DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/29/2011 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION 2017 (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 345111 12/15/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **600 EAST RHODE ISLAND AVENUE** PENICK VILLAGE SOUTHERN PINES, NC 28387 SUMMARY STATEMENT OF DEFICIENCIES (X4) JD PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 156 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF This corrective action plan will serve F 156 SS=C RIGHTS, RULES, SERVICES, CHARGES as Penick Village's allegation of compliance with the requirements of The facility must inform the resident both orally 42 CFR, Part 483, Subpart B for and in writing in a language that the resident understands of his or her rights and all rules and long-term care facilities as of January regulations governing resident conduct and 7, 2012. responsibilities during the stay in the facility. The facility must also provide the resident with the Administrator notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the F156 A posting of names, addresses resident's stay. Receipt of such information, and 12/15/11 any amendments to it, must be acknowledged in and telephone numbers to pertinent writing. State client advocacy groups was posted on 12/15/11 as soon as it was The facility must inform each resident who is brought to the facility's attention. entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the An updated posting with names, resident becomes eligible for Medicaid of the 1/6/12 addresses and telephone numbers to items and services that are included in nursing facility services under the State plan and for pertinent State client advocacy which the resident may not be charged; those groups was posted on 1/6/12. other items and services that the facility offers and for which the resident may be charged, and Social Worker to review postings the amount of charges for those services; and 1/6/12 inform each resident when changes are made to monthly basis for the next three the items and services specified in paragraphs (5) months and quarterly for the next (i)(A) and (B) of this section. nine months for current and accurate information and update as necessary. The facility must inform each resident before, or Any updates will be reviewed with at the time of admission, and periodically during Residents and Families. Results to the resident's stay, of services available in the facility and of charges for those services. be reported to Quality Assurance including any charges for services not covered Committee on a quarterly basis over under Medicare or by the facility's per diem rate. the next 12 months.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

legal rights which includes:

The facility must furnish a written description of

Administrator

(X6) DATE

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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		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l		PLE CONSTRUCTION	(X3) DATE	NO. 0938-0391 SURVEY LETED
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l			345111	B. WA	lG		1:	2/15/2011
	NAME OF P	ROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE		
	PENICK V	/ILLAGE			1	500 EAST RHODE ISLAND AVENUE		
	OVA ID	CHIMADVOTA	TENENT OF PERIOD VOICE			SOUTHERN PINES, NC 28387		
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		A description of the mapersonal funds, under section; A description of the rector establishing eligibilithe right to request an 1924(c) which determine non-exempt resources institutionalization and spouse an equitable sheannot be considered at toward the cost of the immedical care in his or his down to Medicaid eligible. A posting of names, adnumbers of all pertinent groups such as the State agency, the State licens	paragraph (c) of this quirements and procedures ty for Medicaid, including assessment under section nes the extent of a couple's at the time of attributes to the community hare of resources which available for payment nstitutionalized spouse's er process of spending sility levels. dresses, and telephone a State client advocacy the survey and certification stare office, the State	F	156			
	in the second se	ombudsman program, to advocacy network, and unit; and a statement the complaint with the State agency concerning residuality, and non-compliadirectives requirements. The facility must comply specified in subpart I of pelated to maintaining we procedures regarding acceptivements include procedure written informatical and very covide written in	the protection and the Medicaid fraud control at the resident may file a survey and certification dent abuse, neglect, and dent property in the since with the advance with the requirements part 489 of this chapter ritten policies and twance directives. These positions to inform and on to all adult residents except or refuse medical I, at the individual's					

		1				UIND I	<u>(O. 0936-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE S COMPLE	
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NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
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WAID	CHAMADV CT	ATEMENT OF DEFICIENCIES	1 .		SOUTHERN PINES, NC 28387		
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			1				
F 156	Continued From page	2	F	156			
	includes a written des	cription of the facility's					
		advance directives and					
	applicable State law.						
	The facility must inforr	n each resident of the					
	name, specialty, and v	vay of contacting the				,	
	physician responsible	for his or her care.	ĺ				
	The facility must promi	inently display in the facility					
	written information, an	d provide to residents and					
	applicants for admission						
	information about how Medicare and Medicaid						
		vious payments covered by					
	such benefits.	, , , , , , , , , , , , , , , , , , , ,		Į			
	This REQUIREMENT	is not met as evidenced					
1	by:						
Ì	Based on observation,			Ì			
		alled to maintain current					
1	state agency contact in	ioination,		j			
-	The findings include:	;					
1.	On 12/15/11 at 8:45 am	Resident # 55 was					
	interviewed about her F			ı			
		d that she was admitted to					
	he facility during March						
	egularly attended their	meetings and was an red that she wasn't sure if					
		about the state contact					
		sure where it was located.					
1	On 12/15/11 at 9:20 am	, the Administrative Staff					
#	5 was interviewed. Sh	e stated that as a staff					
	nember, she assisted ti					ļ	
ìo	onducting their monthly	v meetings. She relaved		- 1			1

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	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	OLTIPLE CONSTRUCTION DING	(X3) DATE	<u>IB NO. 0938-0391</u> TE SURVEY MPLETED	
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	F PROVIDER OR SUPPLIER K VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 600 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387		10/2011	
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F 286 SS=C	that during the meetin residents important intrights and advocacy or including contacting the mentioned that the infer hallways, near the number office door. On 12/15/11 at 9:25 are information was review posting contained refer as The Division of Faci contained phone number number of the second prior to July, 2007. On 12/15/11 at 9:35 are #6 was alerted to the stander of the second prior to July, 2007. On 12/15/11 at 9:35 are #6 was alerted to the stander of the second prior to July, 2007. A facility must determine the state agency and stander and update the 483.20(d) MAINTAIN 18 RESIDENT ASSESSME. A facility must maintain completed within the president's active record. This REQUIREMENT is by: Based on record review facility failed to ensure the Set) assessments were set.	gs, she would discuss with formation about resident ontact information, e state agency. She ormation was posted in the se's stations and outside of the state agency contact red. It revealed that their rences to the state agency lity Services and it pers and addresses to the e and certification branch, at department that were to the sign on the ground count of the sign of the	F 18		tial to be	1/12/12	

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE S COMPLE	
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1	PROVIDER OR SUPPLIER VILLAGE			51	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST RHODE ISLAND AVENUE OUTHERN PINES, NC 28387	1 2	10/2011
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F 286	residents. The finding 1. Resident #62 was a OB/15/11. Review of the an admission MDS as and a quarterly MDS at These assessments of 29-33 of the assessments of 29-33 of the assessments of 12/14/11 at 10:55 A was interviewed. She print pages 1-4 and 29 the chart (current assessments of the MDS use the computer in he staff #1 further stated the were the only staff mentice the computer. She staff was a computer was a c	distribute: admitted to the facility on the resident's chart revealed sessment dated 08/22/11 assessment dated 10/12/11. Ontained pages 1-4 and onts. AM, Administrative staff #1 stated that she was told to -33 and to keep them in assment) and in the file ated that if you want to see assessment, you have to roffice. Administrative	F	286	All future MDS's and CAA's printed until new software AOD is implement. AOD s will have MDS's as part of elemedical record. Medical record consultant to charts monthly for the nex months and quarterly for the nine months for MDS prese resident charts and to report re Quality Assurance Commit quarterly meeting for the months.	system oftware ectronic review t three ne next nce on sults to tee at	1/12/12
	was interviewed. She st print pages 1-4 and 29-3 the chart (current assess cabinet. She further state	e resident's records DS assessment dated Quarterly MDS ne file cabinet dated These assessments d 29-33 of the M, Administrative staff #1 nated that she was told to 33 and to keep them in					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SI COMPLE	
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NAME OF PR	ROVIDER OR SUPPLIER			50	REET ADDRESS, CITY, STATE, ZIP CODE 00 EAST RHODE ISLAND AVENUE COUTHERN PINES, NC 28387		
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F 286	use the computer in he staff #1 further stated were the only staff me the computer. She sta	or office. Administrative that the 2 MDS Nurses mbers who have access to ated that MDS assessments computers at the nurse's	F	286			
-	12/18/08. Review of th revealed an annual ME 10/11/11. In the file ca quarterly MDS assessi 04/26/11 found. These pages 1-4 and 29-33 o	DS assessment dated abinet, there were 2 ments dated 07/18/11 and e assessments contained of the assessments. The essments) were also not	Transferred Admin Transferred	***************************************			
	was interviewed. She aprint pages 1-4 and 29- the chart (current asse- cabinet. She further sta all sections of the MDS CAAs, you have to use Administrative staff #1 to MDS Nurses were the co	ated that if you want to see assessment including the the computer in her office. further stated that the 2 only staff members who aputer. She stated that the not loaded in the					
1	assessment dated 08/0 vere 1 significant chang	resident's records Minimum Data Set (MDS) 1/11. In his chart, there		***************************************			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l · ·	ULTIPL LDING	E CONSTRUCTION	(X3) DATE S COMPLE	
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was interviewed. She si print pages 1-4 and 29-3 the chart (current assess cabinet. She further state all sections of the MDS at CAAs, you have to use the Administrative staff #1 fut MDS Nurses were the on have access to the computers at the nurse's 5. Resident # 25 was add 7/26/11. Review of the refrevealed an admission Massessment dated 08/01 were 1 significant change	hese assessments d 29-33 of the s (Care Area o not found in the M., Administrative staff #1 tated that she was told to 33 and to keep them in sment) and in the file led that if you want to see assessment including the lither computer in her office. The computer in her office. The computer in her office. The stated that the 2 lither stated that the 2 lither stated that the stations. In the facility on esident's records finimum Data Set (MDS) /11. In her chart, there is MDS assessment arterly MDS assessment lates assessments 129-33 of the (Care Area lither in the most of the station of the most of th	F	286			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/29/2011 FORM APPROVED 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 B. WING 345111 12/15/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 EAST RHODE ISLAND AVENUE PENICK VILLAGE** SOUTHERN PINES, NC 28387 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 7 F 286 F 286 Administrative staff #1 further stated that the 2 MDS Nurses were the only staff members who have access to the computer. She stated that MDS assessments were not loaded in the computers at the nurse's stations. 6. Resident #7 was admitted to the facility on 3/30/11. Review of the resident's records revealed an admission Minimum Data Set (MDS) assessment dated 04/12/11 and 2 quarterly MDS assessments dated 07/06/11 and 09/27/11 found. These assessments contained pages 1-4 and 29-33 of the assessments. The CAA (Care Area Assessments) were also not found in the resident's records. On 12/14/11 at 10:55 AM, Administrative staff #1 was interviewed. She stated that she was told to print pages 1-4 and 29-33 and to keep them in the chart (current assessment) and in the file cabinet. She further stated that if you want to see all sections of the MDS assessment including the CAAs, you have to use the computer in her office. Administrative staff #1 further stated that the 2 MDS Nurses were the only staff members who have access to the computer. She stated that MDS assessments were not loaded in the computers at the nurse's stations. 7. Resident # 37 was admitted to the facility on 06/29/11. Review of the resident's records revealed an admission Minimum Data Set (MDS) assessment dated 07/06/11 and one quarterly MDS dated 10/03/11 found. These assessments contained pages 1-4 and 29-33 of the assessments. The CAA (Care Area Assessments) were also not found in the

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE (COMPL	
		345111	B. WI	ю <u></u>		12	/15/2011
NAME OF P	ROVIDER OR SUPPLIER			50	EET ADDRESS, CITY, STATE, ZIP CODE 00 EAST RHODE ISLAND AVENUE OUTHERN PINES, NC 28387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	was interviewed. She print pages 1-4 and 29 the chart (current asse cabinet. She further stall sections of the MDS CAAs, you have to use Administrative staff #1 MDS Nurses were the have access to the corn MDS assessments were computers at the nurse 8. Resident # 34 was a 07/25/11. Review of the revealed an admission dated 08/01/11 and 1 q 10/26/11 found. These pages 1-4 and 29-33 of CAA (Care Area Assessment of the resident's revealed an admission dated 08/01/11 at 10:55 A was interviewed. She sorint pages 1-4 and 29-the chart (current assessments were cabinet. She further statall sections of the MDS CAAs, you have to use administrative staff #1 fereigness and the chart (current assessments were the manual sections of the MDS CAAs, you have to use administrative staff #1 fereigness and the chart (current assessments were the control of the con	AM, Administrative staff #1 stated that she was told to 1-33 and to keep them in resment) and in the file ated that if you want to see 3 assessment including the 4 the computer in her office. 5 further stated that the 2 only staff members who reputer. She stated that the not loaded in the 1's stations. I dmitted to the facility on the resident's records Minimum Data Set (MDS) uarterly MDS dated assessments contained 1 the assessments. The sments) were also not the assessments was told to 33 and to keep them in sment) and in the file the that if you want to see assessment including the the computer in her office. The stated that the 2 only staff members who puter. She stated that the tot loaded in the the stations. Itted to the facility on	F	286			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING B. WING 345111 12/15/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE PENICK VILLAGE SOUTHERN PINES, NC 28387 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 9 F 286 revealed a quarterly MDS assessment dated 9/9/11 and a quarterly assessment dated 12/1/11. There was an admission MDS assessments found in the file cabinet dated 8/23/11. These assessments contained pages 1-4 and 29-33 of the assessments. The Care Area Assessments (CAA) were not found in the resident's records. On 12/14/11 at 10:55 AM, Administrative staff #1 was interviewed. She stated that she was told to print pages 1-4 and 29-33 and to keep them in the chart (current assessment) and in the file cabinet. She further stated that if you want to see all sections of the MDS assessment including the CAAs, you have to use the computer in her office. Administrative staff #1 further stated that the 2 MDS Nurses were the only staff members who have access to the computer. She stated that MDS assessments were not loaded in the computers at the nurse's stations. 10. Resident #32 was admitted to the facility on 8/16/08 and readmitted on 9/28/11. Review of the resident's records revealed an annual MDS assessment dated 9/6/11 amd a quarterly MDS assessment dated 11/29/11. There were 3 quarterly MDS assessments found in the file cabinet dated 1/14/11, 3/31/11 and 6/27/11. There was also an annual MDS dated 10/15/10. These assessments contained pages 1-4 and 29-33 of the assessments. The Care Area Assessments (CAA) were not found in the resident's records. On 12/14/11 at 10:55 AM, Administrative staff #1 was interviewed. She stated that she was told to print pages 1-4 and 29-33 and to keep them in the chart (current assessment) and in the file

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII	ULTIPLE CONSTRUCTION LDING	•	(X3) DATE SU COMPLE	
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	cabinet. She further s all sections of the MD CAAs, you have to us Administrative staff #/ MDS Nurses were the have access to the co MDS assessments we computers at the nurs 11. Resident # 26 wa 11/15/2011. A review revealed an Admission dated 11/26/11. The a pages 1-4 and pages / Assessments (CAA) we resident's records. On 12/14/2011 at 10:5 #1 was interviewed. S for print pages 1-4 and them in the chart (currefile cabinet. She further to see all the sections you had to use the computer assessments were not the nurse's stations. 12. Resident #50 was 2/30/2010. A review of medical record revealer in the contained pages 1-4 and pages 1-4 and muraterly MDS dated 1 contained pages 1-4 and pages	tated that if you want to see S assessment including the te the computer in her office. If further stated that the 2 to only staff members who imputer. She stated that tere not loaded in the te's stations. Is admitted to the facility of the resident's chart of Minimum Data Set (MDS) tassessment contained 29-33. The Care Area tere not found in the Is AM., Administrative staff the stated that she was told pages 29-33 and to keep tent assessment) and in the ter stated that if you wanted of the MDS assessment, inputer in her office. Is stated that the two MDS taff members who had of the Stated that MDS loaded in the computers at admitted to the facility of the resident's chart and d a Quarterly MDS dated S dated 8/8/11 and a 1/7/11. The assessments	F	286			

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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 B. WING_ 345111 12/15/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 EAST RHODE ISLAND AVENUE** PENICK VILLAGE SOUTHERN PINES, NC 28387 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 286 | Continued From page 11 F 286 #1 was interviewed. She stated that she was told to print pages 1-4 and pages 29-33 and to keep them in the chart (current assessment) and in the file cabinet. She further stated that if you wanted to see all the sections of the MDS assessment, you had to use the computer in her office. Administrative staff #1 stated that the two MDS nurses were the only staff members who had access to the computer. She stated that MDS assessments were not loaded in the computers at the nurse's stations. 13. Resident #64 was admitted to the facility on 10/13/2011. A review of the resident's chart revealed an Admission MDS dated 10/20/11. The assessment contained pages 1-4 and pages 29-33. The Care Area Assessments (CAA) were not found in the resident's record. On 12/14/2011 at 10:55 AM., Administrative staff #1 was interviewed. She stated that she was told to print pages 1-4 and pages 29-33 and to keep them in the chart (current assessment) and in the file cabinet. She further stated that if you wanted to see all the sections of the MDS assessment. you had to use the computer in her office. Administrative staff #1 stated that the two MDS nurses were the only staff members who had access to the computer. She stated that MDS assessments were not loaded in the computers at the nurse's stations. 14. Resident # 2 was admitted to the facility on 6/14/2011. A review of the resident's chart revealed an Admission MDS dated 6/21/2011 and a Quarterly MDS dated 9/9/11. The assessments contained pages 1-4 and pages 29-33. The Care Area Assessments (CAA) were not found in the

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NAME OF P	ROVIDER OR SUPPLIER		1	51	REET ADDRESS, CITY, STATE, ZIP CODE 600 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387		1078017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ACTION SHOULD BE TO THE APPROPRIATE	
	#1 was interviewed. So to print pages 1-4 and them in the chart (currifile cabinet. She furthed to see all the sections you had to use the corn Administrative staff #1 nurses were the only saccess to the compute assessments were not the nurse's stations. 15. Resident # 44 was 5/7/2010. A review of the nurse's stations. 15. Resident # 44 was 5/7/2010. A review of the nurse's stations. 16. Resident # 44 was 5/7/2010. A review of the nurse's stations. 17. Resident # 44 was 5/7/2010. A review of the nurse's stations. 18. Resident # 44 was 5/7/2010. A review of the nurse's records reveal Data Set (MDS) dated assessment dated 5/10	is AM., Administrative staff the stated that she was told pages 29-33 and to keep ent assessment) and in the er stated that if you wanted of the MDS assessment, inputer in her office. It is stated that the two MDS taff members who had entered in the computers at admitted to the facility the resident's chart and end an annual Minimum (2/17/11, a Quarterly (1/11, a Quarterly (1/11), a Quarterly (1/12), and a Quarterly (1/13), and a Quarterly (1/14), and a Quarterly (1/15/11). The assessments and pages 29-33. The Care (1/14), and an annual matter (1/14) and a Quarterly (1/15/11), and a Quart	F	286			

		MEDIOAID OLIVIOES	<u> </u>			OMB N	<u>IO. 0938-039</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ULTIPLE CONSTRUCTION DING		(X3) DATE S COMPLE	
		345111	B. WING	3	_	12/	15/2011
NAME OF P	ROVIDER OR SUPPLIER VILLAGE			STREET ADDRESS, CITY, STATE, 500 EAST RHODE ISLAND AT SOUTHERN PINES, NC 28	VENUE	<u> [21</u>	19/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PI (EACH CORRECTI CROSS-REFERENCI	LAN OF CORRECTION	BE	(X5) COMPLETION DATE
F 329 SS=E		MEN IS FREE FROM IGS	F 3:	F329 Resident # obtained and was			12/15/11
	unnecessary drugs. A drug when used in exc duplicate therapy); or f without adequate moni indications for its use; o	which indicate the dose iscontinued; or any		preparations. X n	s to determine thyroid hor with the hor with hor with the	who mone idents mone	1/6/12
	who have not used anti- given these drugs unles therapy is necessary to as diagnosed and docur record; and residents wi drugs receive gradual de behavioral interventions	st ensure that residents psychotic drugs are not es antipsychotic drug treat a specific condition mented in the clinical ho use antipsychotic ose reductions, and		TSH level will be the consultant pha of the first drug following admission within the past accepted clinical within 90 days therapy and every otherwise ordered by	rmacist at the regimen regimen regimen regimen regime, if not obtain 12 months standards of initiation 12 months u	e time eview ained per and n of nless	1/6/12
T b F	This REQUIREMENT is y: Based on record review acility failed to monitor th	and staff interview, the ne TSH (Thyroid /el for 1 (Resident #62)		Consultant pharms findings related to preparations and monthly for the n and quarterly there six months with Nursing. Results quarterly QA meet months.	thyroid horr TSH monitor ext three monafter for the the Director to be share	none oring on the next of d at	1/6/12
	esident # 62 was admitt e hospital on 08/15/11 v	led to the facility from with multiple diagnoses					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLET	
		345111	B. WIN	IG		12/1	5/2011
NAME OF PE	ROVIDER OR SUPPLIER		• • • • • • • • • • • • • • • • • • • •	5	REET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	in an independent livir hospitalization. The qualitation of the physicial 2011 revealed an order (microgram) by mouth and to check TSH lever (February/August). The facility's policy on Laboratory Determinate reviewed. The policy including T-4 and TSH therapy and every 12 including T-4 and TSH including TSH inclu	ism. Resident #62 was living an apartment prior to parterly MDS assessment led that Resident #62 had making problems. In sorders for December, ar for Synthroid 75 mcg daily for Hypothyroidism led every 6 months "Recommended ion" (undated) was read in part "Thyroid panel 1, 90 days after the start of months". Is records and the hospital port for TSH level. 2's weights revealed that m admission. He weighed 1/22/11, 173 lbs on 10/07/11, 166 lbs on in 12/07/11. An administrative nurse #4 inistrative Nurse #1 stated istanding orders or policy to further stated that labs is order. He also stated the itesident #62 was not due ordered. When asked, he now when the resident had if and when was the last		329			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE S COMPLE	
		345111	B. WNG_		12/	15/2011
ļ	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
SS≃D	On 12/14/11 at 5:25 If interviewed. He state monitoring the TSH is Synthroid was every stated that the doctor TSH every 6 months not due until February stated that he did not resident had started to when the last time TS Resident #62. He also and the hospital had resident #62. 483,25(m)(1) FREE ORATES OF 5% OR Mill The facility must ensure medication error rates. This REQUIREMENT by: Based on observation interviews, the facility free medication error rate by 4 errors out of 70 or resulting in an error rate residents observed dur (Residents #18, #1, an include: 1. Resident #18 was acon/1/05/11 with multiple of cerebrovascular accidents documents accidents	PM, the pharmacist was ad that the facility's policy in evel for residents on 12 months. He further had ordered to check the for Resident #62, so it was 7, 2012. When asked, he know as to when the aking the Synthroid and H was checked for a stated that he checked to records of TSH level for F MEDICATION ERROR ORE The that it is free of of five percent or greater. Is not met as evidenced as than 5% as evidence	F 332	F332 Resident #18 EC AS was changed to ASA 81 medication may be crushed. Consultant pharmacist reviresidents to determine who aspirin therapy. The XX mesidents who are receiving therapy were reviewed to excorrect dosage form (oversus non-crushable) was used. Director of Nursing and Contract of Pharmacist conducted in-ser	ewed all o was on umber of g aspirin usure the crushable is being onsultant vices for egarding	1/5/12
	1. Resident #18 was ac 01/05/11 with multiple o cerebrovascular accide	diagnoses including CVA		LPN's and RN's r appropriate crushing of med	egarding	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S COMPLE	
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PENICK V	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP COD 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387	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 OF C (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(XS) COMPLETION DATE
	2011 revealed that Resident #18 had a doctor's order for "ASA (aspirin) 81 mgs EC (enteric coated) 1 tablet by mouth daily - do not crush, starting 01/05/11 for CVA. On 12/14/11 at 8:40 AM, Nurse # 1 was observed to prepare and to administer Resident #18's medications. Nurse #1 was observed to crush the resident's medication including ACASA and		F 332	med passes on each sh for the next three mon one per shift per quarter nine months. Results with Director of Nursin quarterly 2012 Quality Meetings.	at least one ift per month ths and then r for the next to be shared ag and at the y Assurance	1/12/12
	On 12/14/11 at 8:50 A interviewed. Nurse #1 not know that ACASA	nistered them with apple sauce. 2/14/11 at 8:50 AM, Nurse #1 was riewed. Nurse #1 acknowledged that she did now that ACASA could not be crushed.		"Rinse mouth after use" MAR entry for ADV on Resident #1. Consultant pharmacist physician orders to de	AIR DISCUS reviewed all stermine who	12/15/11
	3/6/09 and had cumula	and had cumulative diagnoses that chronic obstructive pulmonary disease		was on steroid inhalers no other residents util steroid therapy.		War of the latest and
1	Review of the Prescribing Information for ADVAIR DISKUS from the manufacturer dated January 2011 and revised 09/11 revealed, in part, "Indications and Usage", "Maintenance treatment of airflow obstruction and reducing exacerbations in patients with chronic obstructive pulmonary disease (COPD)." Under "Warnings and Precautions" it read, in part, "Localized infections: Candida albicans infection of the mouth and throat may occur. Monitor patients periodically for signs of adverse effects on the oral cavity. Advise patients to rinse the mouth following inhalation." Under the heading Instructions for Using ADVAIR DICKUS "it read, in part, "Rinse your mouth with water after preathing in the medicine. Spit the water out. Do not swallow."			Director of Nursing an pharmacist conducted in appropriate steroid inh mouth rinsing for LPN's	n-services on aler use and	12/16/11
F C C n r r				Director of Nursing medication pass for steroid inhaler use and m	appropriate	12/16/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE	SURVEY LETED	
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NAME OF P			3	STREET ADDRESS, CITY, STATE, ZIP COI 600 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387		2/15/2011
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	2011 revealed that Re order for "Advair 250 orally every 12 hours resident's diagnosis in was COPD. On 12/15/11 at 8:28 A to prepare and to adm medications. When ac Nurse #2 was observe breathe out and then s 250-50 discus (prepare resident's mouth. The breathe in and hold her Nurse #2 then provided drink. Resident #1 was	an's orders for December, esident #1 had a doctor's 0-50 diskus inhale 1 puff " dated 3/6/09. The adicating this medication M, Nurse #2 was observed inister Resident #1's dministering the Advair, and to have the resident	F 33	med passes on each sl for the next three mo one per shift per quart nine months. Also consultant to review pharmacy review to as	at least one nift per month that and then er for the next so pharmacy on monthly sure accuracy administration to be shared and at the y Assurance al Spray for ed by nurse	
ir n re th co N ac do do 3.	ot know that after admesident's needed to be neir mouth. The Product ontaining the Advair Discrete #2 and she read divising patients to rinst dministration. Nurse #5 this in future. Resident #1 was admesored and had cumulaticluded chronic obstruction.	acknowledged that she did sinistration of Advair, instructed to rinse out act insert in the box iskus was then reviewed the section regarding their mouth following then stated she would sitted to the facility on the diagnoses that tive pulmonary disease		Consultant pharmacist in physician orders to assorders were clear and the nasal spray instructions. Director of Nursing and Pharmacist conduced inappropriate clarification instructions nasal sprays and RN's was held.	consultant services on	1/6/12
Re	view of the Prescribing	g Information for Atrovent				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		URVEY TED
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PENICK \ (X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		REET ADDRESS, CITY, STATE, ZIP COD 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387 PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE	CORRECTION ON SHOULD BE	(X5) COMPLETION DATE
	F 332 Continued From page 18 Nasal Spray from the manufacturer, revised 7/11, revealed the indication for the Atrovent is "rhinitis" (runny nose). Review of the physician's orders for December, 2011 revealed that Resident #1 had a doctor's order for "atrovent 0.06% 2 sprays in nose twice a day". There was no indication for the medication noted with the order. The order did not specify if the spray was to be administered as one spray per nostril for a total of two sprays in the nose, or if it was intended to be two sprays in each nostril.		F 332	Pharmacy consultant consultant to observe med passes on each shi for the next three mon one per shift per quarter nine months. Results with Director of Nursin quarterly 2012 Quality Meetings. All residents are potent by this practice.	and/or RN at least one off per month the and then r for the next to be shared ag and at the y Assurance ially affected and Pharmacy	1/12/12
t the transfer of the transfer	to prepare and to admirmedications. When ad Nasal Spray 0.06%, Nugive 2 sprays in each noterview with Administrat 10:30 AM revealed it he order for Atrovent 2 pe clarified, to specify hose given in each nostril. Telephone interview with an 12/23/11 at 1:20 PM lilergy symptoms and the pray was originally order. Resident #70 was ad 1/30/11 with multiple dictionary artery disease orillation.	ministering the Atrovent are #2 was observed to ostril. rative Staff #6 on 12/15/11 was her expectation that sprays in the nose would ow many sprays should h Administrative Nurse #4 revealed the resident had not the Atrovent nasalered on 3/6/09. mitted to the facility on agnoses including (CAD) and atrial		Consultant held in-serve LPN's and RN's on the of Medication Administration Pharmacy consultant consultant to observe med passes on each shi for the next three montone per shift per quarter nine months. Results with Director of Nursin quarterly 2012 Quality Meetings.	and/or RN at least one ft per month ths and then for the next to be shared g and at the	1/5/12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
		345111	B. WING	· · · · · · · · · · · · · · · · · · ·	12/15/2011	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (FIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X6) COMPLETION DATE
F 371 SS=E	doctor's order for "St ASA acetylsalicylic ac 2 tabs (tablets) po qd Review of the medical indication for this mediagalnst thromboembol On 12/15/11 at 8:38 Al to prepare and to admi medications. Nurse #1 ASA into the medicatio she said "enteric coat dispensed the medicati it read "81 mg chewal was shown that the bot was asked if a chewable enteric coated, she staf another bottle of ASA ir was enteric coated. As looked in the medication different bottle of ASA to the medication different coated ASA into 483.35(I) FOOD PROCESTORE/PREPARE/SEF	art EC (Enteric Coated) id 81 mg (milligrams) take (by mouth every day). " record revealed the ication was prophylaxis of ic events. M, Nurse #2 was observed inister Resident #70's I was observed to dispense in cup. While she did this ed. " The bottle the nurse ion from was observed and ible. " When Nurse #2 tile read " chewable " and ie medication could be ied that maybe there was in the medication cart that she said this Nurse #2 in cart and found a that was observed to read '. Nurse #2 then ASA and dispensed the the medication cup. URE, RVE - SANITARY	F 37	F371 All items that were r were discarded. All items in	or labels tem that i. ed items Standard all items ontainer d dated ems not	12/12/11

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Į · ·	(X2) MULTIPLE CONSTRUCTION A. BUILDING		urvey Eted
		345111	B. WING	B. WING		15/2011
NAME OF PR	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP COD 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
i 14 A P P U U U U U U U U U U U U U U U U U	by: Based on observation facility failed to mainta kitchen by not ensurin items were dated and four (4) cases of food if floor in the walk-in free expired quart of whole scoop was secured han to using utensils to pitchey placed food on renot removing contaminands and applying neresumption of food tray included: During the tour of the Administrative staff #2 and and undated, one package in labeled and undated, and undated, and undated, a metal paream dessert unlabeled rapped in plastic container of frozen eggindated; in the walk-in fivealed and undated	is not met as evidenced and staff interview, the sin sanilary conditions in the g opened and sealed food labeled; by not ensuring items were stored off the ezer, by not discarding an milk; by not ensuring a ndle up in the flour bin; by ck up prepared food when sidents' plates and by staff sated gloves, washing w gloves prior to r preparation. Findings e kitchen with on 12/12/2011 at 11:00 e refrigerator revealed one ss cheese unlabeled and of cheddar cheese slices y of a red pepper n (10) slices of cooked ic undated, a small bowl ucumber and one slice of c undated, two plates with d on each plate unlabeled an ½ full of chocolate d and undated, ½ bag of , one slice of ham seled and undated, one substitute opened and reezer, observations	F 37'	Director of Dining Certified Dietary Managan in-service was concerned became 14, 2011 with dining service staff to and dating standards. The Certified Dietary designee will inspect ite and freezers at least week adherence to this policy, an ongoing procedure compliance. Results the with the Dining Service at the Quality Assurant quarterly meeting for months. All four cases removed and shelved.	Services and ger conducted onducted on ith all North review label Manager or ms in coolers ekly to assure to be shared Director and nee Meeting the next 12 from floor exers were of Dining being stored ervices and Manager of all North of items to be at least	12/14/11 12/14/11 12/12/11 12/12/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345111	B. WING		12	15/2011	
PENICK \		STATEMENT OF DEFICIENCIES		TREET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387 PROVIDER'S PLAN OF CO	E		
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
th s	glass of orange bevin the freezer and moby a worker. 2. During a tour of the state of the state of the expiration date of 12/stated the expired midiscarded. 4. On 12/14/11 at 4:5 or expering meal. At 4:5 or expering meal. At 4:5 or expering meal another of the state of the state of the control of the state of the state of the expiration date of 12/stated the expired midiscarded. 4. On 12/14/11 at 4:5 or expering meal. At 4:5 or expering meal another of the state of	ated. He further stated the erage should not have been just have been placed there the freezer 12/12/2011 at as of opened supplement noted on the floor of the live staff #2 stated the boxes in the shelf and not on the shelf and not on the staff whole milk with an 13/11. Administrative staff #2 lik should have been 155 PM., kitchen staff was esident food trays for the 55 PM., staff #1 placed plate with her gloved hand. In plate and began to put her container holding the stated she usually used did the vegetable sticks but and any to use. At 5:00 PM, I sprouts on a plate, then	F 37	The Certified Dietary designee will inspect iter and freezers at least wee proper storage. This will process. Results to be the Dining Service Dirthe Quality Assurant quarterly meeting for months. The quart of whole discarded by Director Services. All items in coolers a were inspected for expirity by Director of Dining Services. An in-service was condu Director of Dining Services.	Manager or ms in coolers all an ongoing shared with ector and at the Meeting the next 12 milk was of Dining and freezers ration dates rvices. Anytioned was of Dining and anager on h all North to review is.	1/9/12 12/14/11 12/14/11 12/14/11	
S T n tu	used her gloved hand, picked up one brussel sprout and moved it to another area on the plate. Throughout the tray line serving, wait staff #1 did not change her gloves and alternated between urning the pages of the menu and then plating he food.			designee will inspect item and freezers at least week there are no expired items be an ongoing process.	ns in coolers tly to assure s. This will	2, 3, 12	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION	(X3) DATE S COMPL	
		345111	B. WING		12	/15/2011
	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X6) COMPLETION DATE
F 371	On 12/14/11 at 5:10 P stated the wait staff st times when they plate	M, Administrative staff #1 nould use utensils at all d the food and not touch the s. He also stated if gloves i, staff should change	F 371	Director and at the Quality Meeting quarterly meetin next 12 months. Director of Dining Service a one-on-one in-service wi	g Service Assurance ag for the performed th Staff #1	12/14/11
SS=E	observation of a scoop handle of the scoop lyl kitchen. Staff #2 state supposed to be in the staff #2 also indicated the container or should with the handle not tou 483.60(c) DRUG REGI IRREGULAR, ACT ON The drug regimen of eareviewed at least once pharmacist. The pharmacist must rethe attending physician,	o in the flour bin with the ing in the flour in the sed the scoop was not container. Administrative the scoop should not be in be stored in the container ching the flour. MEN REVIEW, REPORT sich resident must be a month by a licensed aport any irregularities to	F 428	on the proper use of glo washing, handling of food, appropriate serving utensils. Director of Dining Ser Certified Dietary Manager an in-service with the Not team that on the proper use hand-washing, handling of using appropriate serving Penick Village North Dining a utensil use only operate prepared food will be serve with appropriate utensils.	vices and conducted of gloves, food, and utensils. ng will be ion. All	12/14/11
- i	This REQUIREMENT is by: Based on record review acility's pharmacist faile egarding the TSH level	s not met as evidenced		The Certified Dietary Madesignee will observe at lealine meal service were adherence of utensil use on month and three tray liservices weekly for three Results to be reported to Dining Service and Assurance January and Agmeetings.	st six tray bekly for y for one ine meal months. irector of Quality	1/12/12

PRINTED: 12/29/2011 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION G	(X3) DAT	3 NO. 0938-039 ESURVEY PLETED
-	345111		B. WIN	B. WING			District
PENICK V	ROVIDER OR SUPPLIER			5	REET ADDRESS, CITY, STATE, ZIP CODE 100 EAST RHODE ISLAND AVENUE COUTHERN PINES, NC 28387		2/15/2011
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	H to RE	COMPLETION DATE
F 428	Continued From page	23	F4	28	Dining staff removed sco flour bin.	op fron	12/15/11
R he 22 09 11 The received 10	the hospital on 08/15/1 including Hypothyroidis in an independent living hospitalization. The qui dated 10/12/11 indicate memory and decision in Review of the physiciar 2011 revealed an order (microgram) by mouth of and to check TSH level (February/August). The facility's policy on " aboratory Determination eviewed. The policy re- including T-4 and TSH, sherapy and every 12 mon eviewed of the resident's ecords revealed no report eview of Resident #62's the had lost weights from 20 lbs (pounds) on 08/2 20/05/11, 169 lbs on 10/07/11 and 165 lbs on the drug regimen reviews cords revealed that the viewed the resident's re //03/11, 11/03/11 and 12 the address the need for 1	arterly MDS assessment and that Resident #62 had making problems. It's orders for December, for Synthroid 75 mcg daily for Hypothyroidism every 6 months Recommended on " (undated) was ad in part " Thyroid panel 90 days after the start of onths " . Intercords and the hospital out for TSH level. It weights revealed that admission. He weighed 2/11, 173 lbs on 12/07/11. It were reviewed. The pharmacist had cords on 09/07/11, 2/06/11. The notes did			Director of Dining Serviced all of North Dining team on proper use of scoop items (flour, sugar, rice. handling and storage of sutensil. The Certified Dietary Mandesignee will observe at leatimes a week for adhere scooping utensil use and sto three months and rathereafter. Results to be rep Director of Dining Servi Quality Assurance meeting quality Assurance meeting quality and some control of the control o	ger in- ger Service ing bulk) and scooping ager or ast three ence of rage for andomly orted to ce and	1/9/12
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345111		IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345111	B. WING_		12/	15/2011	
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 500 EAST RHODE ISLAND AVENUE SOUTHERN PINES, NC 28387			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 428	On 12/14/11 at 3:34 PM, administrative nurse #4		F 428	F428 Resident #62 TSI obtained and was in norm		12/15/11	
	was interviewed. Administrative Nurse #4 stated that the facility had no standing orders or policy for labs (laboratory). He further stated that labs were drawn per doctor's order. He also stated that the TSH level for Resident #62 was not due until February, 2012 as ordered. When asked, he stated that he did not know when the resident had started taking Synthroid and when was the last time TSH was checked. On 12/14/11 at 5:25 PM, the pharmacist was interviewed. He stated that the facility's policy in monitoring the TSH level for residents on Synthroid was every 12 months. He further stated that the doctor had ordered to check the TSH every 6 months for Resident #62, so it was not due until February, 2012. When asked, he stated that he did not know as to when the resident had started taking the Synthroid and when the last time TSH was checked for Resident #62. He also stated that he had checked and the hospital had no records of TSH level for Resident #62.			Pharmacist checked a physician's orders to det was taking thyroid preparations. X number were taking thyroid preparations and all had results in the chart. TSH level will be recommended the consultant pharmacist of the first drug regin following admission, if no within the past 12 no accepted clinical standard within 90 days of in therapy and every 12 mo otherwise ordered by the past of	to determine who hyroid hormone amber of residents thyroid hormone all had timely TSH trecommended by reactive at the time a regimen review on, if not obtained 12 months per standards and of initiation of 12 months unless		
				Consultant pharmacist verifindings related to thyroist preparations and TSH monthly for the next the and quarterly thereafter feating months with the I Nursing. Results to be quarterly QA meetings for months.	vill review d hormone monitoring ee months or the next Director of shared at	1/6/12	

PRINTED: 01/08/2012 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION JAN 20 AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 01 - MAIN BUILDING 01 B. WING. 346111 01/05/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **500 EAST RHODE ISLAND AVENUE** PENICK VILLAGE SOUTHERN PINES, NC 28387 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X6) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) This corrective action plan will serve as NFPA 101 LIFE SAFETY CODE STANDARD K 038 K 038 Penick Village's allegation of compliance SS=F with the requirements of 42 CFR, Part 483, Exit access is arranged so that exits are readily and Subpart B for long-term care facilities accessible at all times in accordance with section as of January 5, 2011. 7.1. 19.2.1 K 038 Maintenance staff discovered a 1/5/12 problem with the wiring to the Secure Care Exit door I.D. panel that did not allow the This STANDARD is not met as evidenced by: door to unlock when the fire alarm initiated Based on the observations and staff interviews or with the master kill switch. Maintenance on 1/5/2012 the following means of egress Life staff repaired wiring. To assure that the Safety items were observed as noncompliant with wiring was repaired, the door was tested by the Special Locking arrangements for the facility. activating the fire alarm and the master kill specific findings include: switch was tested also and both times the door released. The required exit at nurse 's station number one released with automatic fire alarm activation and All Secure Care doors were checked during 1/5/12 door release mechanism / kill switch at the fire alarm activation and all other doors nurses station with a delay. This delay was for were found to be operating correctly. several seconds and could give the impression that this required exit door equipped with a All Secure Care doors will be checked when Ongoing special locking would not release with activation conducting monthly fire drills to assure the of the fire alarm system or the kill switch at the proper releasing mechanism works nurses station. appropriately. This will be recorded on the monthly fire drill report. NOTE: The door release mechanism at the door did not have such a delay when tested. The master kill switch will be tested Ongoing monthly and results documented. CFR#: 42 CFR 483.70 (a) Any time repairs are made to the Secure Ongoing Care Doors, the Secure Care Doors will be tested afterwards to assure they are in proper working order. Results of monthly tests will be reported to Ongoing

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Admiriistrator

the Quality Assurance Committee over the

(X6) DATE)

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.

next 12 months.