AUG 1 7 2012

PRINTED: 08/02/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER:  A BUILDING		PLE CONSTRUCTION	(X3) DATE SU COMPLET	
		345246	B. WING		07/2	5/2012
	ROVIDER OR SUPPLIER		5	REET ADDRESS, CITY, STATE, ZIP CODE 107 FREMONT STREET BURGAW, NC 28425		· <u>-</u>
(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 COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X6) COMPLETION DATE
F 157 SS=D	consult with the reside known, notify the resident involving the injury and has the pot intervention; a signific physical, mental, or p deterioration in health status in either life thredinical complications; significantly (i.e., a net existing form of treatments); or a decist the resident from the §483.12(a).  The facility must also and, if known, the resor interested family mechange in room or roospecified in §483.15(resident rights under largulations as specified this section.  The facility must record the address and phonologal representative of this REQUIREMENT by: Based on record reviews.	idely inform the resident; ent's physician; and if dent's legal representative y member when there is an resident which results in ential for requiring physician ant change in the resident's sychosocial status (i.e., a y mental, or psychosocial eatening conditions or y; a need to alter treatment ed to discontinue an ment due to adverse commence a new form of ion to transfer or discharge facility as specified in promptly notify the resident ident's legal representative ember when there is a symmate assignment as e)(2); or a change in Federal or State law or ed in paragraph (b)(1) of and periodically update e number of the resident's rinterested family member.	F 157	CORRECTIVE ACTION ACCORDENTATE FOR THOSE RESIDENTS FOR THOSE RESIDENTS FOR EACTICE BY:  Attending physician notified 8/7 Clinical Coordinator of change status (seizures) on the followin 5/26/2012, 6/3/2012, and 6/4/2 orders received.  CORRECTIVE ACTION ACCORDENTS HAY POTENTIAL TO BE AFFECTE SAME DEFICIENT PRACTICE.  Review and revise current polic having a change in condition on Nursing Unit to include: notifical physician, resident and the resident's physical, mental or president's physical physica	UND TO HAVE EFICIENT  7/2012 by the in resident #1's ng dates: 012. No new  DMPLISHED VING D BY THE is: cy for patients in the Skilled ation of the ident's legal family member nge in the sychological Clinical Status  Clinical Status  Clical records sure no other same deficient in the sychological control of the ident's legal family member nge in the identification of the ident's legal family member nge in the identification of the ident's legal family member nge in the ident's legal family nge in the ident's	8/7/2012
		the attending physician of				

KUHN U. KKUVU U

President

(X6) DATE 8-14-12

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

PRINTED: 08/02/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SUF	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLET	ED
		345245	B. WNG		07/2	5/2012
	OVIDER OR SUPPLIER		6	EET ADDRESS, CITY, STATE, ZIP CODE 07 FREMONT STREET BURGAW, NC 28425	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY 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 BE APPROPRIATE	(X6) COMPLETION DATE
F 157	The facility's Nursing Manual, revised 3/12 provide documentati acute episodes or ur patient/resident char physician will be not conditions and approcurrent policy and prof acute episodes ar include, but are not linjuries, change in st Resident #1 was add 8/26/05 with multiple disorder. Review of revealed current phy seizure medications (milligram) twice dai (intramuscularly) eve seizure, Phenytoin s morning and 100mg Keppra 500mg twice evidenced by eye twhead movements, a movement. Ativan a physician orders. Timinutes. There was physician was notifice Review of nursing programments of the physician was notificed.	of 3 sampled residents with ident #1). Findings include:  Policy and Procedure Policy and Procedure Policy and Procedure Policy - To On in the nurses' notes for nusual occurrences in the It. Procedure - item 2. The ified of the resident's clinical opriate orders carried out per occedure. Item 4 - Examples and unusual occurrences may imited to: symptoms, tatus."  Interview of the facility on a diagnoses including seizure the resident's clinical record resician orders for the following - Lorazepam 0.5mg Ity, Lorazepam 1mg IM Ity four hours if needed for suspension 50mg every nightly at bedtime, and	F 157	All nursing staff will be educated policy by 8/20/2012.  See Attachment B - Education PLANS TO MONITOR PERFORMAKE SURE SOLUTIONS AS Skilled Nursing Facility will mean sample of five medical record starting 8/6/2012, for 1 months to ensure that correct and sustained for the following that all changes in patient's reported to the resident's legal representation of the resident's legal representation of the sustained for the following that all changes in patient's reported to the resident's legal representation of the sustained for the following that all changes in patient's status of the sustained for the following that all changes in patient's sustained for the following that all changes in patient's legal representation of the sustained for the following that all changes in resident's legal representation of the sustained for the following that all changes in resident's legal representation of the sustained for the following that all changes in patient's sustained for the following that all changes in patient's legal representation of the following that all changes in patient's legal representation of the following that all changes in patient's legal representation of the following that all changes in patient's legal representation of the following that all changes in patient's legal representation of the following that all changes in patient's legal representation of the following that all changes in patient's legal representation of the following that all changes in patient's legal representation of the following that all changes in patient's legal representation of the following that all changes in patient's legal representation of the following that all changes in patient's legal representation of the following that all changes in patient's legal representation of the following that all changes in patient's legal representation of the following that all changes in patient's legal representation of the following that all changes in patient's legal representation of the following that all changes in patient's	on Plan FORMANCE TO ARE SUSTAINED: nonitor a random ds per week, h and monthly for ection is achieved ng: confirmation status are ysician, resident esentative or an change Audit Tool will be included w to begin	8/20/2012

Facility ID: 955685

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED		SURVEY ETED	
		345245	B. WNG		07	/25/2012
	ROVIDER OR SUPPLIER MEMORIAL HOSP SNI	F	50	EET ADDRESS, CITY, STATE, ZIP COL 17 FREMONT STREET URGAW, NC 28425	DE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 157	the arm, eyes, and than 2 minutes. The po (oral) dose of A had stopped seizir this shift." There we physician was not in the review of nursing 1:00AM revealed the activity with rapid the twitching. Ativand seizure ceased. That the physician activity.  In an interview on Resource Nurses when any resident she was not at the assessed the residence where the stated all physician activity.  In an interview on Manager stated the Resource Nurse we notifying the physician activity care of the residence of the medication the nursing notes document all physicials.	head. The duration was less the notes read "gave schedule tivan as it was due and patient tig. No further seizures noted was no documentation that the fied of the seizure activity.  progress notes dated 6/4/12 at the resident exhibited seizure nead movements and eye are made in the seizure of the seizure nead movements and the seizure of the seizure of the seizure nead that a change of condition. If a facility, the nurse on duty dent and notified the physician sician notifications were	F 157			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345245	B. WN	G		07/25/	2012
	OVIDER OR SUPPLIER			507	ET ADDRESS, CITY, STATE, ZIP CODE 7 FREMONT STREET JRGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 157	the nurse on duty 6/called the physician condition. If there we the physician. She is supervisor in the builthem. Changes wer shift at shift change. #1 had a short seizuper the standing ord She stated the physician decimal the nurse on duty 6/change of condition initiated any new ord the emergency deprinctified the supervisual physician notification nursing notes. She resident #1's seizur "I think I called the pit."  The nurse on duty a seizure on 5/26/12 Attempts to contact 483.10(n) RESIDEL DRUGS IF DEEME	A/12 (nurse #1) stated she for any acute change in as no response, she paged stated there was always a lding and she also notified e also reported to the next. The nurse stated resident are on 6/4/10, she gave Ativan er, and the seizure stopped. Ician notification would have a the nursing notes.  Aiew on 7/27/12 at 4:25PM, 3/12 (nurse #2) stated for she notified the physician and ders or sent the resident to artment if ordered. She also for on duty. Nurse #2 stated ations were documented in the didn't recall the details of e on 6/3/12. The nurse stated or on 6/3/12. The nurse stated or on the time of resident #1's was not available for interview. The nurse were unsuccessful. The SELF-ADMINISTER D SAFE		157	PRACTICE BY:	O TO HAVE CIENT	8/6/2012
	the interdisciplinary	ent may self-administer drugs if team, as defined by as determined that this			Medications were removed from re 33's room on 8/6/2012.  Review and revise current policy (I Medications - Self Administration of	NM-9A	8/6/2012
	This REQUIREMED by:	NT is not met as evidenced			See attachment E: Policy - Medica Administration of - SNF	ations - Self	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

DELANI	VICTOR TO THE STATE STAT	MEDICAID SEDVICES			OMB NO.	0830-0381
		MEDICAID SERVICES	CVNIM	III TIDI	E CONSTRUCTION (X3) DATE SURVI	ΕY
STATEMENT O AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LDING	COMPLETED	•
		345245	B. WIN	IG	07/25/	2012
	OVIDER OR SUPPLIER			50	EET ADDRESS, CITY, STATE, ZIP CODE 07 FREMONT STREET	
PENDER N	MEMORIAL HOSP SNF			В	URGAW, NC 28425	
(X4) ID PREFIX TAG	(CACH DESICIEN)	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 176	Based on observati interviews the facilit Interdisciplinary Tea safely self administe ensure proper stora	ge 4 ons, record review and staff y failed to ensure that the am assessed a resident to ar medications and failed to ge of the medications for 1 of a (Resident #33) that was self cations. The findings include:	F	· 176	The SINE litteral sciplinary team account	8/9/2012
	The facility policy till Self-Administration Facility)/Swing Bed effective date of 04 Nursing Facility reshave the opportunit controlled medication to self-administer in team will assess with safely using the Medical Assessment. The facility policy is not to the resident must	led Medications - of - SNF (Skilled Nursing revised on 04/2012 with the /2012 read: "Il Procedure. All idents determined eligible will by to self-administer non ons." 2. If the resident wishes nedications the interdisciplinary hether the resident can do so edication Self-Administration ollowing criteria will be used. demonstrate: a. The			CORRECTIVE ACTION ACCOMPLISHED FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE:  SNF Clinical Coordinator audited 100% of residents who are self administering medication to confirm an interdisciplinary team assessment was completed and on medical record ensuring the resident's ability to safely self administer medications.  See Attachment G: Self Administration Audit Tool	8/6/2012
	The knowledge of appropriate amour container. c. The k take the medicatio label on the medic dexterity sufficient accurately. 3. The quarterly as long a self-administer. 4.	the medications are for. b. correctly measure the st of medication from the nowledge of correct times to n. d. The ability to read the ation container. e. The manual to self-administer medication resident will be reassessed as he/she desires to Medications will be stored in			MEASURES/SYSTEMIC CHANGES PUT IN PLACE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT OCCUR:  Re-educate nursing staff regarding residents self administration of medication to include revision of policy, forms, and quality assessment process.  See attachment B: Education Plan	8/20/12
	the medication can medication nurse. medication nurse medications. The resident his/her m and record on the	t under the supervision of the The resident will contact the to obtain access to his/her medication nurse will give the edication drawer and observe MAR (Medication cord) the self-administration of the policy included an attached			PLANS TO MONITOR PERFORMANCE TO MAKE SURE SOLUTIONS ARE SUSTAINED:  Self administration of medications was added to Quality Assurance/Assessment Form.  See attachment D	8/9/201

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		RVEY ED
		345245	B. WING		07/25	5/2012
	OVIDER OR SUPPLIER		5	EET ADDRESS, CITY, STATE, ZIP CODE 07 FREMONT STREET BURGAW, NC 28425		
(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 CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLO BE	(X5) COMPLETION DATE
F 176	form titled Evaluation Safely Self-Administer above criteria.  Resident #33 was ad 1/29/10 and had diagonal Heart Failure, Atrial Foisease, Degenerating Gastro-Esophageal Foementia and Constitute The Care Area Assessived that the resident was cognitively in The most recent Minic Assessment (Quarter that the resident was The resident was The resident 's Care updated 06/26/12 did regarding self adminic On 07/25/12 at 4:00 to observed to have mulmedications on the office The following items with scalp itch medicine (control to footile of Genteal eyer for dry eyes), one both asal spray (a nasal L Lysine 1,000 milligr supplement), one both bottle of Osteo Bi-Flechondroitin and gluccommitted.	of Resident's Ability to be Medication that listed the mitted to the facility on moses including Congestive Fibrillation, Coronary Artery ve Joint Disease, Reflux Disease, Insomnia, pation.  Sement dated 03/16/12 dent was alert and oriented intact.  Imum Data Set (MDS) rely) dated 05/25/12 showed cognitively intact.  Plan dated 03/20/12 and Into include information stration of medications.  PM the resident was altiple over the counter ver bed table in the room. Vere observed: One bottle of contains salicylic acid), one drops (contains 2 lubricants title of Oxymetozoline 0.05% decongestant), one bottle of ram tablets (protein title of Vitamin B12, one ex (combination of osamine used as a parthritis), one jar of Vick's of Leg Aide Herbal	F 176	SNF will monitor all residents who a medicating weekly for 1 month and for 6 months to ensure the interdisc team has conducted an assessment patients wishing to self administer and completed the Medication Self Administration form.  See Attachment G: Weekly Self Adaudit Tool	monthly ciplinary nt for medications	8/6/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL		ONSTRUCTION	(X3) DATE S COMPLI	COMPLETED	
		345245	B. WING	·		07	/25/2012	
	ROVIDER OR SUPPLIER			607 FE	ADDRESS, CITY, STATE, ZIP CODE REMONT STREET GAW, NC 28425			
(X4) ID PREFIX TAG	/EACH DESCRENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	(SHOULD BE	(X5) COMPLETION DATE	
F 176	circulation), one jar of analgesic gel pain reconstruction of the resident could know the resident to self-administer and counter medication the family wanted to self-administer medication the family wanted to self-administer medication the family wanted the resident is compared to self-administer medication the family wanted that counter medication the family wanted the resident is counter medication.	of Ultra blue cream (topical diever) and one jar of generic ed vaporub decongestant). On the resident stated that it medications close by in em. The resident resided in a dent's medical record in a dent's medical record in a dent's order dated 4/28/12 that eep vick's vapor rub at the a physician's order dated ident to keep Vitamin B12, hondroitin, natural herbal detary supplement at the elf-administer the medications. Interdisciplinary Team for the inister medications and there in the form for the resident to lications.  O PM the Unit Manager stated they have a policy and a form on of medications but have not due to trying to get all of their he Manager stated that they order for the resident to self ions and they make sure that petent to do so. The Manager y they have no residents that	F	176				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  A DULDING  DEMPIRED AND PROVIDER SUPPLIER  PENDER MEMORIAL HOSP SNF  COAD DEPENDENT STEPPED AND PROVIDER SUMMARY STATEMENT OF DEFICIENCIES PERFORM TAG  PENDER MEMORIAL HOSP SNF  COAD DEFICIENCY MUST SEP PRECEDED BY PILL REGULATORY OR LSC IDENTIFYMON INFORMATION)  FOR THE PENDER MEMORIAL HOSP SNF  PENDER MEMORIAL HOSP SNF  COAD DEFICIENCY MUST SEP PRECEDED BY PILL REGULATORY OR LSC IDENTIFYMON INFORMATION)  FOR THE PENDER MEMORIAL HOSP SNF  FOR THOSE RESIDENTS PLAN OF CORRECTION  GRAND CHARGE STATEMENT OF DEFICIENCIES  FROM DEFICIENCY OF THE APPROPRIATE  PRETTY TAG  FOR OTHER PLAN OF CORRECTION  FROM DEFICIENCY OF THE APPROPRIATE  PRETTY TAG  FOR OTHER PLAN OF CORRECTION  FOR OTHER PROVIDERS PLAN OF CORRECTION  FOR OTHER PROVIDERS PLAN OF CORRECTION  FOR OTHER PLAN OF CORRECTION  FOR THOSE RESIDENTS FOUND TO HAVE  BEEN AFFECTED BY THE DEFICIENT  FRACTICE BY:  CORRECTIVE ACTION ACCOMPLISHED  FOR THOSE RESIDENTS FOUND  FOR THOSE RESIDENTS HAVING  A nutritional care plan was developed for resident #14  See attachment I: Care Plan  A nutritional care plan was developed for resident #14  See attachment I: Care Plan  A nutritional care plan was developed for resident #14  See attachment I: Care Plan  A nutritional care plan was developed for resident #14  See attachment I: Care Plan  A nutritional care plan was developed for resident By highest practi	DELANTIN	CENTERS FOR MEDICARE & MEDICAID SERVICES					ONE NO. C.	
AND PLAN OF CORRECTION  345246  NAME OF PROVIDER OR SUPPLIER  PENDER MEMORIAL HOSP SNF  SUMMARY STATEMENT OF DEPICIENCES (PARIED DEPICIENCY MAJE REPREDEDED BY FULL PRIESTS)  (PAGE 10 PRESTAL PROSESS, CITY, STATE, APP CODE SOT FREMONT STREET BURGAW, NC 28425  (PAGE 10 PROVIDER OR LOCAL DEPICIENCY MAJE REPREDEDED BY FULL PRIESTS (PAGE 10 PROVIDERS PLAN OF CORRECTION POWER FOR CONTRE UNITS APPROPRIATE ONTE OF THE WAY PROPRIATE ONTE ONTE ONTE OF THE WAY PROPRIATE ONTE ONTE ONTE ONTE ONTE ONTE ONTE ON	STATEMENT OF	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA		(X2) MULTIPLE CONSTRUCTION				
NAME OF PROMOBER OR SUPPLIER  PENDER MEMORIAL HOSP SNF  SUMMARY STATEMENT OF DESIGNACIES  GRADINER GENORY MUST SEP PRECEDED BY FILL  (PAST TAG  F 176  CONTINUED From page 7  over the counter medications. The Unit Manager stated in an interview that because there was a physician so order for the resident to seep her medications in her room, she thought that the resident had been assessed for self administration of medications.  On 07/25/12 at 6:20 PM The Unit Manager stated in an interview that because there was a physician in so or commence of the self-resident to keep her medications in her room, she thought that it was OK for her to do so. The Unit Manager stated that she was unable to find documentation that the resident had been assessed for self administration of medications.  F 279  SS=D  COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25, and any services that would otherwise be required under §483.25, and any services that need gas and provided due to the resident's services of rights under §483.20, and any services that revoluted otherwise be required under §483.25 but are not provided due to the resident's energies or rights under §483.25, and any services that would otherwise be required under §483.25, and any services that would otherwise be required under §483.25, and any services that would otherwise be required under §483.25, and any services that would otherwise be required under §483.25, and any services that would otherwise be required under §483.25, and any ser	AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:					
PENDER MEMORIAL HOSP SNF  SUMMAY STATEMENT OF DEFIGIENCIES BURGAW, NC 28425  SUMMAY STATEMENT OF DEFIGIENCY STATEMENT OF DEFIGIENCIES GEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG  F 176  Continued From pags 7 over the counter medications. The Unit Manager stated that the physician makes the decision whether a resident can or can not self administer medications.  On 07/25/12 at 6:20 PM The Unit Manager stated in an interview that because there was a physician 's order for the resident to keep her medications in her room, she thought that it was OK for her to do so. The Unit Manager stated that she was unable to find documentation that the resident had been assessed for self administration of medications.  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25, and any services that would otherwise be required under §483.5, to including the right to refuse treatment  set remove the counter redication of precipies of the properties of the properties of properties. Properties of the plan of care.  F 279  CORRECTIVE ACTION ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE SAME DEFICIENT PRACTICE:  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25, and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.25 but are not provided due to the resident's exercise of rights under §483.25 but are not provided due to the resident's exercise of rights under §483.25 but a			345245	B. WIN	G		07/25/2	012
SUMMARY STATEMENT OF DEFICIENCY SET	İ			507 FREMONT STREET				
SUMMAY STATEMENT OF DEPICENCY OF THE PRECIDENT MAY BE CROSS-REFERENCED TO THE APPROPRIATE DEPICIENCY MAY BE CROSS-REFERENCED TO THE APP	PENDER M	IEMORIAL HOSP SNF			В			(75)
over the counter medications. The Unit Manager stated that the physician makes the decision whether a resident can or can not self administer medications.  On 07/25/12 at 6:20 PM The Unit Manager stated in an interview that because there was a physician's order for the resident to keep her medications in her room, she thought that it was OK for her to do so. The Unit Manager stated that she was unable to find documentation that the resident had been assessed for self administration of medications.  F 279 SS=D  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under \$483.25 but are not provided due to the resident's exercise of rights under \$483.15, including the right to refuse treatment	PREFIX	CACH DESIGNA	NAMEST RE PRECEDED BY FULL	PREF	IX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE   '	OMPLETION
due to the resident's exercise of rights under plans to ensure accuracy and completeness.  §483.10, including the right to refuse treatment	F 176	Continued From page over the counter me stated that the physis whether a resident of medications.  On 07/25/12 at 6:20 in an interview that it physician's order for medications in her of the county	dications. The Unit Manager ician makes the decision can or can not self administer.  PM The Unit Manager stated because there was a or the resident to keep her room, she thought that it was. The Unit Manager stated that find documentation that the assessed for self edications.  (A) DEVELOP E CARE PLANS  The results of the assessment and revise the resident's an of care.  Evelop a comprehensive care ent that includes measurable etables to meet a resident's and mental and psychosocial intified in the comprehensive  at describe the services that are attain or maintain the resident's exphysical, mental, and being as required under services that would otherwise 4483.25 but are not provided	   F	176	CORRECTIVE ACTION ACCOMPLIST FOR THOSE RESIDENTS FOUND TO BEEN AFFECTED BY THE DEFICIE PRACTICE BY:  Care plan for resident #33 was revise reflect self administration of medicatic competency.  See attachment H: Care Plan  A nutritional care plan was developed resident #14  See attachment I: Care Plan  CORRECTIVE ACTION ACCOMPLETOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY SAME DEFICIENT PRACTICE:	ed to ion  ed for  USHED  THE	8/9/2012 8/6/2012
		due to the resident's exercise of rights under §483.10, including the right to refuse treatment				plans to ensure accuracy and comp	oleteness.	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTM	SOUNDICABLE &	MEDICAID SERVICES				ONE NO.	
CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  PENTIFICATION NI IMPER:		TAXA PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
STATEMENT O AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING				
		345245	B. WIN	G		07/25/	2012
	OR OLIOPUSE				EET ADDRESS, CITY, STATE, ZIP CODE		
	OVIDER OR SUPPLIER				7 FREMONT STREET		
PENDER N	MEMORIAL HOSP SNF			В	URGAW, NC 28425	CTION	(X5)
(X4) ID PREFIX TAG	- A OULD EDUCATE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE
	Continued From parthis REQUIREMEN by: Based on observatinterviews the facility care plan for self-artifor 1 of 1 residents medications (Residents with weigh findings include:  1. Resident #33 was 1/29/10 and had different Failure, Atrian Disease, Degenerated Gastro-Esophages Dementia and Correct The Care Area As showed that the resident was cognitive The most recent Massessment (Quality that the resident was cognitive to 10 or 1/25/12 at 4 observed to have medications on the following iter scalp itch medicinations of the control of Cantent and C	ge 8  AT is not met as evidenced  ion, record review and staff ty failed to develop a written dministration of medications who was self-administering lent #33) and failed to develop for nutrition for 1 of 3 sampled that loss (Resident #14). The  as admitted to the facility on lagnoses including Congestive al Fibrillation, Coronary Artery active Joint Disease, al Reflux Disease, Insomnia, astipation.  sessment dated 03/16/12 esident was alert and oriented by intact.  Minimum Data Set (MDS) arterly) dated 05/25/12 showed was cognitively intact.  Is are Plan dated 03/20/12 and and did not include information ministration of medications.  100 PM the resident was a multiple over the counter the over bed table in the room. The were observed: One bottle of the (contains salicylic acid), one eve drops (contains 2 lubricants		279	MEASURES/SYSTEMIC CHANG	or a random er week, en monthly n is achieved Accurate n for rehensive  udit Tool  RMANCE TO E SUSTAINED: ewed and of weekly for 4	8/6/2012
	nasal spray (a na	e bottle of Oxymetozoline 0.05% asal decongestant), one bottle of	<u> </u>	<u> </u>	To the ID. OFFCOR	If continuation	sheet Page 9
1		e .110.00	OE44		Facility ID: 955685		

STATEMENT C	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		CONSTRUCTION	(X3) DATE SI COMPLE	
AND PLAN OF	COMEDITOR	345245	B. WIN			07/25/2012	
	OVIDER OR SUPPLIER			507	ET ADDRESS, CITY, STATE, ZIP CODE FREMONT STREET IRGAW, NC 28425		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	ix	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 279	L Lysine 1,000 milli supplement), one b bottle of Osteo Bi-F chondroitin and glu supplement for oste Vaporub, one bottle Supplement (used circulation), one jar analgesic gel pain Chest Rub (medica During the observashe liked to keep h case she needed to The Clinical Coord 07/25/12 at 5:29 P medications was a 03/20/12 but was current care plan.  The Unit Manager 07/25/12 at 6:20 F plans prior to 03/2 administration of r stated that she did was dropped from Resident #14 was 10/17/11 with mulappetite	gram tablets (protein ottle of Vitamin B12, one lex (combination of cosamine used as a coarthritis), one jar of Vick 's of Leg Aide Herbal for leg cramps and of Ultra blue cream (topical reliever) and one jar of generic ated vaporub decongestant). It in the resident stated that er medications close by in hem.  Inator stated in an interview on M that self-administration of addressed on care plans prior to not included on the resident 's estated in an interview on M that the resident 's care 10/12 included self medications. The Unit Manager of the care plan.	F	279			
	6/29/12 indicated intact. The reside assistance with h (ADLS), including resident received	nimum data set (MDS) dated the resident was cognitively ent required extensive er activities of daily living geating. The MDS indicated the la therapeutic diet.					

CENTERS	FOR MEDICARE &	MEDICAID SERVICES			(X3) DAT		ATE SURVEY	
STATEMENT OF	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COMPLETED		
AND PLAN OF	CORRECTION	IDENTITION OF THE PROPERTY OF	A. BUIL					
		345245	B. WN	G		07/25	2012	
NAME OF PR	OVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
					REMONT STREET			
PENDER N	IEMORIAL HOSP SNF		BURGAW, NC 28425		PROVIDER'S PLAN OF CORRE	CORRECTION (X6)		
(X4) ID PREFIX TAG	CACH DESIGNA	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE	
			F	279				
F 279	Continued From pag	ge 10	•	2.0				
	read in part: "nutriti	on - she is routinely on an		Ì		i		
	AHA (American Hea	art Association) diet and has a She was started on Megace		]				
•	poor to rair intake.	on 5/1/12 and has improved	Ì	 			Í	
	some with intakes of	f 25-100% in the past / days						
	ner the dietary cons	sumption record. She eats						
	lose in the evening.	She was also started on	l İ					
	Pasource 2.0 (SUDE	ntement) 4 oz. twice dally. Sne		ļ				
	has gained wt (weig	aht) (10 lb) in the past month						
	as recorded in the	wt book as her wt in May was						
	114. Will Proceed	to care plan to monitor for any		Ì				
	decrease in wt and	any loss of interest in food. hysician) & RD (registered	Ì	İ			ļ	
	dicticion) se neede	d." The CAA indicated	Ì	!				
1	nutritional and fund	tional status would be	Ì	İ				
	addressed in the C	are plan. The overall objective		ļ				
	l was improvement a	and to slow or minimize	1					
	decline The CAA	read "Describe impact of this	ļ					
	problem/need on ti	he resident and your rationale						
1	for care plan decis	ion - she will be monitored for					ļ	
1	any reverse of fair	to good intake. Any loss of		1				
	interest in food bea	plan dated 6/12/12 revealed it	Ì					
	did not identify are	blems, goals, or approaches		!				
	enecific to the resi	dent's nutrition.		ļ				
	In an interview Off	7/25/12 at 1:59PM, the MDS						
	Coordinator stated	she completed the resident's	]					
	MDS and CAA. S	the stated her intent was to care			1			
	plan nutrition for the	he resident but she did not						
	complete it.	TIGGIAO AL AIGEDIA the Linit						
	In an interview on	7/25/12 at 4:35PM, the Unit	Ì					
	Care Manager sta	ated the MDS coordinator was	Ì		!			
	responsible for co	impleting care plans. Her for nutrition to have been						
	expectation was t	ent #14's care plan.			CORRECTIVE ACTION ACCO	MPLISHED		
	NUCIONE OF LESION	REGIMEN IS FREE FROM		F 329	LEOR THOSE RESIDENTS FO	UND TO HAVE	:	
F 32 SS=		DRUGS			BEEN AFFECTED BY THE DE PRACTICE BY:	FICIENT		

CENTERS	S FOR MEDICARE &	MEDICAID SERVICES		II TIDI	E CONSTRUCTION	(X3) DATE SURVEY	
STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		EGONSTRUCTION	COMPLETED	
		345245	B. WIN	G		07/25/2	2012
	OVIDER OR SUPPLIER			50	EET ADDRESS, CITY, STATE, ZIP CODE 17 FREMONT STREET URGAW, NC 28425		
TERDETT		TOUTNOISE	PROMDER'S PLAN OF		PROVIDER'S PLAN OF CORRECT	ION	(X5) COMPLETION
(X4) ID PREFIX TAG	ACACH DESIGNA	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LUUL	DATE
F 329	unnecessary drugs. drug when used in eduplicate therapy); of without adequate mindications for its us adverse consequents should be reduced combinations of the Based on a compressident, the facility who have not used given these drugs therapy is necessal as diagnosed and orecord; and resident drugs receive grading physicial intervents.	An unnecessary drug is any excessive dose (including or for excessive duration; or onitoring; or without adequate e; or in the presence of ces which indicate the dose or discontinued; or any	F	329	The SNF Clinical Coordinator contaresident # 13's attending physician obtained orders to discontinue Meg Megace was discontinued 8/7/2012  See Attachment K: Copy of medical discontinuation order  CORRECTIVE ACTION ACCOMP FOR THOSE RESIDENTS HAVIN'POTENTIAL TO BE AFFECTED B SAME DEFICIENT PRACTICE:  100% audit of all current SNF residents are unnecessary drugs.  See Attachment L: Pharmacy Audit MEASURES/SYSTEMIC CHANG PLACE TO ENSURE THAT THE PRACTICE WILL NOT OCCUR:  The SNF consultant pharmacist we current residents medication regin to confirm their drug regimens are	and and and ace.  Ition  LISHED G Y THE  dents was st to confirm free from  It Tool  ES PUT IN DEFICIENT  It monitor all then monthly	8/10/2012
	by: Based on record a staff interviews, the duplicate therapy receiving appetite Findings include: Resident #13 was 7/20/09 with multiperehrovascular a	not met as evidenced review, physician interview, and e facility failed to assess for 1 of 3 sampled residents stimulants (resident #13).  I admitted to the facility on ple diagnoses including accident, depression, and ew of the resident's clinical			unnecessary drugs, to include du therapy. Documentation will be co monthly by the consultant pharma medical record.  PLANS TO MONITOR PERFORI MAKE SURE SOLUTIONS ARE  Residents medication reviews wi the Quality Assessment/Assuran agenda monthly for 6 months to compliance.	plicate ompleted acist in the MANCE TO SUSTAINED: If be added to be Committee	8/16/2012

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

DELAKT	AICIAI OL LITUADE OL	MEDICAID SERVICES					0938-0391
	S FOR MEDICARE & I OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLI	E CONSTRUCTION	(X3) DATE SUR\ COMPLETE	ÆY D
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILE	DING			
		345245	B. WING	·		07/25	/2012
NAME OF PR	OVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
	MEMORIAL HOSP SNF		ŀ		7 FREMONT STREET JRGAW, NC 28425		
PENDER	_				PROVIDER'S PLAN OF CORRECT	ION	(X5)
(X4) ID PREFIX TAG	(EACH DESICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION DATE
F 329	record revealed phys for Prozac (antidepre twice daily, orders da (megestrol) 200mg to	e 12 sician orders dated 7/20/09 essant) 20mg (milligram) ated 3/6/12 for Megace wice daily, and orders dated a 45mg every night for	F:	329	The consultant pharmacist, dieticial dietary manager was educated regregulation F329 483.25 (1), unnecedrugs and F428 483.60(c) drug regreview, report irregular, act on.  See Attachment B: Education Plan	arding essary ilmen	8/10/2012
	treatment of anorexi weight loss in the elantidepressant also  The manufacturer's Megace read in part exacerbation of precede in associated Adverse effects with	FDA (Federal Drug roved indication for the a, cachexia, or unexplained derly. Remeron is an used to stimulate appetite.  product information for to "Warnings/Precautions - existing diabetes has been ion with the use of Megace." In chronic use included enal insufficiency, and					
	2/7/12 read in part from 45mg down to weight and increase						
	Record review reve Megace 200mg twi	ealed new orders on 3/6/12 for ce daily.					
	3/22/12 read in part to poor appetiten med), metoprolol (continuous)	Nutrition Assessment dated t: "pt (patient) on megace due neds - phenytoin (seizure antihypertensive), KCL ment), zantac (reflux), esic)." Review revealed no the dietician that the resident neron for appetite. Review sment of the need for two					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE S COMPL	
		345245	B. WING		07	/25/2012
	ROVIDER OR SUPPLIER	:	\$	STREET ADDRESS, CITY, STATE, ZIP 6 507 FREMONT STREET BURGAW, NC 28425	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL. R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 329	4/13/12 read in particle decreased appetite increase Remeron previous dose, more gain, so his Remer back to original dose Review of the prograssessment of the with Megace.  Record review of larevealed blood glu (milligram/deciliter 124mg/dl, with new (anti-diabetic agent Record review of possince increasing the first of the progress not the need for additional Record review of a 7/5/12 read in particle increasing the need for additional Record review of a 7/5/12 read in particle increasing the need for additional Record review of a 7/5/12 read in particle increasing the need for additional Record review of a 7/5/12 read in particle increasing the need for additional Record review of a 7/5/12 read in particle increasing the need for additional Record review of a 7/5/12 read in particle increasing the need for additional Record review of a 7/5/12 read in particle increasing the need for additional Record review of a 7/5/12 read in particle increasing the need for additional Record review of a 7/5/12 read in particle increasing the need for additional Record review of a 7/5/12 read in particle increasing the need for additional Record review of a 7/5/12 read in particle increasing the need for additional Record review of a 7/5/12 read in particle increasing the need for additional Record review of a 7/5/12 read in particle increasing the need for additional Record review of a 7/5/12 read in particle increasing the need for additional Record review of a 7/5/12 read in particle increasing the need for additional Record review of a 7/5/12 read in particle increasing the need for additional Record review of a 7/5/12 read in particle increasing the need for additional Record review of a 7/5/12 read in particle increasing the need for additional Record review of a 7/5/12 read in particle increasing the need for additional Record review of a 7/5/12 read in particle increasing the need for additional Record review of a 7/5/12 read in particle increasing the need for additional Record review of a 7/5/12 read in particle in	by the dietician.  hysician progress notes dated  t: "more recently has had e and weight lossplan - will to 45mg which was his re recently patient had a weight on was decreased. Will go se of 45mg at bedtime." ress notes revealed no need for additional therapy  aboratory results dated 5/7/12 cose of 221 mg/dl b, normal range less than or orders for metformin	F3	29		
	In an interview on	7/25/12 at 3:10PM, the Dietary sted the nursing staff requested				

PRINTED: 08/02/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mi A. BUIL		E CONSTRUCTION	(X3) DATE SUR' COMPLETE	
		345245	B. WIN	3		07/25	/2012
	OVIDER OR SUPPLIER			507	ET ADDRESS, CITY, STATE, ZIP CODE FREMONT STREET RGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	DATE COMPLETION DATE
F 329	gains or losses. He is such as the addition stimulant to the phys Dietician (RD) visited reviewed the recomma resident would not agents for appetite a examined resident # administration record resident was receiving Remeron. The DM is was unable to reach In an interview on 7/3 Manager stated she consultant pharmacis reported the use of the also would have expresident's medication appetite stimulant or In a telephone interview the physician stated regarding the concur Remeron until 7/26/11 In a telephone interview and monitored weight residents with weigh supplements and/or made to the physician stimulant, she monitioned intake. The RD recommended the use of the physician initiated ar stimulant, she monitioned weight residents with weigh supplements and/or made to the physician initiated ar stimulant, she monitioned weight recommended the use of the physician initiated ar stimulant, she monitioned weight recommended the use of the physician initiated ar stimulant, she monitioned weight recommended the use of the physician initiated ar stimulant, she monitioned weight recommended the use of the physician initiated ar stimulant, she monitioned weight recommended the use of the physician initiated ar stimulant, she monitioned weight recommended the use of the physician initiated are stimulant.	there were significant weight made recommendations of a supplement or appetite lician. The Registered I the facility weekly and mendations. The DM stated usually be prescribed two to the same time. He 13's medication I and acknowledged the log both Megace and mmediately called the RD but her.  25/12 at 3:30PM, the Unit would have expected the lost to have identified and low appetite stimulants. She lected the RD to check the lost before approving a new ladditional therapy.  In the facility once weekly the loss, recommendations for appetite stimulants were lost, recommendations for appetite stimulants were lost, recommendations for appetite ored the resident's weight	F	329			

Facility ID: 955685

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CO AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A BUILDING		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345245	B. WING		07/2	5/2012
	OVIDER OR SUPPLIER		5	EET ADDRESS, CITY, STATE, ZIP CODE 07 FREMONT STREET BURGAW, NC 28425		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 329 F 425 SS=D	one agent used for th been an oversight." 483.60(a),(b) PHARM ACCURATE PROCE	is resident and "it must have	F 329 F 425	CORRECTIVE ACTION ACCOMPL FOR THOSE RESIDENTS FOUND BEEN AFFECTED BY THE DEFICI PRACTICE BY:	TO HAVE	
	drugs and biologicals them under an agreet §483.75(h) of this par unlicensed personnel law permits, but only supervision of a license.  A facility must provide	to its residents, or obtain ment described in t. The facility may permit to administer drugs if State under the general		The one bottle of unopened, unrefrightumulog insulin was removed from medication cart and discarded on 7.  CORRECTIVE ACTION ACCOMPLE FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY SAME DEFICIENT PRACTICE:	the /25/2012 ISHED	7/25/2012
	acquiring, receiving, of administering of all dr the needs of each res  The facility must emp a licensed pharmacis	dispensing, and rugs and biologicals) to meet sident.  loy or obtain the services of twho provides consultation provision of pharmacy		Audit of all medication carts was co 8/7/2012 on SNF to confirm all insustored appropriately per policy and no additional unopened, unrefrigera bottles/vials in the medication carts.  MEASURES/SYSTEMIC CHANGE PLACE TO ENSURE THAT THE DI	lin was there were ted S PUT IN	8/7/2012
	by: Based on observatio interviews the facility	is not met as evidenced n, record review and staff failed to ensure that insulin or 1 of 2 medication carts.		PRACTICE WILL NOT OCCUR:  Staff will be educated on Policy "Via Ampules of Injectable Medication"  See Attachment B: Education Plan  PLANS TO MONITOR PERFORMA MAKE SURE SOLUTIONS ARE SU	als and	8/20/2012
	Ampules of Injectable	ed 01/01/12 titled eral Guidelines for Vials and Medications reads as and ampules of injectable		Medication carts will be audited wee weeks and monthly for 6 weeks to e compliance. Results will be discuss Quality Assessment/Assurance Med	ensure ed at the	8/7/2012

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) ĐATE SUF COMPLETI	
		345245	B. WIN	G		07/2	5/2012
	OVIDER OR SUPPLIER			50	EET ADDRESS, CITY, STATE, ZIP CODE 07 FREMONT STREET URGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE	(X6) COMPLETION DATE
F 425	manufacturer's recompharmacy's directions disposal."  The manufacturer's Humulog Insulin read should be stored in a be kept unrefrigerated.  On 07/25/12 at 3:35 F medication cart for the one bottle of unopened Insulin. The bottle of inpharmacy dispensed no information on the bottle was put on the stated that the vial of the refrigerator. The No could not be used and from the cart and put to the pharmacy.  The Unit Manager sta 07/27/12 at 11:33 AM	in accordance with the imendations or the provider for storage, use, and product information for s: " Humulog not in-use refrigerator. Humulog can drup to 28 days."  PM, an observation of the pupper 200 Hall revealed for unrefrigerated Humulog	F	425	CORRECTIVE ACTION ACCOMPL		
F 428 SS=D	until it was needed.	GIMEN REVIEW, REPORT	F	428	FOR THOSE RESIDENTS FOUND BEEN AFFECTED BY THE DEFICIE PRACTICE BY:		
		each resident must be e a month by a licensed			The SNF Clinical Coordinator contact resident #13's attending physician at obtained orders to discontinue Megace was discontinued 8/7/2012.	nd ace.	8/7/2012
	the attending physicia	report any irregularities to in, and the director of corts must be acted upon.		1000	See Attachment K: Copy of medicati to discontinue	on order	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345245	B. WIN	IG		07/2	5/2012	
	ROVIDER OR SUPPLIER  MEMORIAL HOSP SNF			50	REET ADDRESS, CITY, STATE, ZIP CODE 07 FREMONT STREET BURGAW, NC 28425			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPRO DEFICIENCY)	LD BE	(X6) COMPLETION DATE	
F 428	Continued From page	÷17	F	428	CORRECTIVE ACTION ACCOMPL FOR THOSE RESIDENTS HAVING POTENTIAL TO BE AFFECTED BY SAME DEFICIENT PRACTICE:	<b>i</b>		
	by: Based on record revi- physician interview, a	is not met as evidenced iew, pharmacist interview, and staff interviews, the		7.700.045	100% audit of all SNF residents will completed by pharmacist to confirm regimens for all residents are free frunnecessary drugs.	drug	8/10/2012	
	sampled residents red (resident #13). Findin Resident #13 was adr	ate therapy for #1 of 3 ceiving appetite stimulants ngs include: mitted to the facility on			See attachment L: Pharmacy Audit  MEASURES/SYSTEMIC CHANGES PLACE TO ENSURE THAT THE DE PRACTICE WILL NOT OCCUR:	S PUT IN		
	record revealed physi- for Prozac (antidepres twice daily, orders dat (megestrol) 200mg tw	dent, depression, and of the resident's clinical ician orders dated 7/20/09 ssant) 20mg (milligram)		**************************************	The SNF consultant pharmacist will current residents medication regime to confirm their drug regimens is free unnecessary drugs, to include duplic therapy. Documentation will be commonthly by the consultant pharmacis medical record.	n monthly e from cate pleted st in the	8/10/2012	
	weight loss in the elde	ved indication for the , cachexia, or unexplained			PLANS TO MONITOR PERFORMA MAKE SURE SOLUTIONS ARE SU Resident medication resident review added to the Quality Assessment/As Committee Meeting agenda monthly months to ensure compliance.	STAINED: s will be ssurance	8/16/2012	
	exacerbation of preexi	"Warnings/Precautions - isting diabetes has been n with the use of Megace." chronic use included			The consultant pharmacist, dietician dietary manager was educated rega regulation F329 483.25 (1), unneces drugs and F428 483.60(c) drug regir review, report irregular, act on.  See attachment B: Education Plan	rding sary	8/10/2012	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLET	
		345245	B, WIN	G		07/2	5/2012
	NOVIDER OR SUPPLIER			5	REET ADDRESS, CITY, STATE, ZIP CODE 107 FREMONT STREET BURGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 428	2/7/12 read in part "pl from 45mg down to 30 weight and increased Record review of the dated 2/26/12 revealed mirtazapine (Remeron 30mg at bedtime.  Record review revealed Megace 200mg BID (Increased 200mg BID (Increase	sician progress notes dated an - will decrease Remeron Dmg due to increased appetite."  pharmacist progress notes dan entry that noted had been changed to ed new orders on 3/6/12 for twice daily).  pharmacist progress notes dan entry which read "3/6 - appetite)." The progress cumentation that the the concurrent use of hor requested an entry which read "3/6 had weight lossplan - will 45mg which was his eccently patient had a weight was decreased. Will go of 45mg at bedtime." Is notes revealed no ed for additional therapy	F	428			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		CONSTRUCTION	(X3) DATE SUI COMPLET	
		345245	B. WN	G	-	07/2	5/2012
	ROVIDER OR SUPPLIER			507	ET ADDRESS, CITY, STATE, ZIP CODE FREMONT STREET RGAW, NC 28425	1 0.172	×/
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	JD PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILO BE	(X5) COMPLETION DATE
F 428	Record review of labor revealed blood glucor (milligram/deciliter), r 124mg/dl, with new or (anti-diabetic agent) of the progress notes the need for additional Record review of the dated 5/16/12, 6/14/14 documentation that the concurrent use of Merequested an evaluat In an interview on 7/2 Manager stated the presidents' charts mon reports of any irregular monitoring for duplication was for the consultant identified and reported Megace with Remero In a telephone interview of Meredia Record review of Meredia Remero In a telephone interview of Meredia Remero Interview of	pratory results dated 5/7/12 see of 221 mg/dl sormal range less than reders for metformin 500mg daily.  sician progress notes dated "appetite has improved dose of Remeron." Review revealed no assessment of all therapy with Megace.  pharmacist progress notes 2, and 7/18/12 revealed no ee pharmacist assessed the gace with Remeron or on from the physician.  5/12 at 3:30PM, the Unit harmacist reviewed the thly and provided written arities. The review included te therapy. Her expectation the pharmacist to have do the concurrent use of no.  Sew on 7/27/12 at 12:10PM, we had not been contacted regarding the gace with Remeron.	F	428			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE SI COMPLE	
		345245	B, WIN	lG		07/	25/2012
	ROVIDER OR SUPPLIER MEMORIAL HOSP SNF			6	REET ADDRESS, CITY, STATE, ZIP CODE 507 FREMONT STREET BURGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 428	who then relayed ther review included monit She stated resident # for depression more that Megace the The pharmacist stated Megace therapy after effects were observed recommendation had	n to the unit manager. Her oring for duplicate therapy. 13 was receiving Remeron nan appetite. She was erapy had been added. I she usually evaluated 3 months, but sooner if side i. She stated if a been made regarding the pace with Remeron, it would	F	428			

F-958

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

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

STATEME AND PLAN	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		PLE CONSTRUCTION (X3) DATE COMP	2/2012
	PROVIDER OR SUPPLI MEMORIAL HOSP SNF	345246 ER	STREET AL	CONSTRUCTION SECTION DDRESS, CITY, STATE, ZIP CODE MONT STREET N, NC 38425	(X5)
(X4) ID PREFIX TAG	パスクロ からだいだんだん	ATEMENT OF DEFICIENCIES Y MUST BE PREDECED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLÉTION DATE
K 029 SS=D	at 42CFR 483.70 (a) Care section of the L Publications. This bu Construction, one sto sprinkler system.  The deficiencies dete Are as follows: NFPA 101 LIFE SAF  One hour fire rated of fire-rated doors) or a extinguishing system and/or 19,3.5.4 prote the approved autom option is used, the a spaces by smoke re doors. Doors are sel field-applied protectl 48 inches from the to Permitted. 19,3.2.  This STANDARD is Based on observation Approximately 9:00 noted: 1) The corridor doo Room did not have 2) The comidor doo adioining bathroom	e (LSC) was e Code of Federal Register gusing the Existing Health SC and its referenced uiding is Type II (2 (211) ory, with a complete automatic  ermined during the survey ETY CODE STANDARD construction (with ½ hour in approved automatic fire in accordance with 8.4.1 ects hexardous areas. When atic fire extinguishing system reas are separated from other sisting partitions and if closing and non-rated or ve plates that do not exceed another of the door are  1  not met as evidenced by: on on Wadnesday 8/22/12 at AM onward the following was r to the old copier/storage	K 029	CORRECTIVE ACTION ACCOMPLISHED TO CORRECT THE DEFICIENT PRACTICE:  1) The positive latch has been replaced to the corridor door that leads to the copier/storage room effective 9/5/12.  2) Positive closures have been placed to the corridor door to room 240 and the door to the adjoining bathroom in the room effective 9/5/12.  CORRECTIVE ACTION ACCOMPLISHED TO IDENTIFY OTHER LIFE SAFETY ISSUES HAVING THE POTENTIAL TO AFFECT RESIDENTS BY THE SAME DEFICIENT PRACTICE:  1) All rooms and bathrooms on the SNF were assessed 9/6/12 and are in compliance with positive latches. (see attachment A)  2) All storage rooms and doors adjoining storage rooms on the Skilled Nursing Facility were assessed 9/5/12 and have self closures in place. (see attachment A)	9/5/12 9/5/12 9/5/12
LABORAT Kl	ITA PL. YKEV	ROVIDER/SUPPLIER REPRESENTATIVE		RE PRESICION +  THE PRESICION +  The providing it is determined to the providing it is determined to the providing it is determined.	(X6) DATE  9-6-12  rmined that

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

continued program participation. Form CMS-2567(02-99) Previous Versions Obsolete

Event ID BOG521

Facility ID 955685

If continuation sheet Page 1 of 2

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

F-958

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED A. BUILDING CONSTRUCTION SECTION IDENTIFICATION NUMBER AND PLAN OF CORRECTION 08/22/2012 WING 345245 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 507 FREMONT STREET **BURGAW, NC 38425** PENDER MEMORIAL HOSP SNF COMPLÉTION PROVIDERS PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES DATE (EACH CORRECTIVE ACTION SHOULD BE (X4) ID ID (EACH DEFICIENCY MUST BE PREDEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE REGULATORY OR LSC IDENTIFYING INFORMATION APPROPRIATE DEFICIENCY) TAG TAG MEASURES/SYSTEMIC CHANGES PUT K 029 IN PLACE TO ENSURE THAT THE Continued from page 1 K 029 DEFICIENT PRACTICE WILL NOT RECUR: All requests to temporarily change the use of a room must be submitted in writing to 9/6/12 Plant Operations and the COO for approval. Plant Operations will ensure the appropriate door closures are in place prior to utilization. (see attachment B) Education will be provided to the SNF 9/6/12 Manager and Coordinator regarding procedure for submitting request to temporarily change the use of a room. (see Attachment D) PLANS TO MONITOR PERFORMANCE TO MAKE SURE SOLUTIONS ARE SUSTAINED: All doors will be checked for positive 9/5/12 latches and self closures monthly for 3 months, by Plant Operations, and will then be monitored during the unit Environmental Tours by Plant Operations ongoing. (see attachment A) All requests to temporarily change the use of a room will be monitored by the Plant 9/6/12 Operations Manager for completion. Education will be provided to Plant operations staff regarding monitoring for 9/6/12 positive latches and self closures by 9/7/12, (see attachment C) Education will be provided to the SNF Manager and Coordinator regarding 9/6/12 procedure for submitting request to temporarily change the use of a room. (see Attachment D)