DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 06/01/2011 FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUC (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WNG 345429 05/12/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **801 PINEHURST AVENUE PEAK RESOURCES - PINELAKE** CARTHAGE, NC 28327 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X6) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Filing the plan of correction does F 323 483.25(h) FREE OF ACCIDENT F 323 not constitute an admission that HAZARDS/SUPERVISION/DEVICES SS=D the deficiencies alleged did in fact exist. This plan of correction is The facility must ensure that the resident filed as evidence of the facility's environment remains as free of accident hazards desire to comply with the as is possible; and each resident receives requirements and to continue to adequate supervision and assistance devices to prevent accidents. provide high quality of care. This REQUIREMENT is not met as evidenced Based on staff interviews and record reviews, the F323 facility failed to provide adequate supervision to 6/9/11 prevent the fall of 1 of 3 sampled residents who Corrective action for resident #3: was at risk for falls. Resident #3. The MDS for resident #3 was found to have been coded incorrectly in Findings included: that resident #3 actually should have been coded as one person assist instead of 2 person assist. Resident #3 was admitted to the facility on Subsequently, the MDS was 12/26/05 with diagnoses which included: dementia; congestive heart failure; osteoporosis; corrected to indicate one person assist for resident #3. The resident muscle weakness; abnormality of gait; and, information sheet (source of anxiety. communication for staff) was The review of the quarterly MDS (Minimum Data updated as well. Staff was in Set) dated 12/6/10 indicated Resident #3 had serviced about revision made severely impaired memory and cognition regarding care requirements for problems, and required the extensive assistance resident #3. of two staff for transfers, bed mobility, and toileting to the bathroom.

LABORATORY DIRECTOR'S OR PROVIDER SUPPLIED REPRESENTATIVE SISIGNATURE

A review of the Nurse's Notes revealed that on

2/19/11 at 2:30pm, Resident #3 was found by

staff sitting on the bathroom floor in front of the

toilet. The resident informed staff that she was

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excusely 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.

(X6) DATE

For those residents with the

potential to be affected, the

following was completed:

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S LOW MEDICAKE &	MEDICAID SEKVICES				ON DIVID	<i>J.</i> 0930-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	IULTIPLI ILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PR	OVIDER OR SUPPLIER	West of the second seco		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	-	
PEAK RE	SOURCES - PINELAKE			1	1 PINEHURST AVENUE ARTHAGE, NC 28327		
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F 323	wheelchair, unassisted facility's interventional Resident/Accident restaff were to offer to thours during the day. Review of Resident #2/2011) revealed the related to impaired mimpaired vision. Intervesident while in bath two hours; ensure stabigh risk for falls; and and evaluate for patter the Physical Therapirevealed Resident #3 times each week for abnormality. The resident of the Review of the Quarted the State of the State	r from the toilet to the ed; but slid to the floor. The documented on the port on 2/20/11 indicated the toilet the resident every two days. Care Plan (updated resident was a fall risk hobility, unsteady gait, and eventions included: assist proom; offer to toilet every aff aware that resident is at dr., maintain record of falls, erns. By Plan of Care (2/23/11) areceived treatment five four weeks for gait ident was discharged from and referred to be continuation of ambulation ent was to have use of a rt distances and a istances. By Screens/Fall Risk Screen and Resident #3 was a high mual MDS (Minimum Data licated Resident #3 had		323	1. The care plan and M for each current resident have been reviewed by the DO and MDS Coordinate for accuracy. 2. The information contained in each assessment and care plan have been measured for accuracy by re-assessing each resident face to face and ensuring that be forms of assessment match. 3. Staff was in service regarding any chang related to the requirement of care any resident. Measures taken/put in place ar follows: 1. Each MDS nurse will continue to complete a through face to face assessment of each resid and will conduct staff interviews prior to the completion of any care principles.	N or e as	
	of two staff for transfe toileting to the bathro	ers, bed mobility, and nom.					
	A review of the Nurse	s inde dated 5/2/11	1				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345429	B. WIN	G		05/1	2/2011
	NOVIDER OR SUPPLIER			80	EET ADDRESS, CITY, STATE, ZIP CODE 1 PINEHURST AVENUE ARTHAGE, NC 28327		
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F 323	ambulating Resident the rolling walker; as stepped from behind bathroom door, the recausing the resident telbow hit the door car facility's intervention of Resident/Accident restaff were to ensure the leave the resident; the assistance. The Care Plan for Fall and the interventions schedule and request members are aware the for falls; remind resident light and most free within reach; provide to call when needing incontinent pad when During an observation Resident #3 was obsolounge chair in her romoommate. The residence confusion. During an interview of (Nursing Assistant) reweightbearing and rewith transfers. NA#5	#3 to the bathroom using the nursing assistant the resident to open the esident's legs weakened to fall. The resident's right using a small skin tear. The documented on the port on 5/3/11 indicated the he door was open and not to be resident required standby Ils was updated on 5/2011 were: toilet resident per try, make sure that all staff that ressident is at high risk tent to not toilet self; keep requently used personal items verbal reminders to resident assistance; and, change	F	323	 The MDS nurse will complete the resident information sheet for ear resident and make such changes whenever a significant change is warranted. Staff will be re-in service on where to find residen care information sheets when the information she will be changed. The DON will continue to review MDSs and Care plin addition to making rout to ensure the information contained in MDS and caplan coincide with the viassessment being made her rounds. Maintaining for compliant will be as follows: DON will conduct random reviews of assessments for the 90 days, and continuation of the initial stage assessments. Findings will be take QA meeting and continuation of assessment and 	ed t and leets o lans unds in are sible on nce first led the	
	bathroom every two h that Resident #3 was bathroom with one pe	nours. NA#5 also revealed able to ambulate to the erson assist; but due to the time the resident was			frequency will be determined by the results of findings fro assessments.	om	

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F 323	bathroom by one per	eelchair and assisted to the	. F	323				
· ·	MDS Coordinator sta required extensive as the resident's most re assessment. She rev was obtained from th of Daily Living) Flow	ted that Resident #3 sistance of two people per						
	there should have be with the resident insta- revealed that the nur- informed of any chan from the hall nurses a		THE PROPERTY OF THE PROPERTY O	***************************************	e total			
·	second reference she After reviewing the re Care Information Ste	eet by nursing assistants. sident's current "Resident eet", the MDS Coordinator an accurate reflection of the	**					
	Information Sheet" w nursing station indica wheelchair mobility re the resident required	nt #3's "Resident Care hich was maintained at the ted the resident's bed and equired self supervision; and, assistance with transfers s continent of bowel and Fall Risk".			e	· <u>.</u>		
F 329 SS=D	483.25(I) DRUG REG UNNECESSARY DR Each resident's drug unnecessary drugs. drug when used in ex	SIMEN IS FREE FROM		329	Corrective action for re were: Residents #34 ar assessed immediately a omissions of BPs were in There were no negative as a result missed blood	nd #83 were after the identified. e outcomes	6/9/11	

		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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without adequate moindications for its use adverse consequence should be reduced or combinations of the resident, the facility resident, the facility resident, the facility resident these drugs untherapy is necessary as diagnosed and do record; and residents drugs receive gradual behavioral intervention contraindicated, in an drugs. This REQUIREMENT by: Based on observation interview the facility of pressures as ordered sampled residents for (Resident #83, #34 and Findings include: 1. Resident # 34 was 8/17/09 re-admit 9/2 Hypertension and Caster of the residents of the resident # 34 was 8/17/09 re-admit 9/2 Hypertension and Caster of the resident was 1.	nitoring; or without adequate ; or in the presence of es which indicate the dose discontinued; or any easons above. ensive assessment of a nust ensure that residents ntipsychotic drugs are not less antipsychotic drug to treat a specific condition cumented in the clinical who use antipsychotic al dose reductions, and ons, unless clinically n effort to discontinue these is not met as evidenced on, record review and staff ailed to monitor blood by a physician for 3 of 10 r unnecessary medications admitted to the facility on 4/10 Diagnosis included		329	for each resident was notified of the omission of blood pressures Medication incident forms were filled out for both residents. For those with the potential to be affected, the following was completed: 1. All administrative nurses (DON, MDS nurse, SDC, Clinical Coordinator and won nurse) will ensure the each resident will receive the appropriassessment and intervention to inclusion determined by the resident's attending physician. 2. An audit tool has be developed to determ compliance. Each administrative nurse will conduct an audie each resident to determine compliance with physician's ore to include blood pressure monitorint. 3. Any failure to comp with physician's ore or to my service of the ser	en e	
•	onic physician orders for the	Performant of the Control of the Con		1		
	CORRECTION COVIDER OR SUPPLIER SOURCES - PINELAKE SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page without adequate mo indications for its use adverse consequence should be reduced or combinations of the r Based on a compreh resident, the facility n who have not used a given these drugs un therapy is necessary as diagnosed and do record; and residents drugs receive gradual behavioral interventic contraindicated, in ar drugs. This REQUIREMENT by: Based on observation interview the facility f pressures as ordered sampled residents fo (Resident #83, #34 a Findings include: 1. Resident # 34 was 8/17/09 re-admit 9/2 Hypertension and Ca left Hemiparesis.	CORRECTION A 345429 COVIDER OR SUPPLIER SOURCES - PINELAKE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 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 observation, record review and staff interview the facility failed to monitor blood pressures as ordered by a physician for 3 of 10 sampled residents for unnecessary medications. (Resident #83, #34 and #8) Findings include: 1. Resident # 34 was admitted to the facility on 8/17/09 re-admit 9/24/10 Diagnosis included Hypertension and Cardio Vascular Accident with	CONTERECTION IDENTIFICATION NUMBER: 345429 COVIDER OR SUPPLIER COURCES - PINELAKE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 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. 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This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to monitor blood pressures as ordered by a physician for 3 of 10 sampled residents for unnecessary medications. (Resident #3.4 was admitted to the facility on 8/17/10 pre-admit 9/24/10 Diagnosis included 1. Resident #3.4 was admitted to the facility on 8/17/10 re-admit 9/24/10 Diagnosis included 1. Resident #3.4 was admitted to the facility on 8/17/10 pre-admit 9	OVIDER OR SUPPLIER 345429 STREET ADDRESS, CITY, STATE, 2P CODE 801 PINELURST AVENUE CARTHAGE, NC 28327 FROMDERS PINEL OR CORRECTION (EXCH OF PINEL ARE) SUMMARY STATEMENT OF DEPOICEMENS GENT INFORMATION) CONTINUED FROM THE PINCE OF PINEL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 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 are not given these drugs unless different interpretation to include Blood Pressure Monitoring as determined by the resident's attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility falled to monitor blood pressures as ordered by a physician for 3 of 10 sampled residents for unnecessary medications. (Resident #34 was admitted to the facility on 8/17/09 re-admit 9/24/10 Diagnosis included 1. Resident #34 was admitted to the facility on 8/17/09 re-admit 9/24/10 Diagno

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F 329	resident was being to Isosorbide 20mg daily (diuretic) 80mg daily was to be taken week. A review of the Medic (MAR) for the months 2011 revealed that or recorded for the mon 3/16/11. A review of the month of March. The MAR for April 20 was to be recorded womenth. A review of the nurses notes for the no documentation of taken. A review of the NAR recorded blood press 11th. A review of the no documentation of month of May 2011. I revealed a monthly s blood pressure of 100 A review of the pharm recommendations for identified the lack of I An interview on 5/11/1 revealed that Blood I documented on the Max I are the Isosof I are the	and May 2011 revealed the eated for hypertension with y for Hypertension and Lasix Also the blood pressure dy on Wednesday. Sation Administration Record of March, April and May ally one blood pressure was the of March 2011 on the vital sign sheet and the ch 2011 revealed no other blood pressure for 11 where the blood pressure evital sign sheet and the month of April 2011 revealed a blood pressure being for May 2011 revealed no ure from the 1st through the vital sheet record revealed a blood pressure for the A review of the nurses notes aummary dated 5/9/11 with a 3/58 recorded. March, April and May 2011 pressure were either March weekly Blood	F 329	4. Each Staff member responsible for the identified omission will be individually educated to ensure continued compliance. 5. Audits were completed on 100% of all current residents. Monitoring for compliance will be as follows: 1. Audits will continue with 50% being done weekly for six weeks and then 25% every two weeks for one month. 2. Future audits will be determined by the results of the prior ten weeks of audits. All audit results will be discussed in the facility QA Meeting. Systemic changes are as follows: 1. A list of residents	
	Pressure or in the ch	art under Vital signs. She know of any other place the		A list of residents with routine vitals are now given to the CNAs at the beginning	

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F 329	Resident #34 revea should be recorded notes. Further discurding to the aides at wall so the nurses of the pharmacy consistency tests, be have had an issue documented. We have talked to the foressures not being audit on all the residual to note the clinical coordinator reveale each hall to follow recommendation. "form used for the fout "I usually write corrections."	om Nurse #4 who works with led the weekly Blood Pressure on MARS or in the nurses assion revealed a list was not then they put the list on the can record them. It is a telephone interview with sulted revealed that monitoring on they; she checked for haviors and vital signs "We with the blood pressure being ave done 2 in-services on errors and documentation. I acility about the blood precorded. I tried to do an dents when I was there in May sed some I left a general g my recommendations with ator."	F 329	of his/her shift and must be returned to the nurse two hours prior to the end of their shift. 2. For residents with parameters for vitals associated with certain medications, the charge nurse will be responsible for obtaining and documenting the vial sign. 3. Staff has been in serviced on the importance of appropriately obtaining, monitoring and documenting Physician ordered blood pressures. Staff are aware through in services the systemic approach that must be followed in order to ensure continued compliance regarding achievement of all required physician orders.			
	on the 400 half rev recording the blood usually gets the blo	Oam an interview with nurse #3 vealed the process for d pressures was "that the nurse bod pressures or they give a list them. The aides tape it to the			•		

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F 329	document on the destroyed after th Nurse #3 reviewe	page 7 es are to get them and MAR" The list for the aides are e blood pressures are recorded. d the MAR for Resident #34 and od pressure for this month was	F	329	* :*				
	5/15/11 10:30am on the 400 hall re blood pressures t	the DON (Director of Nurses) on revealed that she did an audit garding the recording of the out "I do not have documentation-did an in-service last month on problem."		100 100 100 100 100 100 100 100 100 100					
		vas admitted to the facility on nosis that included Hypertension	-						
	for the months of the resident was with Novasc 5mg 20mg. Also the p	ectronic printed physician orders April and May of 2011 revealed being treated for hypertension , Lotensin 20mg and Lopressor hysician orders stated take the eekly and document.			• •				
	Record) for the m blood pressure w April 11th. The bl 25th were blank. and the nurses n	IAR (Medication Administration nonth of April 2011 revealed the las recorded on April 4th and on lood pressure for April 18th and A review of the vital sign sheet lotes had no documentation of a lor April 18th and 25th.							
	blood pressure for was blank. The b	MAR for May 2011 revealed the or 5/2/11, 5/16/11 and 5/22/11 lood pressure due on 5/9/11 was he MAR. A review of the vital		ž		•			

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F 329	documentation of a t and 22 available.	urses notes revealed no plood pressure for May 2, 16	F 329					
	An interview on 5/11 revealed that Blood documented on the Pressure or in the cl	or April and May 2011 blood pressure monitoring. i/11 at 12:05pm with Nurse #1 Pressures were either MAR for weekly Blood hart under Vital signs. She know of any other place the						
	On 5/11/11 at 2:46p Resident #83 reveal should be recorded notes. Further discu	m Nurse #4 who works with led the weekly Blood Pressure on MARS or in the nurses ission revealed a list was and then they put the list on the			e] e			
	the pharmacy consist was part of her more laboratory tests, bethave had an issue of documented. We have talked to the foressures not being audit on all the residual may have missisted.	am a telephone interview with ulted revealed that monitoring on the property of the property o						
		n an interview with the clinical ad a manager was assigned						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	DING	ONSTRUCTION	COMPLETED		
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F 329	form used for the fo but "I usually write of corrections." We are monitoring t		F	329				
	on the 400 hall reviewed usually gets the blo to the aides to get the wall and the nurses document on the Midestroyed after the Nurse #3 reviewed	pam an interview with nurse #3 ealed the process for pressures was "that the nurse od pressures or they give a list hem. The aides tape it to the are to get them and AR" The list for the aides are blood pressures are recorded. the MAR for Resident #34 and it pressure for this month was						
	5/15/11 10:30am re on the 400 hall reg blood pressures bu	ne DON (Director of Nurses) on evealed that she did an audit arding the recording of the it "I do not have documentation d an in-service last month on problem."						
		admitted 10/06/2010 with uded Hypertension (HTN), and Quadriplegia.				e, i		
	Orders for 3/1-3/31 5/1-5/31/2011 that receiving three me	ctronic printed Physician /2011, 4/1-4/30/2011, and indicated Resident #8 was dications daily for HTN and Pressures (BPs) documented		· ·				

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F 329	Continued From page	e 10	F	329			
	reviewed for the mon revealed that BPs we 3/9/11, 3/23/11, 3/30	ation Records (MAR) ths of March, April, and May ere not recorded on 3/2/11, //11, 4/20/11, 4/27/11, or n Sheet reviewed contained	-			-	
	weekly BPs not docu There was an addition	macist 's Medication March 2011 found "many mented on March MAR." nal note dated 5/5/11 that e aware of BP needs.			e Se	*.	
	Clinical Coordinator were either on the M chart on the Vital Sig	11/2011 at 12:05 pm the and Nurse #2 stated that BPs AR for weekly BP or in the in sheet. Nurse #1 indicated did not know of any other we been recorded.					
	(DON) stated in an induction documented on the	/11 the Director of Nurses Interview that BPs should be MAR or in Medicare Notes for Interview indicated					
	took BPs and how d needed to have BPs the nurses would lea needed to have BPs	am NA #1 was asked who did they know which residents taken. She responded that we a list of residents who taken for the NA, the NA and write it on the list and give					
	a facility Pharmacist	iew on 5/12/2011 at 9:50 am when asked about t of her review, stated that					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MU A. BUILT	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
		345429	B. WING	.	6 05/12/2011		
	ROVIDER OR SUPPLIER SOURCES - PINELAKE		STREET ADDRESS, CITY, STATE, ZIP CODE 801 PINEHURST AVENUE CARTHAGE, NC 28327				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X6) COMPLETION DATE	
F 329	pharmacists looked a and vital signs. She a an issue with BPs not resulting in two inserverors and documentate revealed that when a electronic sheets, the had discussed with the being recorded. She can audit on resident Estatement for the Clinher recommendations. During an interview of Clinical Coordinator's followed up on the pharecommendations by monitoring documentations by monitoring the nurses documentation for the linear interview on 5/1 #3 revealed that she condocumentation is a remember when. She audits of the charts for 483.35(i) FOOD PROSTORE/PREPARE/S The facility must - (1) Procure food from considered satisfactor authorities; and	It the orders, checked labs, also indicated that there was to being documented vices regarding medication ation. The Pharmacist Physician signed the y became orders and she are facility about BPs not confirmed that she had done BPs and left a general ical Coordinator regarding ical Coordina	F3		ntified, the t forth the erventions: after the	6/9/11	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING			<u>_</u>
	- -	345429	B. WING		05.	7 /12/2011
	ROVIDER OR SUPPLIER SOURCES - PINELAK		8:	EET ADDRESS, CITY, STATE, ZIP CODI 01 PINEHURST AVENUE EARTHAGE, NC 28327	E	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 371	by: Based on observa	NT is not met as evidenced tion and staff interviews the ve cold beverages in 4 of 6	F 371	noticed touc the facility st ice container scoops befor continuing to any resident 2. The staff me directly invo educated im	taff cleaned rs and ice re o serve to ss. embers lved was imediately.	
	scooping ice from I glasses and then p The ice scoop was used for pouring th residents. The ice is protected. The san again to scoop ice glasses and then p and delivering the on the 300 and 400 and at 12:44pm. Exwas set down on a white liquid was po On 5/10/11 at 12:1 observed sitting on The ice scoop was scoop ice in to glasses fill poured into them of On 5/11/11 at 11:3 taking the ice scoop container flat again	4pm the ice scoop was the lid to the ice container. taken off the lid and used to ses by 2 different aides. The on the tray which was used to ed with ice while liquid was		affected, the following completed: 1. Policies and Procregarding the stored distribution and professional procession of food; and more specifically, the hice, have been reaccuracy by the Administrator. 2. All staff have been regarding the polyprocedures related proper handling of Monitoring: All salso observed by Administrator, Di Nursing and Dietato ensure staff has complete undersithe procedure regardistribution and hice. The procedu	edures rage, preparation e andling of viewed for en educated icies and ed to the of ice. staff were rector of ary Manager as a tanding of garding nandling of	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SI COMPLE	
		·	A. BUILDING			
		345429	B. WING		05/	1 2/2011
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(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 371	poured into the glas 11:42am an aide w picking up the scoore-used for a differe a glass and then poor on 5/11/11 at 11:50 scooping ice out of glasses with ice potentially the scoot had just poured liquid served filling glas liquid and delivering residents on the 20 On 5/11/11 at 12nd aide #2 (NA) reveal have a plastic bag it to place the scoop to put ice in glasses kitchen did not send not go and get one.	glasses while liquid was uses on the 300 hall. At as observed on the 300 hall p which laye on the tray and intresident, scooping ice in to ruring liquid into the glass. It is an ice container and filling uring liquid into the glass and op down on the tray where she id into a glass. The aide was uses with ice, filling them with the glass of fluid to all to hall and on 100 hall. It is an interview with nurses used she had been trained to hanging from the ice container in it when not using the scoop is. She indicated that the did a plastic bag up and she did the ice scoop was to be	F 371	follows: During dofice, the ice scoremain on a clean in the ice with har upward with hand touching the ice. Administrator, Director and/or Dietary Manager monitor using audit tool continued compliance the comprehensive rounds. person responsible for not for compliance will obseice container on every houdit will be conducted times a day (at mealtimes 10 days and three times 20 days, thereafter. Any findings will be reported Administrator immediates staff involved will be inceducated. All audit restreviewed in QA Meeting continuation of daily rouseless of audits.	op must surface or ndle turned dle not of Nursing r will to ensure chrough Each nonitoring give each all. An three es) daily for a week for y negative if to iely and dividually ults will be g and the unds past	
	the 100 hall reveale she was trained to would find out and When asked if ever responded that she scoop in the ice be contaminations. Wh	Ipm an interview with NA#4 on d that she was not sure how use an ice scoop but that she get back with the answer. received training she then was not suppose to put the cause of cross len asking what she was to do in not using it she responded "I				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	2) MULTIPL BUILDING	E CONSTRUCTION	(X3) DATE SUF COMPLET	
		345429	В.	WING		05/1	2/2011
	OVIDER OR SUPPLIER		•	80	ET ADDRESS, CITY, STATE, ZIP CODE 1 PINEHURST AVENUE ARTHAGE, NC 28327	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID REFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 371	Continued From page do not know."	÷ 14		F 371			
	watched the NA's usi serving fluids to resid clinical coordinator st the scoop any more a instructions on how to prevent cross continuations.	m the clinical coordinator ng the ice scoop while ents on the 200 hall. The opped the NA's from using and provided them with o use the scoop in a manner amination. The clinical at all the NA's were trained and the ice scoop			-		
F 428 SS=D	483.60(c) DRUG REGIRREGULAR, ACT C	GIMEN REVIEW, REPORT		F 428	F428 Corrective Action for resident #83 and #8 is as follows: R #34, #83 and #8 have beer	esidents	6/9/11
	pharmacist. The pharmacist must the attending physici.	report any irregularities to an, and the director of ports must be acted upon.	- (assessed for any negative outcomes as a result of on physician ordered blood p There was no negative out The attending physician for resident was notified of the omitted blood pressures.	nission of ressures. come. or each	
	by: Based on record rev review and staff inter respond to Pharmaci regarding Blood Pres sampled residents. (I	ssure monitoring for 3 of 10 Resident #34, #83, #8)			For those having the pote be affected, the following completed: 1. All residents will be by the facility's pha each month, throug pharmacist's recommendations. 2. For any resident id to have a missing b pressure; the DON immediately educa	reviewed rmacist gh the lentified lood will	
	1. Resident # 34 was	admitted to the facility on					

The plantage of the second of		4'''	X3) DATE SURVEY COMPLETED				
							4 :
		345429	B. WiN	ن <u></u>		05	/12/2011
	ROVIDER OR SUPPLIER SOURCES - PINELAKE			801	ET ADDRESS, CITY, STATE, ZIP CODE 1 PINEHURST AVENUE ARTHAGE, NC 28327		-
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F 428	Hypertension and Calleft Hemiparesis. A review of the electromonth of March, April resident was being to Isosorbide 20mg daily. Was to be taken week A review of the Medic (MAR) for the months 2011 revealed that or recorded for the month 3/16/11. A review of the month of March. The MAR for April 20 was to be recorded womentation of any the month of March. The MAR for April 20 was to be recorded womentation of taken. A review of the MAR recorded blood pressure of the no diocumentation of month of May 2011. A review of the no diocumentation of month of May 2011. A review of the pharm recommendations for identified the lack of bright and the second secon	4/10 Diagnosis included radio Vascular Accident with onic physician orders for the land May 2011 revealed the eated for hypertension with y for Hypertension and Lasix Also the blood pressure kly on Wednesday. Cation administration Record of March, April and May ally one blood pressure was the of March 2011 on the vital sign sheet and the chapter of the blood pressure for the blood pressure for the entire evital sign sheet and the month of April 2011 revealed a blood pressure being for May 2011 revealed no ure from the 1st through the vital sheet record revealed a blood pressure for the a review of the nurses notes ummary dated 5/9/11 with a kl/58 recorded.	F	428	employee responsite omission. 3. In addition, all administrative nurse MDS nurse, SDC, Cli Coordinator and we nurse) will routinely to ensure that approassessment and into occurs for each resigniculate Blood Pressigniculate Blood Pressignicu	es (DON, nical und monitor opriate ervention dent to ure will be ON prior linical inator for edications and the DON at in needs to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPI LDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345429	B. WIN			05/1	₽ 2/2011
	ROVIDER OR SUPPLIER	The second state of the se	your to the second	80	EET ADDRESS, CITY, STATE, ZIP CODE 11 PINEHURST AVENUE ARTHAGE, NC 28327	1 00/1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 428	the pharmacy consul was part of her mont laboratory tests, beh have had an issue w documented. We have regarding medication have talked to the fa pressures not being audit on all the residibut I may have misse statement regarding the clinical coordinate. 5/12/11 at 10:16am a coordinator revealed each hall to follow up recommendation." We form used for the follout "I usually write or corrections." We are nurses know but we documentation for the to get the nurses to opressures.". An interview with the 5/15/11 10:30am revented on the 400 hall regard blood pressures but	ted revealed that monitoring hly; she checked for aviors and vital signs "We with the blood pressure being we done 2 in-services a errors and documentation. I cility about the blood recorded. I tried to do an ents when I was there in May ed some I left a general my recommendations with or." In interview with the clinical a manager was assigned to on pharmacy when asked if there was a low up; the response was not in the side of the form for the monitoring them and the do not have any forms or at "I know it is still a problem document the blood. DON (Director of Nurses) on realed that she did an audit ding the recording of the "I do not have documentation an in-service last month on	F	428	of Blood Pressures or ot clinical issues identified the pharmacist. 3. The pharmacist's recommendations will be discussed monthly during the administrative nurse meeting. The recommendations will be discussed the first week each month. 4. Based on the findings from pharmacist's recommendations, the Desire will determine the staff to require immediate in service education. Monitoring is as follows: Education records will be reviewed by DON each month to ensure improved compliance with blood pressure monitoring. Results will be reviewed the QA Meeting over the next three months.	e g g s s e of - oom oon hat	
	1	admitted to the facility on is that included Hypertension				·	
	A review of the elect	ronic printed physician orders					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345429	B. WING		05/1	2/2011
	OVIDER OR SUPPLIER		8	REET ADDRESS, CITY, STATE, ZIP CODE 01 PINEHURST AVENUE CARTHAGE, NC 28327	•	-
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F 428	the resident was bein with Novasc 5mg, Lo	ril and May of 2011 revealed ng treated for hypertension tensin 20mg and Lopressor ician orders stated take the	F 428			
	Record) for the mont blood pressure was r April 11th. The blood 25th were blank. A re	(Medication Administration h of April 2011 revealed the recorded on April 4th and on pressure for April 18th and eview of the vital sign sheet had no documentation of a pril 18th and 25th.				
	blood pressure for 5/ was blank. The blood documented on the N sign sheet and the n	for May 2011 revealed the 2/11, 5/16/11 and 5/22/11 dipressure due on 5/9/11 was MAR. A review of the vital urses notes revealed no slood pressure for May 2, 16				
	On 5/12/11 at 9:50ar the pharmacy consul was part of her mont laboratory tests, behave had an issue w documented. We have regarding medication have talked to the far pressures not being audit on all the reside but I may have misse	r April and May 2011 blood pressure monitoring. In a telephone interview with ted revealed that monitoring hly; she checked for aviors and vital signs "We lith the blood pressure being we done 2 in-services a errors and documentation. I				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SUF COMPLET	
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	OVIDER OR SUPPLIER		801 F	ADDRESS, CITY, STATE, ZIP CODI PINEHURST AVENUE THAGE, NC 28327	•	
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F 428	the clinical coordinate 5/12/11 at 10:16am a coordinator revealed each hall to follow up recommendation." We form used for the follo but "I usually write on corrections." We are nurses know but we o documentation for the to get the nurses to d pressures.". An interview with the 5/15/11 10:30am reve on the 400 hall regard blood pressures but "	n interview with the clinical a manager was assigned on pharmacy hen asked if there was a low up; the response was not the side of the form for the monitoring them and the do not have any forms or at "I know it is still a problem occument the blood DON (Director of Nurses) on ealed that she did an audit ding the recording of the I do not have documentation an in-service last month on	F 428			
	diagnoses that includ Diabetes Mellitus, and A review of the electroders for 3/1-3/31/20 5/1-5/31/2011 that increceiving three medic was to have Blood Prweekly on Wednesda Medication Administrativiewed for the montrevealed that BPs we 3/9/11, 3/23/11, 3/30/	onic printed Physician D11, 4/1-4/30/2011, and dicated Resident #8 was ations daily for HTN and essures (BPs) documented ys.				

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ı	ULTIPLE LDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	•	345429	B. WIN	IG		05/	12/2011
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 428	Continued From page one BP for 10/06/10.	: 19	F	428			
	weekly BPs not documented nurses were at 12:15 pm on 5/11/(DON) stated in an initial documented on the M residents on Medicare that Resident #8 was On 5/12/11 at 9:50 and the pharmacy consult was part of her month laboratory tests, behave had an issue with documented. We have regarding medication have talked to the facing pressures not being reaudit on all the reside but I may have missed	March 2011 found "many mented on March MAR." hal note dated 5/5/11 that a aware of BP needs. If the Director of Nurses terview that BPs should be IAR or in Medicare Notes for a Record review indicated not on Medicare. In a telephone interview with ed revealed that monitoring ly; she checked for viors and vital signs "We he blood pressure being a done 2 in-services errors and documentation. I will about the blood ecorded. I tried to do an interview in May disome I left a general my recommendations with					
	coordinator revealed a each hall to follow up- recommendation." Wh form used for the follo- but "I usually write on corrections." We are n nurses know but we d	ten asked if there was a w up; the response was no the side of the form for the monitoring them and the o not have any forms or t"I know it is still a problem	THE PARTY OF THE P				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ULTIPLE CONSTRUCTION DING.		(X3) DATE SURVEY COMPLETED	
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	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 801 PINEHURST AVENUE CARTHAGE, NC 28327	ATE, ZIP CODE E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETION DATE	
F 428	Continued From page pressures.".	2 20 ·	F 4	328			
	5/15/11 10:30am reve on the 400 hall regard blood pressures but "	DON (Director of Nurses) on ealed that she did an audit ding the recording of the I do not have documentation an in-service last month on them."					
	In an interview on 5/1 #3 revealed that she in on documentation " a	2/2011 at 10:50 am Nurse remembered an in-service while back, "but can't further stated "they do					
					:		
				-			
THE PERSON NAMED IN COLUMN 1							

T-424 P005/008 F-792 06-30-'11 17:21 FROM-OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING 01 - BUILDING 0101 B. WING 06/14/2011 345429 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 801 PINEHURST AVENUE **PEAK RESOURCES - PINELAKE** CARTHAGE, NC 28327 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS: REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Filing the plan of correction does not K 018 . K 018 NFPA 101 LIFE SAFETY CODE STANDARD constitute an admission that the SS=E deficiencies alleged did, in fact, exist. Doors protecting corridor openings in other than The plan of correction is filed as required enclosures of vertical openings, exits, or evidence of the facility's desire to hazardous areas are substantial doors, such as comply with the requirements and to those constructed of 1% inch solid-bonded core continue to provide high quality of wood, or capable of resisting fire for at least 20 · care. minutes. Doors in sprinklered buildings are only K018 7/29/11: required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors · The following corrections were are provided with a means suitable for keeping completed: The 100 hall supply room the door closed. Dutch doors meeting 19.3,6.3.6 door and the nourishment room door 19.3.6.3 are permitted. In the special care unit have been adjusted and both close and latch for Roller latches are prohibited by CMS regulations smoke tight seal. in all health care facilities. in regard to other potential life safety Issues, the ESD has inspected all doors . In the facility to ensure that each door does indeed close and latch for smoke tight seal. The following measures have been put in place to maintain compliance: The ESD will perform monthly inspections on each door to ensure continued This STANDARD is not met as evidenced by: compliance. Surveyor, 27871 Based on observations and staff interview at Corrective actions will be monitored by approximately 11:00 am onward, the following a review of the inspections each month items were noncompliant, specific findings: in facility's safety meeting. include: supply room door on 100 hall would not.

One hour fire rated construction (with 1/4 hour LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATORE

NFPA 101 LIFE SAFETY CODE STANDARD

close and latch and nourishment door on special care unit did not close and latch for smoke tight

Any deficiency statement ending with an esterick I denotes a deficiency which the institution may be excused from correcting providing it is detempted 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.

K 029

(X6) DATE

7/29/11

K029

The following correction was

storage door in the dietary

completed: A magnetic locking

activation of fire alarm system.

TITLE

mechanism was installed to the dry

department. The lock will release upon

seal.

K 029

SS¤E

42 CFR 483.70(a)

OMB NO, 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 - BUILDING 0101 B. WING 06/14/2011 345429 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **801 PINEHURST AVENUE PEAK RESOURCES - PINELAKE** CARTHAGE, NC 28327 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X6) COMPLETION (D (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) In regard to other potential life safety K 029 K 029 Continued From page 1 issues, all doors throughout the facility fire-rated doors) or an approved automatic fire have been inspected by the ESD for . extinguishing system in accordance with 8.4.1 compliance. and/or 19,3,5,4 protects hazardous areas. When The following measures have been put the approved automatic fire extinguishing system in place to maintain compliance: The option is used, the areas are separated from ESD will conduct a monthly inspection other spaces by smoke resisting partitions and for all doors throughout the facility to doors. Doors are self-closing and non-rated or ensure continued compliance. --field-applied protective plates that do not exceed 48 Inches from the bottom of the door are Corrective actions will be monitored by permitted. 19.3.2.1 a review of the inspections each month in facility's safety meeting. This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 11:00 am onward, the following items were noncompliant: door to dry storage room in kitchen held open with a box. 42 CFR 483,70(a) 7/29/11 NFPA 101 LIFE SAFETY CODE STANDARD K 066 ·K 066 K066 SS≍E Smoking regulations are adopted and include no The following corrections were completed: Ashtrays and a self-closing less than the following provisions: container, all which meets NFPA guidelines, were appropriately placed (1) Smoking is prohibited in any room, ward, or in the designated smoking area outside compartment where flammable liquids, of the special care unit. combustible gases, or oxygen is used or stored and in any other hazardous location, and such in regard to other potential life safety area is posted with signs that read NO SMOKING issues, the ESD has inspected all other or with the international symbol for no smoking. designated smoking areas to ensure that all preas had proper ashtrays and (2) Smoking by patients classified as not self-closing containers placed responsible is prohibited, except when under appropriately in the designated direct supervision. smoking areas.

CENTERS FOR MEDICARE & MEDICAID SERVICES

- CIVINI UL I 1/07 X F.D. OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - BUILDING 0101 B. WING 345429 06/14/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **801 PINEHURST AVENUE PEAK RESOURCES - PINELAKE** CARTHAGE, NC 28327 SUMMARY SYATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 066 Continued From page 2 K 066 The following measures have been put (3) Ashtrays of noncombustible material and safe in place to maintain compliance: design are provided in all areas where smoking is Education will be provided to staff that permitted. ... the appropriate materials, i.e., proper ashtrays and self-closing container (4) Metal containers with self-closing cover must be readily accessible and devices into which ashtrays can be emptied are appropriately placed at all-designated readily available to all areas where smoking is smoking areas. The ESD and the permitted. .. 19.7.4 Administrator will conduct weekly inspections to ensure continued compliance. Corrective actions will be monitored by weekly inspections being reviewed in This STANDARD is not met as evidenced by: the facility's monthly safety meetings. Surveyor: 27871 Based on observations and staff interview at approximately 11:00 am onward, the following Items were noncompliant: sitting area out of special care unit has excessive amounts of 7/29/11 X104 cigarette butts on ground. Facility had proper ashtrays and self-closing container. However they The following correction was were hidden on side of building. completed: The return damper in duct in smoke barrier wall on 100 Hall has 42 CFR 483,70(a) been serviced and is working properly. K 104 NFPA 101 LIFE SAFETY CODE STANDARD K 104 in regard to other potential life safety SS≂E Penetrations of smoke barriers by ducts are issues, the ESD has inspected the entire protected in accordance with 8.3.6. duct system to determine that all smoke dampers work properly. The following measures have been put in place to maintain compliance: The ESD will conduct a monthly inspection of all ducts to ensure continued This STANDARD is not met as evidenced by: compliance. Surveyor: 27871 Based on observations and staff interview at Corrective actions will be monitored by approximately 11:00 am onward, the following

items were noncompliant; return damper in duct

review of the inspections each month

in the facility's monthly safety meeting.

CENTE	RS FOR MEDICARE	& MEDICAL	D SERVICES				OMB NO.	0938-0391	
STATEMEN' AND PLAN C	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER	RISUPPLIER/CLIA ATION NUMBER:		MULTI JILOIN	TIPLE CONSTRUCTION NG 01 × BUILDING 0101	(X3) DATE SURVEY COMPLETED		
		.	345429	B. WI	ING _	•	06/1	3/14/2011	
NAME OF PROVIDER OR SUPPLIER				J.		REET ADDRESS, CITY, STATE, ZIP COD			
PEAK RESOURCES - PINELAKE				CARTHAGE, NC 28327	••				
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	42 CFR 483.70(a)	•							
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW REHAB ADDITION			(X3) DAYE SURVEY COMPLETED	
	•	345429	B. WII	NG		06/1	4/2011
	PROVIDER OR SUPPLIER ESOURCES - PINELA	KE		801	et address, city, state, zip code I pinehurst avenue IRTHAGE, NC 28327		
(X4) ID PREFIX YAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREP TAG		PROVIDER'S PLAN.OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	, (x6) COMPLETION DAYE
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•	42 CFR 483.70(a)				77.00		
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LABORATOR'	Y DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESIONTATIVE'S SIG	NATURE		YITLE A	,	(X6) DATE
<i>y</i>	5. 0	//			W	. 61	70/11

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.