ordered. When asked, he stated that he did not know when the resident had started taking Synthroid and when was the last time TSH was checked.	F 329		

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F 329	Continued From page 15 On 12/14/11 at 5:25 PM, the pharmacist was interviewed. He stated that the facility's policy in monitoring the TSH level for residents on Synthroid was every 12 months. He further stated that the doctor had ordered to check the TSH every 6 months for Resident #62, so it was not due until February, 2012. When asked, he stated that he did not know as to when the resident had started taking the Synthroid and when the last time TSH was checked for Resident #62. He also stated that he checked and the hospital had no records of TSH level for Resident #62.	F 329		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to ensure a medication error rate less than 5% as evidenced by 4 errors out of 70 opportunities for error, resulting in an error rate of 5.7%, for 3 of 10 residents observed during medication pass (Residents #18, #1, and #70). The findings include: 1. Resident #18 was admitted to the facility on 01/05/11 with multiple diagnoses including CVA (cerebrovascular accident). Review of the physician's orders for December,	F 332	F332 Resident #18 EC ASA 81 mg was changed to ASA 81 mg. This medication may be crushed. Consultant pharmacist reviewed all residents to determine who was on aspirin therapy. The XX number of residents who are receiving aspirin therapy were reviewed to ensure the correct dosage form (crushable versus non-crushable) was being used. Director of Nursing and Consultant Pharmacist conducted in-services for LPN's and RN's regarding appropriate crushing of medications were completed.	12/14/11 1/6/12 1/5/12

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F 332	Continued From page 16 2011 revealed that Resident #18 had a doctor's order for " ASA (aspirin) 81 mgs EC (enteric coated) 1 tablet by mouth daily - do not crush, starting 01/05/11 for CVA. On 12/14/11 at 8:40 AM, Nurse # 1 was observed to prepare and to administer Resident #18's medications. Nurse #1 was observed to crush the resident's medication including ACASA and administered them with apple sauce. On 12/14/11 at 8:50 AM, Nurse #1 was interviewed. Nurse #1 acknowledged that she did not know that ACASA could not be crushed. 2. Resident #1 was admitted to the facility on 3/6/09 and had cumulative diagnoses that included chronic obstructive pulmonary disease (COPD). Review of the Prescribing Information for ADVAIR DISKUS from the manufacturer dated January 2011 and revised 09/11 revealed, in part, " Indications and Usage ", " Maintenance treatment of airflow obstruction and reducing exacerbations in patients with chronic obstructive pulmonary disease (COPD). " Under " Warnings and Precautions " it read, in part, " Localized infections: Candida albicans infection of the mouth and throat may occur. Monitor patients periodically for signs of adverse effects on the oral cavity. Advise patients to rinse the mouth following inhalation. " Under the heading " Instructions for Using ADVAIR DICKUS " it read, in part, " Rinse your mouth with water after breathing in the medicine. Spit the water out. Do not swallow. "	F 332	Pharmacy consultant and/or RN consultant to observe at least one med passes on each shift per month for the next three months and then one per shift per quarter for the next nine months. Results to be shared with Director of Nursing and at the quarterly 2012 Quality Assurance Meetings. "Rinse mouth after use" was added to MAR entry for ADVAIR DISCUS on Resident #1. Consultant pharmacist reviewed all physician orders to determine who was on steroid inhalers. There were no other residents utilizing inhaled steroid therapy. Director of Nursing and Consultant pharmacist conducted in-services on appropriate steroid inhaler use and mouth rinsing for LPN's and RN's. Director of Nursing observed medication pass for appropriate steroid inhaler use and mouth rinsing.	1/12/12 12/15/11 12/16/11 12/16/11 12/16/11

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F 332	Continued From page 17 Review of the physician's orders for December, 2011 revealed that Resident #1 had a doctor's order for " Advair 250-50 diskus inhale 1 puff orally every 12 hours " dated 3/6/09. The resident's diagnosis indicating this medication was COPD. On 12/15/11 at 8:28 AM, Nurse #2 was observed to prepare and to administer Resident #1's medications. When administering the Advair, Nurse #2 was observed to have the resident breathe out and then she placed the Advair 250-50 discus (prepared for inhalation) at the resident's mouth. The resident was instructed to breathe in and hold her breath, which she did. Nurse #2 then provided water to the resident to drink. Resident #1 was not instructed to rinse her mouth and spit out the water. Resident #1 then swallowed the water. On 12/15/11 at 9:15 AM, Nurse #2 was interviewed. Nurse #2 acknowledged that she did not know that after administration of Advair, resident's needed to be instructed to rinse out their mouth. The Product insert in the box containing the Advair Diskus was then reviewed Nurse #2 and she read the section regarding advising patients to rinse their mouth following administration. Nurse #2 then stated she would do this in future. 3. Resident #1 was admitted to the facility on 3/6/09 and had cumulative diagnoses that included chronic obstructive pulmonary disease (COPD). Review of the Prescribing Information for Atrovent	F 332	Pharmacy consultant and/or RN consultant to observe at least one med passes on each shift per month for the next three months and then one per shift per quarter for the next nine months. Also pharmacy consultant to review on monthly pharmacy review to assure accuracy of medication administration instructions. Results to be shared with Director of Nursing and at the quarterly 2012 Quality Assurance Meetings. Order for Atrovent Nasal Spray for Resident #1 was clarified by nurse with physician to "one spray per nostril twice daily." Consultant pharmacist reviewed all physician orders to assure that all orders were clear and this included nasal spray instructions. Director of Nursing and Consultant Pharmacist conduced in-services on appropriate clarification of dosage instructions nasal sprays for LPN's and RN's was held.	12/16/11 12/15/11 1/6/12 12/16/11

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F 332	Continued From page 18 Nasal Spray from the manufacturer, revised 7/11, revealed the indication for the Atrovent is " rhinitis " (runny nose). Review of the physician's orders for December, 2011 revealed that Resident #1 had a doctor's order for " atrovent 0.06% 2 sprays in nose twice a day ". There was no indication for the medication noted with the order. The order did not specify if the spray was to be administered as one spray per nostril for a total of two sprays in the nose, or if it was intended to be two sprays in each nostril. On 12/15/11 at 8:28 AM, Nurse #2 was observed to prepare and to administer Resident #1's medications. When administering the Atrovent Nasal Spray 0.06%, Nurse #2 was observed to give 2 sprays in each nostril. Interview with Administrative Staff #6 on 12/15/11 at 10:30 AM revealed it was her expectation that the order for Atrovent 2 sprays in the nose would be clarified, to specify how many sprays should be given in each nostril. Telephone interview with Administrative Nurse #4 on 12/23/11 at 1:20 PM revealed the resident had allergy symptoms and that the Atrovent nasal spray was originally ordered on 3/6/09. 4. Resident #70 was admitted to the facility on 11/30/11 with multiple diagnoses including coronary artery disease (CAD) and atrial fibrillation. Review of the Physician's Telephone Orders dated 12/12/11, revealed that Resident #70 had a	F 332	Pharmacy consultant and/or RN consultant to observe at least one med passes on each shift per month for the next three months and then one per shift per quarter for the next nine months. Results to be shared with Director of Nursing and at the quarterly 2012 Quality Assurance Meetings. All residents are potentially affected by this practice. Director of Nursing and Pharmacy Consultant held in-services for the LPN's and RN's on the Five Rights of Medication Administration. Pharmacy consultant and/or RN consultant to observe at least one med passes on each shift per month for the next three months and then one per shift per quarter for the next nine months. Results to be shared with Director of Nursing and at the quarterly 2012 Quality Assurance Meetings.	1/12/12 12/16/11 1/5/12 1/5/12

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F 332	Continued From page 19 doctor's order for " Start EC (Enteric Coated) ASA acetylsalicylic acid 81 mg (milligrams) take 2 tabs (tablets) po qd (by mouth every day). " Review of the medical record revealed the indication for this medication was prophylaxis of against thromboembolic events. On 12/15/11 at 8:38 AM, Nurse #2 was observed to prepare and to administer Resident #70's medications. Nurse #1 was observed to dispense ASA into the medication cup. While she did this she said " enteric coated. " The bottle the nurse dispensed the medication from was observed and it read " 81 mg chewable. " When Nurse #2 was shown that the bottle read " chewable " and was asked if a chewable medication could be enteric coated, she stated that maybe there was another bottle of ASA in the medication cart that was enteric coated. As she said this Nurse #2 looked in the medication cart and found a different bottle of ASA that was observed to read " 81 mg enteric coated " . Nurse #2 then removed the chewable ASA and dispensed the enteric coated ASA into the medication cup.	F 332		
F 371 SS=E	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	F 371	F371 All items that were not dated were discarded. All items in coolers and freezers were inspected for labels and expiration dates. Any item that was questioned was discarded. To ensure that all open/stored items will be labeled and dated a Standard Guideline was revised that all items opened from its original container will be covered, labeled and dated with a used by date. All items not used by the used by date will be discarded.	12/12/11 12/14/11

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F 371	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain sanitary conditions in the kitchen by not ensuring opened and sealed food items were dated and labeled; by not ensuring four (4) cases of food items were stored off the floor in the walk-in freezer, by not discarding an expired quart of whole milk; by not ensuring a scoop was secured handle up in the flour bin; by not using utensils to pick up prepared food when they placed food on residents' plates and by staff not removing contaminated gloves, washing hands and applying new gloves prior to resumption of food tray preparation. Findings included: 1. During the tour of the kitchen with Administrative staff #2 on 12/12/2011 at 11:00 AM., observations of the refrigerator revealed one package of opened swiss cheese unlabeled and undated, one package of cheddar cheese slices unlabeled and undated, ½ of a red pepper undated, eight (8) to ten (10) slices of cooked bacon wrapped in plastic undated, a small bowl with a slice of tomato, cucumber and one slice of onion wrapped in plastic undated, two plates with a scoop of chicken salad on each plate unlabeled and undated, a metal pan ½ full of chocolate cream dessert unlabeled and undated, ½ bag of opened lettuce undated, one slice of ham wrapped in plastic unlabeled and undated, one container of frozen egg substitute opened and undated; in the walk-in freezer, observations revealed one (1) bowl of strawberry ice cream unlabeled and undated and one glass of orange beverage unlabeled and undated. Administrative staff #2 stated all of the food items should have	F 371	Director of Dining Services and Certified Dietary Manager conducted an in-service was conducted on December 14, 2011 with all North dining service staff to review label and dating standards. The Certified Dietary Manager or designee will inspect items in coolers and freezers at least weekly to assure adherence to this policy. This will be an ongoing procedure to assure compliance. Results to be shared with the Dining Service Director and at the Quality Assurance Meeting quarterly meeting for the next 12 months. All four cases removed from floor and shelved. All coolers and freezers were inspected by Director of Dining Services for any items being stored on floor. Director of Dining Services and Certified Dietary Manager conducted in-services for all North dining on proper storage of items to include all items must be at least eight inches off of the floor.	12/14/11 12/14/11 12/12/11 12/12/11 1/9/12

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F 371	Continued From page 21 been labeled and dated. He further stated the glass of orange beverage should not have been in the freezer and must have been placed there by a worker. 2. During a tour of the freezer 12/12/2011 at 11:00 AM., four cases of opened supplement health shakes were noted on the floor of the freezer. Administrative staff #2 stated the boxes should have been on the shelf and not on the floor. 3. During a tour of the kitchen 12/12/2011 at 11:00 AM., observation of the refrigerator revealed one quart of whole milk with an expiration date of 12/3/11. Administrative staff #2 stated the expired milk should have been discarded. 4. On 12/14/11 at 4:55 PM., kitchen staff was observed preparing resident food trays for the evening meal. At 4:55 PM., staff #1 placed vegetable sticks on a plate with her gloved hand. She obtained another plate and began to put her gloved hands in the container holding the vegetable sticks to place them on the plate. When asked if that was her routine for plating the vegetable sticks, she stated she usually used tongs when she plated the vegetable sticks but had been unable to find any to use. At 5:00 PM, staff #1 plated brussel sprouts on a plate, then used her gloved hand, picked up one brussel sprout and moved it to another area on the plate. Throughout the tray line serving, wait staff #1 did not change her gloves and alternated between turning the pages of the menu and then plating the food.	F 371	The Certified Dietary Manager or designee will inspect items in coolers and freezers at least weekly to assure proper storage. This will an ongoing process. Results to be shared with the Dining Service Director and at the Quality Assurance Meeting quarterly meeting for the next 12 months. The quart of whole milk was discarded by Director of Dining Services. All items in coolers and freezers were inspected for expiration dates by Director of Dining Services. Any item that was questioned was discarded by Director of Dining Services. An in-service was conducted by the Director of Dining Services and Certified Dietary Manager on December 14, 2011 with all North dining service staff to review discarding of expired items. The Certified Dietary Manager or designee will inspect items in coolers and freezers at least weekly to assure there are no expired items. This will be an ongoing process. Any found	1/9/12 12/14/11 12/14/11 12/14/11 1/6/12

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F 371	Continued From page 22 On 12/14/11 at 5:10 PM, Administrative staff #1 stated the wait staff should use utensils at all times when they plated the food and not touch the food with gloved hands. He also stated if gloves become contaminated, staff should change gloves. 5. On 12/15/11 at 8:15 AM., there was an observation of a scoop in the flour bin with the handle of the scoop lying in the flour in the kitchen. Staff #2 stated the scoop was not supposed to be in the container. Administrative staff #2 also indicated the scoop should not be in the container or should be stored in the container with the handle not touching the flour.	F 371	are to be discarded. Results to be shared with the Dining Service Director and at the Quality Assurance Meeting quarterly meeting for the next 12 months. Director of Dining Service performed a one-on-one in-service with Staff #1 on the proper use of gloves, hand-washing, handling of food, and using appropriate serving utensils.	12/14/11
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review, and staff interview, the facility's pharmacist failed to report irregularity regarding the TSH level to the attending physician and/or DON (Director of Nursing) for 1 (Resident #62) of 10 sampled residents. The findings include:	F 428	Director of Dining Services and Certified Dietary Manager conducted an in-service with the North Dining team that on the proper use of gloves, hand-washing, handling of food, and using appropriate serving utensils. Penick Village North Dining will be a utensil use only operation. All prepared food will be served/handled with appropriate utensils. The Certified Dietary Manager or designee will observe at least six tray line meal service weekly for adherence of utensil use only for one month and three tray line meal services weekly for three months. Results to be reported to Director of Dining Service and Quality Assurance January and April 2012 meetings.	12/14/11 1/12/12

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F 428	Continued From page 23 Resident # 62 was admitted to the facility from the hospital on 08/15/11 with multiple diagnoses including Hypothyroidism. Resident #62 was living in an independent living apartment prior to hospitalization. The quarterly MDS assessment dated 10/12/11 indicated that Resident #62 had memory and decision making problems. Review of the physician's orders for December, 2011 revealed an order for Synthroid 75 mcg (microgram) by mouth daily for Hypothyroidism and to check TSH level every 6 months (February/August). The facility's policy on " Recommended Laboratory Determination " (undated) was reviewed. The policy read in part " Thyroid panel including T-4 and TSH, 90 days after the start of therapy and every 12 months ". Review of the resident's records and the hospital records revealed no report for TSH level. Review of Resident #62's weights revealed that he had lost weights from admission. He weighed 220 lbs (pounds) on 08/22/11, 173 lbs on 09/05/11, 169 lbs on 10/07/11, 166 lbs on 11/07/11 and 165 lbs on 12/07/11. The drug regimen reviews were reviewed. The records revealed that the pharmacist had reviewed the resident's records on 09/07/11, 10/03/11, 11/03/11 and 12/06/11. The notes did not address the need for TSH level for Resident #62.	F 428	Dining staff removed scoop from flour bin. Director of Dining Service and Certified Dietary Manager in-serviced all of North Dining Service team on proper use of scooping bulk items (flour, sugar, rice...) and handling and storage of scooping utensil. The Certified Dietary Manager or designee will observe at least three times a week for adherence of scooping utensil use and storage for three months and randomly thereafter. Results to be reported to Director of Dining Service and Quality Assurance meeting quarterly.	12/15/11 1/9/12 1/9/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING _____ B. WING _____	12/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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 428	Continued From page 24 On 12/14/11 at 3:34 PM, administrative nurse #4 was interviewed. Administrative Nurse #4 stated that the facility had no standing orders or policy for labs (laboratory). He further stated that labs were drawn per doctor's order. He also stated that the TSH level for Resident #62 was not due until February, 2012 as ordered. When asked, he stated that he did not know when the resident had started taking Synthroid and when was the last time TSH was checked. On 12/14/11 at 5:25 PM, the pharmacist was interviewed. He stated that the facility's policy in monitoring the TSH level for residents on Synthroid was every 12 months. He further stated that the doctor had ordered to check the TSH every 6 months for Resident #62, so it was not due until February, 2012. When asked, he stated that he did not know as to when the resident had started taking the Synthroid and when the last time TSH was checked for Resident #62. He also stated that he had checked and the hospital had no records of TSH level for Resident #62.	F 428	F428 Resident #62 TSH level was obtained and was in normal limits. Pharmacist checked all resident physician's orders to determine who was taking thyroid hormone preparations. X number of residents were taking thyroid hormone preparations and all had timely TSH results in the chart. TSH level will be recommended by the consultant pharmacist at the time of the first drug regimen review following admission, if not obtained within the past 12 months per accepted clinical standards and within 90 days of initiation of therapy and every 12 months unless otherwise ordered by the physician. Consultant pharmacist will review findings related to thyroid hormone preparations and TSH monitoring monthly for the next three months and quarterly thereafter for the next six months with the Director of Nursing. Results to be shared at quarterly QA meetings for next 12 months.	12/15/11 1/6/12 1/6/12 1/6/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345111	A. BUILDING 01 - MAIN BUILDING 01 B. WING	01/05/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENICK VILLAGE	500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387

(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=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 1/5/2012 the following means of egress Life Safety items were observed as noncompliant with the Special Locking arrangements for the facility, specific findings include: The required exit at nurse ' s station number one released with automatic fire alarm activation and door release mechanism / kill switch at the nurses station with a delay. This delay was for several seconds and could give the impression that this required exit door equipped with a special locking would not release with activation of the fire alarm system or the kill switch at the nurses station. NOTE: The door release mechanism at the door did not have such a delay when tested. CFR#: 42 CFR 483.70 (a)	K 038	This corrective action plan will serve as Penick Village's allegation of compliance with the requirements of 42 CFR, Part 483, and Subpart B for long-term care facilities as of January 5, 2011. Administrator K 038 Maintenance staff discovered a problem with the wiring to the Secure Care Exit door I.D. panel that did not allow the door to unlock when the fire alarm initiated or with the master kill switch. Maintenance staff repaired wiring. To assure that the wiring was repaired, the door was tested by activating the fire alarm and the master kill switch was tested also and both times the door released. All Secure Care doors were checked during fire alarm activation and all other doors were found to be operating correctly. All Secure Care doors will be checked when conducting monthly fire drills to assure the proper releasing mechanism works appropriately. This will be recorded on the monthly fire drill report. The master kill switch will be tested monthly and results documented. Any time repairs are made to the Secure Care Doors, the Secure Care Doors will be tested afterwards to assure they are in proper working order. Results of monthly tests will be reported to the Quality Assurance Committee over the next 12 months.	1/5/12 1/5/12 Ongoing Ongoing Ongoing Ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	1/13/12

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.