STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345245	A. BUILDING _____ B. WING _____	07/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENDER MEMORIAL HOSP SNF	507 FREMONT STREET BURGAW, NC 28425

(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 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to notify the attending physician of	F 157	CORRECTIVE ACTION ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE BY: Attending physician notified 8/7/2012 by the Clinical Coordinator of change in resident #1's status (seizures) on the following dates: 5/26/2012, 6/3/2012, and 6/4/2012. No new orders received. CORRECTIVE ACTION ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Review and revise current policy for patients having a change in condition on the Skilled Nursing Unit to include: notification of the physician, resident and the resident's legal representative or an interested family member when there is a significant change in the resident's physical, mental or psychological status. See attachment A - Change in Clinical Status for SNF Resident policy. 100% of current resident's medical records were audited on 8/6/2012to ensure no other residents were affected by the same deficient practice. See attachment C: Status Change Audit Tool MEASURES/SYSTEMIC CHANGES PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR:	8/7/2012 8/10/2012 8/6/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ruth A. Glaser | TITLE: President | (X6) DATE: 8-14-12

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.

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F 157	Continued From page 1 seizure activity for 1 of 3 sampled residents with seizure disorder (resident #1). Findings include: The facility's Nursing Policy and Procedure Manual, revised 3/12, read in part: "Policy - To provide documentation in the nurses' notes for acute episodes or unusual occurrences in the patient/resident chart. Procedure - item 2. The physician will be notified of the resident's clinical conditions and appropriate orders carried out per current policy and procedure. Item 4 - Examples of acute episodes and unusual occurrences may include, but are not limited to: symptoms, injuries, change in status." Resident #1 was admitted to the facility on 8/26/05 with multiple diagnoses including seizure disorder. Review of the resident's clinical record revealed current physician orders for the following seizure medications - Lorazepam 0.5mg (milligram) twice daily, Lorazepam 1mg IM (intramuscularly) every four hours if needed for seizure, Phenytoin suspension 50mg every morning and 100mg nightly at bedtime, and Keppra 500mg twice daily. Review of nursing progress notes dated 5/26/12 at 9AM revealed resident #1 with seizure activity evidenced by eye twitching, continuous rapid head movements, and uncontrolled upper body movement. Ativan 1mg IM was given per physician orders. The seizure lasted less than 10 minutes. There was no documentation that the physician was notified of the seizure activity. Review of nursing progress notes dated 6/3/12 at 9:15PM revealed the resident was found to be in the midst of seizure activity with movements of	F 157	All nursing staff will be educated on revised policy by 8/20/2012. See Attachment B - Education Plan PLANS TO MONITOR PERFORMANCE TO MAKE SURE SOLUTIONS ARE SUSTAINED: Skilled Nursing Facility will monitor a random sample of five medical records per week, starting 8/6/2012, for 1 month and monthly for 6 months to ensure that correction is achieved and sustained for the following: confirmation that all changes in patient's status are reported to the resident's physician, resident and the resident's legal representative or an interested family member. See attachment C: Status Change Audit Tool Changes in resident's status will be included in the SNF weekly QA review to begin 8/9/2012. See attachment D: Quality Assessment/Assurance Committee Form	8/20/2012 8/6/2012 8/9/2012

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F 157	Continued From page 2	F 157		

the arm, eyes, and head. The duration was less than 2 minutes. The notes read "gave schedule po (oral) dose of Ativan as it was due and patient had stopped seizing. No further seizures noted this shift." There was no documentation that the physician was notified of the seizure activity.

Review of nursing progress notes dated 6/4/12 at 1:00AM revealed the resident exhibited seizure activity with rapid head movements and eye twitching. Ativan 1mg was given IM and the seizure ceased. There was no documentation that the physician was notified of the seizure activity.

In an interview on 7/25/12 at 12:19PM, the Resource Nurse stated she called the physician when any resident had a change of condition. If she was not at the facility, the nurse on duty assessed the resident and notified the physician. She stated all physician notifications were documented in the nursing notes.

In an interview on 7/25/12 at 3:30PM, the Unit Manager stated the resident's nurse or the Resource Nurse would be responsible for notifying the physician of any acute changes and documenting the notification in the nursing notes. For seizure activity, she expected the staff to take care of the resident's needs first, and then contact the physician. She expected the staff to document any new orders or medications given on the medication administration record and in the nursing notes. She expected the staff to document all physician notifications in the nursing notes.

In a telephone interview on 7/27/12 at 2:32PM,

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F 157	Continued From page 3 the nurse on duty 6/4/12 (nurse #1) stated she called the physician for any acute change in condition. If there was no response, she paged the physician. She stated there was always a supervisor in the building and she also notified them. Changes were also reported to the next shift at shift change. The nurse stated resident #1 had a short seizure on 6/4/10, she gave Ativan per the standing order, and the seizure stopped. She stated the physician notification would have been documented in the nursing notes. In a telephone interview on 7/27/12 at 4:25PM, the nurse on duty 6/3/12 (nurse #2) stated for change of condition she notified the physician and initiated any new orders or sent the resident to the emergency department if ordered. She also notified the supervisor on duty. Nurse #2 stated all physician notifications were documented in the nursing notes. She didn't recall the details of resident #1's seizure on 6/3/12. The nurse stated "I think I called the physician but didn't document it." The nurse on duty at the time of resident #1's seizure on 5/26/12 was not available for interview. Attempts to contact the nurse were unsuccessful.	F 157		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by:	F 176	CORRECTIVE ACTION ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE BY: Medications were removed from resident # 33's room on 8/6/2012. Review and revise current policy (NM-9A Medications - Self Administration of SNF) See attachment E: Policy - Medications - Self Administration of - SNF	8/6/2012 8/6/2012

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F 176	Continued From page 4 Based on observations, record review and staff interviews the facility failed to ensure that the Interdisciplinary Team assessed a resident to safely self administer medications and failed to ensure proper storage of the medications for 1 of 1 sampled residents (Resident #33) that was self administering medications. The findings include: The facility policy titled Medications - Self-Administration of - SNF (Skilled Nursing Facility)/Swing Bed revised on 04/2012 with the effective date of 04/2012 read: " II Procedure. All Nursing Facility residents determined eligible will have the opportunity to self-administer non controlled medications. " 2. If the resident wishes to self-administer medications the interdisciplinary team will assess whether the resident can do so safely using the Medication Self-Administration Assessment. The following criteria will be used. The resident must demonstrate: a. The knowledge of what the medications are for. b. The knowledge of correctly measure the appropriate amount of medication from the container. c. The knowledge of correct times to take the medication. d. The ability to read the label on the medication container. e. The manual dexterity sufficient to self-administer medication accurately. 3. The resident will be reassessed quarterly as long as he/she desires to self-administer. 4. Medications will be stored in the medication cart under the supervision of the medication nurse. The resident will contact the medication nurse to obtain access to his/her medications. The medication nurse will give the resident his/her medication drawer and observe and record on the MAR (Medication Administration Record) the self-administration of medications. " The policy included an attached	F 176	The SNF interdisciplinary team assessed resident # 33 on 8/9/12 to ensure resident's ability to safely self administer medications. She was deemed safe to self administer medications and to store them in the bedside stand. See attachment F - Medication Self Administration Assessment Form CORRECTIVE ACTION ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: SNF Clinical Coordinator audited 100% of residents who are self administering medication to confirm an interdisciplinary team assessment was completed and on medical record ensuring the resident's ability to safely self administer medications. See Attachment G: Self Administration Audit Tool MEASURES/SYSTEMIC CHANGES PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: Re-educate nursing staff regarding residents self administration of medication to include revision of policy, forms, and quality assessment process. See attachment B: Education Plan PLANS TO MONITOR PERFORMANCE TO MAKE SURE SOLUTIONS ARE SUSTAINED: Self administration of medications was added to Quality Assurance/Assessment Form. See attachment D	8/9/2012 8/6/2012 8/20/12 8/9/2012

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F 176	Continued From page 5 form titled Evaluation of Resident ' s Ability to Safely Self-Administer Medication that listed the above criteria. Resident #33 was admitted to the facility on 1/29/10 and had diagnoses including Congestive Heart Failure, Atrial Fibrillation, Coronary Artery Disease, Degenerative Joint Disease, Gastro-Esophageal Reflux Disease, Insomnia, Dementia and Constipation. The Care Area Assessment dated 03/16/12 showed that the resident was alert and oriented and was cognitively intact. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 05/25/12 showed that the resident was cognitively intact. The resident ' s Care Plan dated 03/20/12 and updated 06/26/12 did not include information regarding self administration of medications. On 07/25/12 at 4:00 PM the resident was observed to have multiple over the counter medications on the over bed table in the room. The following items were observed: One bottle of scalp itch medicine (contains salicylic acid), one bottle of Genteal eye drops (contains 2 lubricants for dry eyes), one bottle of Oxymetozoline 0.05% nasal spray (a nasal decongestant), one bottle of L Lysine 1,000 milligram tablets (protein supplement), one bottle of Vitamin B12, one bottle of Osteo Bi-Flex (combination of chondroitin and glucosamine used as a supplement for osteoarthritis), one jar of Vick ' s Vaporub, one bottle of Leg Aide Herbal Supplement (used for leg cramps and	F 176	SNF will monitor all residents who are self medicating weekly for 1 month and monthly for 6 months to ensure the interdisciplinary team has conducted an assessment for patients wishing to self administer medications and completed the Medication Self Administration form. See Attachment G: Weekly Self Administration Audit Tool	8/6/2012

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F 176	Continued From page 6 circulation), one jar of Ultra blue cream (topical analgesic gel pain reliever) and one jar of generic Chest Rub (medicated vaporub decongestant). During the observation the resident stated that she liked to keep her medications close by in case she needed them. The resident resided in a private room. A review of the resident ' s medical record revealed a physician ' s order dated 4/28/12 that the resident could keep vick ' s vapor rub at the bedside. There was a physician ' s order dated 05/12/12 for the resident to keep Vitamin B12, Glucosamine and Chondroitin, natural herbal leg-aid and lysine dietary supplement at the bedside and may self-administer the medications. There was no documentation found regarding an assessment by the Interdisciplinary Team for the resident to self-administer medications and there was not an assessment form for the resident to self-administer medications. On 07/25/12 at 4:40 PM the Unit Manager stated in an interview that they have a policy and a form for self administration of medications but have not implemented it yet due to trying to get all of their policies updated. The Manager stated that they get a physician ' s order for the resident to self administer medications and they make sure that the resident is competent to do so. The Manager stated that currently they have no residents that wander into other resident ' s rooms. On 07/25/12 at 5:18 PM the Unit Manager stated in an interview that the staff observed over the counter medications in the resident ' s room and the family wanted the resident to be able to be independent with taking her supplements and	F 176		

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F 176	Continued From page 7 over the counter medications. The Unit Manager stated that the physician makes the decision whether a resident can or can not self administer medications. On 07/25/12 at 6:20 PM The Unit Manager stated in an interview that because there was a physician ' s order for the resident to keep her medications in her room, she thought that it was OK for her to do so. The Unit Manager stated that she was unable to find documentation that the resident had been assessed for self administration of medications.	F 176		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	CORRECTIVE ACTION ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE BY: Care plan for resident #33 was revised to reflect self administration of medication competency. See attachment H: Care Plan A nutritional care plan was developed for resident #14 See attachment I: Care Plan CORRECTIVE ACTION ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: The MDS coordinator audited all resident care plans to ensure accuracy and completeness. See attachment J: Care Plan Audit Tool	8/9/2012 8/6/2012 8/9/2012

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F 279	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews the facility failed to develop a written care plan for self-administration of medications for 1 of 1 residents who was self-administering medications (Resident #33) and failed to develop a written care plan for nutrition for 1 of 3 sampled residents with weight loss (Resident #14). The findings include: 1. Resident #33 was admitted to the facility on 1/29/10 and had diagnoses including Congestive Heart Failure, Atrial Fibrillation, Coronary Artery Disease, Degenerative Joint Disease, Gastro-Esophageal Reflux Disease, Insomnia, Dementia and Constipation. The Care Area Assessment dated 03/16/12 showed that the resident was alert and oriented and was cognitively intact. The most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 05/25/12 showed that the resident was cognitively intact. The resident ' s Care Plan dated 03/20/12 and updated 06/26/12 did not include information regarding self administration of medications. On 07/25/12 at 4:00 PM the resident was observed to have multiple over the counter medications on the over bed table in the room. The following items were observed: One bottle of scalp itch medicine (contains salicylic acid), one bottle of Genteal eye drops (contains 2 lubricants for dry eyes), one bottle of Oxymetozoline 0.05% nasal spray (a nasal decongestant), one bottle of	F 279	MEASURES/SYSTEMIC CHANGES PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: Skilled Nursing Facility will monitor a random sample of five medical records per week, starting 8/6/2012, for 1 month, then monthly for 6 months to ensure correction is achieved and sustained for the following: Accurate development, review and revision for completeness of residents comprehensive care plans. See attachment J: Care Plan Audit Tool PLANS TO MONITOR PERFORMANCE TO MAKE SURE SOLUTIONS ARE SUSTAINED: Care Plan Audit tool will be reviewed and discussed at the Weekly Quality Assessment/Assurance Meeting weekly for 4 weeks, starting 8/9/2012, then monthly for 6 months	8/6/2012 8/9/2012

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F 279	Continued From page 9 L Lysine 1,000 milligram tablets (protein supplement), one bottle of Vitamin B12, one bottle of Osteo Bi-Flex (combination of chondroitin and glucosamine used as a supplement for osteoarthritis), one jar of Vick ' s Vaporub, one bottle of Leg Aide Herbal Supplement (used for leg cramps and circulation), one jar of Ultra blue cream (topical analgesic gel pain reliever) and one jar of generic Chest Rub (medicated vaporub decongestant). During the observation the resident stated that she liked to keep her medications close by in case she needed them. The Clinical Coordinator stated in an interview on 07/25/12 at 5:29 PM that self-administration of medications was addressed on care plans prior to 03/20/12 but was not included on the resident ' s current care plan. The Unit Manager stated in an interview on 07/25/12 at 6:20 PM that the resident ' s care plans prior to 03/20/12 included self administration of medications. The Unit Manager stated that she did not know why the care area was dropped from the care plan. Resident #14 was admitted to the facility on 10/17/11 with multiple diagnoses including poor appetite. The resident's minimum data set (MDS) dated 6/29/12 indicated the resident was cognitively intact. The resident required extensive assistance with her activities of daily living (ADLS), including eating. The MDS indicated the resident received a therapeutic diet. The Care Area Assessment (CAA) dated 6/29/12	F 279		

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F 279	Continued From page 10 read in part: "nutrition - she is routinely on an AHA (American Heart Association) diet and has a poor to fair intake. She was started on Megace (appetite stimulant) on 5/1/12 and has improved some with intakes of 25-100% in the past 7 days per the dietary consumption record. She eats less in the evening. She was also started on Resource 2.0 (supplement) 4 oz. twice daily. She has gained wt (weight) (10 lb) in the past month as recorded in the wt book as her wt in May was 114. Will Proceed to care plan to monitor for any decrease in wt and any loss of interest in food. Will refer to MD (physician) & RD (registered dietician) as needed." The CAA indicated nutritional and functional status would be addressed in the care plan. The overall objective was improvement and to slow or minimize decline. The CAA read "Describe impact of this problem/need on the resident and your rationale for care plan decision - she will be monitored for any reverse of fair to good intake. Any loss of interest in food bears looking in to." Review of the care plan dated 6/12/12 revealed it did not identify problems, goals, or approaches specific to the resident's nutrition. In an interview on 7/25/12 at 1:59PM, the MDS Coordinator stated she completed the resident's MDS and CAA. She stated her intent was to care plan nutrition for the resident but she did not complete it. In an interview on 7/25/12 at 4:35PM, the Unit Care Manager stated the MDS coordinator was responsible for completing care plans. Her expectation was for nutrition to have been included on resident #14's care plan.	F 279		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329	CORRECTIVE ACTION ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE BY:	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345245	A. BUILDING _____ B. WING _____	07/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENDER MEMORIAL HOSP SNF	507 FREMONT STREET BURGAW, NC 28425

(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 329	Continued From page 11 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, physician interview, and staff interviews, the facility failed to assess duplicate therapy for 1 of 3 sampled residents receiving appetite stimulants (resident #13). Findings include: Resident #13 was admitted to the facility on 7/20/09 with multiple diagnoses including cerebrovascular accident, depression, and malnutrition. Review of the resident's clinical	F 329	The SNF Clinical Coordinator contacted resident # 13's attending physician and obtained orders to discontinue Megace. Megace was discontinued 8/7/2012. See Attachment K: Copy of medication discontinuation order CORRECTIVE ACTION ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: 100% audit of all current SNF residents was completed by consultant pharmacist to confirm drug regimens for all residents are free from unnecessary drugs. See Attachment L: Pharmacy Audit Tool MEASURES/SYSTEMIC CHANGES PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: The SNF consultant pharmacist will monitor all current residents medication regimen monthly to confirm their drug regimens are free from unnecessary drugs, to include duplicate therapy. Documentation will be completed monthly by the consultant pharmacist in the medical record. PLANS TO MONITOR PERFORMANCE TO MAKE SURE SOLUTIONS ARE SUSTAINED: Residents medication reviews will be added to the Quality Assessment/Assurance Committee agenda monthly for 6 months to ensure compliance.	8/7/2012 8/10/2012 8/10/2012 8/16/2012

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345245	A. BUILDING _____ B. WING _____	07/25/2012

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PENDER MEMORIAL HOSP SNF	507 FREMONT STREET BURGAW, NC 28425

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F 329	Continued From page 12 record revealed physician orders dated 7/20/09 for Prozac (antidepressant) 20mg (milligram) twice daily, orders dated 3/6/12 for Megace (megestrol) 200mg twice daily, and orders dated 4/13/12 for Remeron 45mg every night for bedtime. Megace has a non-FDA (Federal Drug Administration)-approved indication for the treatment of anorexia, cachexia, or unexplained weight loss in the elderly. Remeron is an antidepressant also used to stimulate appetite. The manufacturer's product information for Megace read in part: "Warnings/Precautions - exacerbation of preexisting diabetes has been reported in association with the use of Megace." Adverse effects with chronic use included hyperglycemia, adrenal insufficiency, and thrombophlebitis. Record review of physician progress notes dated 2/7/12 read in part "plan - will decrease Remeron from 45mg down to 30mg due to increased weight and increased appetite." Record review revealed new orders on 3/6/12 for Megace 200mg twice daily. Record review of a Nutrition Assessment dated 3/22/12 read in part: "pt (patient) on megace due to poor appetite...meds - phenytoin (seizure med), metoprolol (antihypertensive), KCL (potassium supplement), zantac (reflux), oxycodone (analgesic)." Review revealed no documentation by the dietician that the resident was receiving Remeron for appetite. Review revealed no assessment of the need for two	F 329	The consultant pharmacist, dietician, and dietary manager was educated regarding regulation F329 483.25 (1), unnecessary drugs and F428 483.60(c) drug regimen review, report irregular, act on. See Attachment B: Education Plan	8/10/2012

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	345245	A. BUILDING _____ B. WING _____	07/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENDER MEMORIAL HOSP SNF	507 FREMONT STREET BURGAW, NC 28425

(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 329	Continued From page 13 appetite stimulants by the dietician. Record review of physician progress notes dated 4/13/12 read in part: "more recently has had decreased appetite and weight loss...plan - will increase Remeron to 45mg which was his previous dose, more recently patient had a weight gain, so his Remeron was decreased. Will go back to original dose of 45mg at bedtime." Review of the progress notes revealed no assessment of the need for additional therapy with Megace. Record review of laboratory results dated 5/7/12 revealed blood glucose of 221 mg/dl (milligram/deciliter), normal range less than 124mg/dl, with new orders for metformin (anti-diabetic agent) 500mg daily. Record review of physician progress notes dated 5/18/12 read in part: "appetite has improved since increasing the dose of Remeron." Review of the progress notes revealed no assessment of the need for additional therapy with Megace. Record review of a Nutrition Assessment dated 7/5/12 read in part: "f/u (follow-up) assessment - wt (weight) May 127, June 131.2, April - no wt, no wt July, new dx (diagnosis) since last review hyperglycemia, meds - megace, zantac, metformin, plavix (anti-platelet)." Review revealed no documentation by the dietician that the resident was receiving Remeron for appetite. Review revealed no assessment of the need for two appetite stimulants by the dietician. In an interview on 7/25/12 at 3:10PM, the Dietary Manager (DM) stated the nursing staff requested	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345245	A. BUILDING _____ B. WING _____	07/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENDER MEMORIAL HOSP SNF	507 FREMONT STREET BURGAW, NC 28425

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F 329	Continued From page 14	F 329		

a consult from him if there were significant weight gains or losses. He made recommendations such as the addition of a supplement or appetite stimulant to the physician. The Registered Dietician (RD) visited the facility weekly and reviewed the recommendations. The DM stated a resident would not usually be prescribed two agents for appetite at the same time. He examined resident #13's medication administration record and acknowledged the resident was receiving both Megace and Remeron. The DM immediately called the RD but was unable to reach her.

In an interview on 7/25/12 at 3:30PM, the Unit Manager stated she would have expected the consultant pharmacist to have identified and reported the use of two appetite stimulants. She also would have expected the RD to check the resident's medications before approving a new appetite stimulant or additional therapy.

In a telephone interview on 7/27/12 at 12:10PM, the physician stated he had not been contacted regarding the concurrent use of Megace with Remeron until 7/26/12.

In a telephone interview on 7/31/12 at 3:25PM, the RD stated she was in the facility once weekly and monitored weight gains and losses. For residents with weight loss, recommendations for supplements and/or appetite stimulants were made to the physicians for their approval. If the physician initiated an order for an appetite stimulant, she monitored the resident's weight and intake. The RD stated she never recommended the use of Megace and Remeron together. She stated there should have been only

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	345245	A. BUILDING _____ B. WING _____	07/25/2012

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F 329	Continued From page 15 one agent used for this resident and "it must have been an oversight."	F 329		
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. 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 observation, record review and staff interviews the facility failed to ensure that insulin was properly stored for 1 of 2 medication carts. The findings include: The facility policy dated 01/01/12 titled Preparation and General Guidelines for Vials and Ampules of Injectable Medications reads as follows: "Policy. Vials and ampules of injectable	F 425	CORRECTIVE ACTION ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE BY: The one bottle of unopened, unrefrigerated Humulog insulin was removed from the medication cart and discarded on 7/25/2012 CORRECTIVE ACTION ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Audit of all medication carts was conducted 8/7/2012 on SNF to confirm all insulin was stored appropriately per policy and there were no additional unopened, unrefrigerated bottles/vials in the medication carts. MEASURES/SYSTEMIC CHANGES PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: Staff will be educated on Policy "Vials and Ampules of Injectable Medication" See Attachment B: Education Plan PLANS TO MONITOR PERFORMANCE TO MAKE SURE SOLUTIONS ARE SUSTAINED: Medication carts will be audited weekly for 4 weeks and monthly for 6 weeks to ensure compliance. Results will be discussed at the Quality Assessment/Assurance Meetings.	7/25/2012 8/7/2012 8/20/2012 8/7/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 425	Continued From page 16 medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, use, and disposal." The manufacturer ' s product information for Humulog Insulin reads: " Humulog not in-use should be stored in a refrigerator. Humulog can be kept unrefrigerated up to 28 days. " On 07/25/12 at 3:35 PM, an observation of the medication cart for the upper 200 Hall revealed one bottle of unopened, unrefrigerated Humulog Insulin. The bottle of insulin contained a pharmacy dispense date of 05/22/12. There was no information on the bottle to indicate when the bottle was put on the medication cart. Nurse #3 stated that the vial of insulin should have been in the refrigerator. The Nurse stated that the insulin could not be used and removed the medication from the cart and put in a container to be returned to the pharmacy. The Unit Manager stated in an interview on 07/27/12 at 11:33 AM that the unopened vial of insulin should have been stored in the refrigerator until it was needed.	F 425		
F 428 SS=D	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.	F 428	CORRECTIVE ACTION ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE BY: The SNF Clinical Coordinator contacted the resident #13's attending physician and obtained orders to discontinue Megace. Megace was discontinued 8/7/2012. See Attachment K: Copy of medication order to discontinue	8/7/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on record review, pharmacist interview, physician interview, and staff interviews, the consultant pharmacist failed to request an assessment of duplicate therapy for #1 of 3 sampled residents receiving appetite stimulants (resident #13). Findings include: Resident #13 was admitted to the facility on 7/20/09 with multiple diagnoses including cerebrovascular accident, depression, and malnutrition. Review of the resident's clinical record revealed physician orders dated 7/20/09 for Prozac (antidepressant) 20mg (milligram) twice daily, orders dated 3/6/12 for Megace (megestrol) 200mg twice daily, and orders dated 4/13/12 for Remeron (mirtazapine) 45mg every night for bedtime. Megace has a non-FDA (Federal Drug Administration)-approved indication for the treatment of anorexia, cachexia, or unexplained weight loss in the elderly. Remeron is an antidepressant also used to stimulate appetite. The manufacturer's product information for Megace read in part: "Warnings/Precautions - exacerbation of preexisting diabetes has been reported in association with the use of Megace." Adverse effects with chronic use included hyperglycemia, adrenal insufficiency, and thrombophlebitis.	F 428	CORRECTIVE ACTION ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: 100% audit of all SNF residents will be completed by pharmacist to confirm drug regimens for all residents are free from unnecessary drugs. See attachment L: Pharmacy Audit Tool MEASURES/SYSTEMIC CHANGES PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR: The SNF consultant pharmacist will monitor all current residents medication regimen monthly to confirm their drug regimens is free from unnecessary drugs, to include duplicate therapy. Documentation will be completed monthly by the consultant pharmacist in the medical record. PLANS TO MONITOR PERFORMANCE TO MAKE SURE SOLUTIONS ARE SUSTAINED: Resident medication resident reviews will be added to the Quality Assessment/Assurance Committee Meeting agenda monthly for 6 months to ensure compliance. The consultant pharmacist, dietician and dietary manager was educated regarding regulation F329 483.25 (1), unnecessary drugs and F428 483.60(c) drug regimen review, report irregular, act on. See attachment B: Education Plan	8/10/2012 8/10/2012 8/16/2012 8/10/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 18 Record review of physician progress notes dated 2/7/12 read in part "plan - will decrease Remeron from 45mg down to 30mg due to increased weight and increased appetite." Record review of the pharmacist progress notes dated 2/26/12 revealed an entry that noted mirtazapine (Remeron) had been changed to 30mg at bedtime. Record review revealed new orders on 3/6/12 for Megace 200mg BID (twice daily). Record review of the pharmacist progress notes dated 3/31/12 revealed an entry which read "3/6 - Megace 200mg BID (appetite)." The progress notes revealed no documentation that the pharmacist assessed the concurrent use of Megace with Remeron or requested an evaluation from the physician. Record review of physician progress notes dated 4/13/12 read in part: "more recently has had decreased appetite and weight loss...plan - will increase Remeron to 45mg which was his previous dose, more recently patient had a weight gain, so his Remeron was decreased. Will go back to original dose of 45mg at bedtime." Review of the progress notes revealed no assessment of the need for additional therapy with Megace. Record review of the pharmacist progress notes dated 4/29/12 revealed an entry that noted mirtazapine (Remeron) had been increased to 45mg at bedtime. The progress notes revealed no documentation that the pharmacist assessed the concurrent use of Megace with Remeron or	F 428		

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	345245	A. BUILDING _____ B. WING _____	07/25/2012

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PENDER MEMORIAL HOSP SNF	507 FREMONT STREET BURGAW, NC 28425

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F 428	Continued From page 19 requested an evaluation from the physician. Record review of laboratory results dated 5/7/12 revealed blood glucose of 221 mg/dl (milligram/deciliter), normal range less than 124mg/dl, with new orders for metformin (anti-diabetic agent) 500mg daily. Record review of physician progress notes dated 5/18/12 read in part: "appetite has improved since increasing the dose of Remeron." Review of the progress notes revealed no assessment of the need for additional therapy with Megace. Record review of the pharmacist progress notes dated 5/16/12, 6/14/12, and 7/18/12 revealed no documentation that the pharmacist assessed the concurrent use of Megace with Remeron or requested an evaluation from the physician. In an interview on 7/25/12 at 3:30PM, the Unit Manager stated the pharmacist reviewed the residents' charts monthly and provided written reports of any irregularities. The review included monitoring for duplicate therapy. Her expectation was for the consultant pharmacist to have identified and reported the concurrent use of Megace with Remeron. In a telephone interview on 7/27/12 at 12:10PM, the physician stated he had not been contacted by the consultant pharmacist regarding the concurrent use of Megace with Remeron. In a telephone interview on 7/27/12 at 1:59PM, the consultant pharmacist stated she reviewed the residents' drug regimens monthly and provided her recommendations to the head nurse	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345245	A. BUILDING _____ B. WING _____	07/25/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENDER MEMORIAL HOSP SNF	507 FREMONT STREET BURGAW, NC 28425

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F 428	Continued From page 20 who then relayed them to the unit manager. Her review included monitoring for duplicate therapy. She stated resident #13 was receiving Remeron for depression more than appetite. She was aware that Megace therapy had been added. The pharmacist stated she usually evaluated Megace therapy after 3 months, but sooner if side effects were observed. She stated if a recommendation had been made regarding the concurrent use of Megace with Remeron, it would be documented in her progress notes.	F 428		

PRINTED: 08/27/2012
FORM APPROVED
OMB NO. 0938-0391

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

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CONSTRUCTION SECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345246	A. BUILDING 01 – MAIN BUILDING 01 B. WING	08/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENDER MEMORIAL HOSP SNF	507 FREMONT STREET BURGAW, NC 28425

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K 000	INITIAL COMMENTS This Life Safety Code (LSC) was conducted as per The Code of Federal Register at 42CFR 483.70 (a); using the Existing Health Care section of the LSC and its referenced Publications. This building is Type II (2 (211) Construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey Are as follows:			
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are Permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on Wednesday 8/22/12 at Approximately 9:00 AM onward the following was noted: 1) The corridor door to the old copier/storage Room did not have positive latching. 2) The corridor door to room 240 and the door to the adjoining bathroom in the room were not self Closing, (resident room used for temporary Storage)	K 029	CORRECTIVE ACTION ACCOMPLISHED TO CORRECT THE DEFICIENT PRACTICE: 1) The positive latch has been replaced to the corridor door that leads to the copier/storage room effective 9/5/12. — 9/5/12 2) Positive closures have been placed to the corridor door to room 240 and the door to the adjoining bathroom in the room effective 9/5/12. — 9/5/12 CORRECTIVE ACTION ACCOMPLISHED TO IDENTIFY OTHER LIFE SAFETY ISSUES HAVING THE POTENTIAL TO AFFECT RESIDENTS BY THE SAME DEFICIENT PRACTICE: 1) All rooms and bathrooms on the SNF were assessed 9/5/12 and are in compliance with positive latches. (see attachment A) — 9/5/12 2) All storage rooms and doors adjoining storage rooms on the Skilled Nursing Facility were assessed 9/5/12 and have self closures in place. (see attachment A) — 9/5/12	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ruth A. Glaser
TITLE: President
(X6) DATE: 9-6-12

Any deficiency statement ending with an (*) 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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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	345245	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/22/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENDER MEMORIAL HOSP SNF	507 FREMONT STREET BURGAW, NC 28425

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K 029	Continued from page 1	K 029	MEASURES/SYSTEMIC CHANGES PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: All requests to temporarily change the use of a room must be submitted in writing to Plant Operations and the COO for approval. Plant Operations will ensure the appropriate door closures are in place prior to utilization. (see attachment B) Education will be provided to the SNF Manager and Coordinator regarding procedure for submitting request to temporarily change the use of a room. (see Attachment D) PLANS TO MONITOR PERFORMANCE TO MAKE SURE SOLUTIONS ARE SUSTAINED: All doors will be checked for positive latches and self closures monthly for 3 months, by Plant Operations, and will then be monitored during the unit Environmental Tours by Plant Operations ongoing. (see attachment A) All requests to temporarily change the use of a room will be monitored by the Plant Operations Manager for completion. Education will be provided to Plant operations staff regarding monitoring for positive latches and self closures by 9/7/12. (see attachment C) Education will be provided to the SNF Manager and Coordinator regarding procedure for submitting request to temporarily change the use of a room. (see Attachment D)	9/6/12 9/6/12 9/6/12 9/6/12 9/6/12