INITIAL COMMENTS

No deficiencies were cited as a result of a complaint investigation survey of 1/10/13. Event ID# PGL811.

483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

Roanoke River Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance.

Roanoke River Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Roanoke River reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.

483.60 (b), (d), (e) Drug Records, Label/Store Drugs and Biologicals

1. The 2 outdated Insulin's noted in the med cart for rooms 12-35 were discarded by E.Brown on 1/10/13
<table>
<thead>
<tr>
<th>ID</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 431</td>
<td>Continued From page 1</td>
<td>F 431</td>
<td>2. All med carts and med rooms were audited for outdated multidose injectables and discarded by administrative nurses completed on 1/23/13</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>This REQUIREMENT</strong> is not met as evidenced by:</td>
<td></td>
<td>3. 100% in-servicing for nurses and medication aides on properly labeling and discarding expired multidose injectables to include insulin's was done by the SDC nurse and completed on 1/25/13.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Based on observation, record review and staff interviews, the facility failed to discard 2 outdated vials of insulin on 1(Medication cart for Rooms 12 -35) of 4 medication carts. Findings include:</td>
<td></td>
<td>Multidose injectables will be audited by the Administrative nurse's weekly X's 4 weeks using a QI audit tool, then monthly.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review of an undated facility policy titled &quot;Medication Expiration Dates&quot; under the section titled &quot;Expiration of Opened Multi-Dose Vials&quot; the policy read in part: &quot;all multi-dose vials shall be dated by the designated staff person at the time that the seal is broken and the first dose drawn. Subsequently the following expiration dates shall be observed: 28 days: Insulin.&quot;</td>
<td></td>
<td>4. The Executive QI committee will meet and review audits to identify and address concerns and/or trends, to follow up as necessary and to determine the frequency and need for continued monitoring weekly X4, then monthly X3.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>An observation, on 01/10/13 at 2:30 PM, was made of the medication cart designated for residents in rooms 12 -35 and in the presence of Nurse #1. During the observation, there were 2 bottles of insulin observed to be opened and dated 11/11/12. The dates on the vials were confirmed with Nurse #1 and she indicated the vials should be discarded after 28 days.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**ID PREFIX**  | **SUMMARY STATEMENT OF DEFICIENCIES** (Each deficiency must be preceded by full regulatory or LSC identifying information) | **ID PREFIX**  | **PROVIDER'S PLAN OF CORRECTION** (Each corrective action should be cross-referenced to the appropriate deficiency) | **DATE COMPLETION**
--- | --- | --- | --- | ---
K 000 | INITIAL COMMENTS | K 000 | Roanoke River Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The plan of correction is submitted as a written allegation of compliance.

Surveyor: 27871
This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, one story. Facility does not have a fully automatic sprinkler system.

The deficiencies determined during the survey are as follows:

**NFPA 101 LIFE SAFETY CODE STANDARD**

One hour fire rated construction (with ½ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

This STANDARD is not met as evidenced by:

Surveyor: 27871
Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliant, specific findings include:
1. laundry room door on clean side did not close and latch
2. door to med. records storage room was not

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**DATE**

**DIRECTOR/REPRESENTATIVE'S SIGNATURE**

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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.
**Statement of Deficiencies and Plan of Correction**

**Provider/Supplier/Clinic Identification Number:** 345145

**Multiple Construction**
- **Building:** 01 - Main Building 01
- **Wing:**

**Completed Date:** 01/30/2013

**Name of Provider or Supplier:** Roanoke River Nursing and Rehabilitation Center

<table>
<thead>
<tr>
<th>ID Tag</th>
<th>Summary Statement of Deficiencies (Each Deficiency Must Be Preceded by Full Regulatory or LSC Identifying Information)</th>
<th>ID Tag</th>
<th>Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency)</th>
<th>Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>K 029</td>
<td>Continued from page 1 self closing and not rated (building is not sprinkled). 42 CFR 483.70(a)</td>
<td>K 029</td>
<td>An audit by the administrator and the maintenance director will be conducted to ensure other doors in the facility are within the guidance of NFPA 19.3.2.1 by 2/14/13. All door found to be in need of replacing will be ordered by 2/15/13.</td>
<td></td>
</tr>
<tr>
<td>K 062</td>
<td>NFPA 101 Life Safety Code Standard Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</td>
<td>K 062</td>
<td>The administrator will inservice the maintenance director on Hazardous Areas and what rating the door must be by 2/14/13.</td>
<td></td>
</tr>
<tr>
<td>K 069</td>
<td>This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: per sprinkler report from Sunland Sprinkler Co. gauge on sprinkler system needs to be replaced. Also, no wrench was in sprinkler box.</td>
<td>K 069</td>
<td>The maintenance director will ensure all doors are at code and will bring to safety meeting monthly for two months.</td>
<td></td>
</tr>
</tbody>
</table>

**SFAR**

- **K 029**
  - The gauge for the sprinkler system was replaced on 2-1-13 and the wrench was ordered and will be in by 2-22-13.
- **K 062**
  - There is no other sprinkler system to audit.
- **K 069**
  - The administrator will inservice the maintenance director on this requirement and ensure the maintenance director will have gauge replace timely by 2-13-13.

**NFPA 101 Life Safety Code Standard**

- **K 029**
  - Smoking regulations are adopted and include no smoking.
  - (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.
  - (2) Smoking by patients classified as not
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
ROANOKE RIVER NURSING AND REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
119 GATING STREET
WILLIAMSTON, NC 27892

<table>
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<tr>
<th>ID</th>
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<tr>
<td>K 066</td>
<td>Continued From page 2 responsible is prohibited, except when under direct supervision.</td>
<td>K 066</td>
<td>1. Ashtrays of noncombustible material have been placed in the smoking areas. A red medal container with self-closing lid has been ordered and will be in place by 2-22-13</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</td>
<td></td>
<td>2. The administrator will audit both smoking areas to ensure they both meet the life safety codes by 2-11-13.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</td>
<td></td>
<td>3. The administrator will in-service the maintenance director on what should be in the smoking areas by 2-13-13.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**OTHER LSC DEFICIENCY NOT ON 2766**

This STANDARD is not met as evidenced by:
Surveyor: 27871
Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings include: employee smoking area is not equipment with noncombustible ash trays and metal container with self closing cover.

42 CFR 483.70(a)
NFPA 101 MISCELLANEOUS

This STANDARD is not met as evidenced by:
Surveyor: 27871
Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings.
**NAME OF PROVIDER OR SUPPLIER**
ROANOKE RIVER NURSING AND REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
119 GATING STREET
WILLIAMSTON, NC 27892

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<tr>
<td>K 130</td>
<td>Continued From page 3: Include: excess lint build up behind dry's in laundry room. 42 CFR 483.70(a)</td>
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<tbody>
<tr>
<td>K 130</td>
<td>K130</td>
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1. The lint behind the dryers have been blown out.
2. The lint behind the dryers has been audited and the lint behind the dryer will be blown out twice a week by the maintenance department.
3. The administrator will inservice the maintenance director on keeping behind the dryers free from lint build up by 2-13-13.
4. The administrator will audit the lint behind the dryer daily (five days a week) for three weeks to ensure cleaning twice a week is sufficient and get with the maintenance director with any changes to the schedule. The administrator will be brought to the monthly safety meeting.

Completion Date: 2/15/13
**Statement of Deficiencies and Plan of Correction**

**Provider/Supplier/CLA Identification Number:**
345145

**Multiple Construction**
A. Building
B. Wing
02 - Building 02

**Date Survey Completed:**
01/30/2013

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**Name of Provider or Supplier:**
Roanoke River Nursing and Rehabilitation Center

**Street Address, City, State, Zip Code:**
116 Gatling Street
Williamston, NC 27892

---

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| K000   | K000       | Surveyor: 27871  
This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, one story. Facility does not have a fully automatic sprinkler system.  
The deficiencies determined during the survey are as follows: no LSC deficiencies noted at time of survey. |                      |

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Laboratory Director's or Provider/Supplier Representative's Signature

**Title**

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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.