		AND HUMAN SERVICES & MEDICAID SERVICES		FC	RM APPROVED
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION (X3)	NO. 0938-0391 DATE SURVEY COMPLETED
/			A. BUILDIN	G	C
		345358	B. WING		07/10/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LOUISBL	JRG NURSING CENT	ER		202 SMOKETREE WAY LOUISBURG, NC 27549	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	S	F 00	0	
	complaint investiga ID# VTI711.	re cited as a result of the tion survey of 7/10/14. Event			
F 253 SS=D	483.15(h)(2) HOUS MAINTENANCE SE		F 25	3	7/31/14
	maintenance servic	ovide housekeeping and les necessary to maintain a ld comfortable interior.			
	by: Based on observation interviews the facility building maintenance safe and comfortabion resident common up s bath/shower room	NT is not met as evidenced ions, record reviews, and staff by failed to ensure adequate ce was provided to ensure a le environment for 2 of 2 se bath/shower rooms (Men ' a 300 hall; Women ' s 300 hall). The findings		F253 Standard Disclaimer: This plan of correction is provided as a necessary requirement of continued participation in the Medicare and Medic program(s) and does not, in any mann constitute an admission to the validity of the alleged deficient practice.	caid er,
	facility was conduct observation of the v bath/shower room I	at 10:20 a.m. a tour of the ed. During the tour an vomen ' s common use ocated on the 300 hall was lowing items were found to be d/or replacement:		The grab bars in the womenJ s common use bath/shower room stalls have been secured, tiles replaced. The light switch cover plate in womenJ s common use bath/shower room has been repaired a secured. The grab bars and tiles in the middle stall of menJ s common use	n :h ind
	observed to be loos could be easily be r inch. Some tiles at were observed to b mounting had put p	3 shower stalls were sely mounted on the walls and noved up and down $\frac{1}{4}$ to $\frac{3}{4}$ the grab bar mounting points e cracked where the loose ressure on the tiles. he room's light switch was		bath/shower room have been secured/repaired. The MenJ s and WomenJ s common u bath/shower rooms have been evaluat for any outstanding environmental needs/repairs.	
LABORATORY		ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

Electronically Signed

07/30/2014

PRINTED: 08/05/2014

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.

	-	AND HUMAN SERVICES				FORM	08/05/2014 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATI COM	E SURVEY PLETED		
		345358	B. WING				C 10/2014		
	PROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE		
F 253	observed to have 2 plate was loose on moved. On 07/08/2014 at 1 observation was co common use bath/ The 3 shower stalls the loose grab bars and could easily be an inch. The cover switch still had the plate was still loose On 07/09/2014 at 1 was conducted of t bath/shower room stalls were observe mounted loosely or moved up and dow plate to the room's broken off screws a the wall. On 07/10/2014 at 7 was conducted of t bath/shower room stalls were observe mounted loosely or moved up and dow plate to the room's broken off screws a the wall. On 07/10/2014 at 7 conducted with nur facility 's maintena procedures. Nurse	P broken off screws and the the wall and could easily be 10:25 a.m. a second onducted of the women's shower room on the 300 hall. s were observed to still have s mounted loosely on the walls e moved up and down $\frac{1}{4} - \frac{3}{4}$ of r plate to the room's light 2 broken off screws and the	F 2	253	The Administrator/designee and/or Environmental Services Manager/designee will use Weekly Common Bath/Shower Room Audi identify and correct environmental Episodes of non-compliance with Common Use Bath/Shower room r will be documented via Weekly Co Bath/Shower Room Audit tool and forwarded to Environmental Servic Director and Administrator for revise follow up. The plan of correction for this alleg deficient practice shall be included addendum to the facilityJ s most re Quality Assurance Committee meet minutes monthly for three months quarterly thereafter.	repair mmon es ew / led as an ecent eting			

		AND HUMAN SERVICES				FORM	08/05/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345358	B. WING				C 10/2014
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LOUISBI	URG NURSING CENT	ER			02 SMOKETREE WAY OUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 253	and when we find, or reported to us need maintenance we log maintenance log bor manager reviews th day) and he initiates in the log book. Wh completed he will si work was done or of We also will do a ver maintenance mana that needs immediate On 07/10/2014 at 1 conducted with the manager. The mai " We have a mainten station and when the finds a problem that replacement the stat in the log. I will rev times a day and init When the repair(s) the book indicating deferred, indicate th parts). We also will the staff will tell me or replacement imme right then and there be entered into the conduct a room audits four DON usually puts th in the log book. " On 07/10/2014 at 1	or a maintenance problem is ding repairs or replacement by g the problem into the bok. The maintenance he log book (several times a s repairs based on the entries hen the repair(s) are ign off the book indicating the deferred for whatever reason. erbal notification to the ore to notify him of an issue ate attention and he will fix the ely. " 2:35 p.m. an interview was facility 's maintenance intenance manager indicated - enance log book at the nurse's he staff or a family member	F 2	:53			

Facility ID: 923313

If continuation sheet Page 3 of 25

		AND HUMAN SERVICES				FORM	08/05/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345358	B. WING				C 10/2014
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LOUISB	JRG NURSING CENT	ER			02 SMOKETREE WAY OUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 253	maintenance mana outstanding log ent maintenance staff v items observed in r in the women 's co The maintenance n administrator would facility 's QA minut needed repair or re On 07/10/2014 at 1 facility's administrat administrator indica currently noted in th place other than the indicating items that replacement. The a had transferred all if were previously in t maintenance log bo been repaired. On 07/10/2014 at 2 the women 's com was conducted with manager and facilit following items wer of repair and/or rep The grab bars in all observed to still be cover plate to the ro observed to still hav the plate was still log 2. On 07/07/2014 at facility was conducted	ducted with the facility's ger. There were no ries indicating the was notified of or aware of the need or repair or replacement immon use bath/shower room. nanager indicated the facility's a sometimes have items in the es indicating something placement. :40 p.m. an interview with the tor was conducted. The ated there were no items ne QA information or any other e maintenance log book it were in need of repair or administrator indicated she items she knew about that he QA information to the bok for repair and they had all 1:00 p.m. a fifth observation of mon use bath/shower rooms in the facility's maintenance y's administrator. The e still observed to be in need lacement: 13 shower stalls were loose on the walls and the bom's light switch was we the 2 broken off screws and bose on the wall.	F 2	253			

If continuation sheet Page 4 of 25

	-	AND HUMAN SERVICES				FORM	08/05/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION		(X3) DATE COM	E SURVEY PLETED
		345358	B. WING				C 10/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE		
LOUISBU	URG NURSING CENT	ER		202 SMOKETREE WAY LOUISBURG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD THE APPROPI	BE	(X5) COMPLETION DATE
F 253	bath/shower room I conducted. The fol need of repair: The grab bar in the observed to be loos be easily moved up the tile at the left sid cracked indicating t and down enough t it was mounted. 07/08/2014 at 10:29 was conducted of th bath/shower room of in the middle shower loose on the wall, c down ¾ of an inch æ mounting point was 07/09/2014 at 10:59 conducted of the m bath/shower room of in the middle shower loose on the wall, c down ¾ of an inch æ mounting point was 07/10/2014 at 7:55 conducted of the m bath/shower room of in the middle shower loose on the wall, c down ¾ of an inch æ mounting point was 07/10/2014 at 7:55 conducted of the m bath/shower room of in the middle shower loose on the wall, c down ¾ of an inch æ mounting point was 07/10/2014 at 7:55 conducted of the m bath/shower room of in the middle shower loose on the wall, c down ¾ of an inch æ mounting point was 0n 07/10/2014 at 1	located on the 300 hall was llowing item was found to be in a middle shower stall was se on the wall. The bar could o and down <sup>3</sup> / <sub>4</sub> of an inch and de mounting point was the bar had been moved up to crack the tile through which 5 a.m. a second observation he men's common use on the 300 hall. The grab bar er stall was observed to still be could be easily moved up and and the tile at the left side as still cracked. 5 a.m. a third observation was nen's common use on the 300 hall. The grab bar er stall was observed to still be could be easily moved up and and the tile at the left side as still cracked. 5 a.m. a third observation was nen's common use on the 300 hall. The grab bar er stall was observed to still be could be easily moved up and and the tile at the left side as still cracked. a.m. a fourth observation was nen's common use on the 300 hall. The grab bar er stall was observed to still be could be easily moved up and and the tile at the left side as the solon hall. The grab bar er stall was observed to still be could be easily moved up and and the tile at the left side	F 253				

If continuation sheet Page 5 of 25

		AND HUMAN SERVICES				FORM	08/05/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		345358	B. WING	i			C 10/2014
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LOUISB	URG NURSING CENT	ER			02 SMOKETREE WAY .OUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 253	maintenance log bo and when we find a or replacement by r problem in the mair maintenance mana (several times a da When the repair(s) the book indicating deferred for whatew verbal notification to notify him of an issu attention and he fix On 07/10/2014 at 1 conducted with the manager. The mai "We have a mainter station and when the finds a problem tha replacement the stat in the log. I will rev times a day and init When the repair(s) the book indicating deferred, indicate th parts). We also will the staff will tell me or replacement imm right then and there entered into the log conduct a room audits fou DON usually puts th in the log book. " On 07/10/2014 at 1 facility's maintenant	book here at the nurse's station a problem that needs a repair maintenance we log the ntenance log book and the iger will review the log book y) and initiate the repairs. are completed he will sign off the work was done or ver reason. We also will do a the maintenance manager to ue that needs immediate es it immediately. " 2:35 p.m. an interview was facility 's maintenance ntenance manager indicated - enance log book at the nurse's the staff or a family member	F 2	253			

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		AND HUMAN SERVICES			FORM	08/05/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345358	B. WING	 		C 10/2014
NAME OF P	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
LOUISBU	IRG NURSING CENT	ER		02 SMOKETREE WAY OUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
	outstanding log enti- maintenance staff v items observed in m in the men 's comm The maintenance m administrator would facility 's QA minute needed repair or re On 07/10/2014 at 1 facility's administrat administrator indica currently noted in the place other than the indicating items tha replacement. The a had transferred all i were previously in t maintenance log bo been repaired. On 07/10/2014 at 2 the men 's commo conducted with the manager and facility following item wase repair and/or replac The middle shower have the loose grab the grab bar 's left 483.25(I) DRUG RE UNNECESSARY D Each resident's dru unnecessary drugs drug when used in o	ger. There were no ries indicating the was notified of or aware of the need or repair or replacement non use bath/shower room. nanager indicated the facility's a sometimes have items in the es indicating something placement. :40 p.m. an interview with the tor was conducted. The ated there were no items ne QA information or any other e maintenance log book at were in need of repair or administrator indicated she items she knew about that he QA information to the book for repair and they had all :00 p.m. a fifth observation of n use bath/shower room was facility's maintenance y's administrator. The e still observed to be in need of cement: stall was observed to still o bar and the cracked tiles at mounting point. EGIMEN IS FREE FROM	F 2			7/31/14

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMF	E SURVEY PLETED
		345358	B. WING			( 07/1	C 1 <b>0/2014</b>
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
LOUISBU	JRG NURSING CENT	ER		2 L			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	without adequate m indications for its us adverse consequer should be reduced combinations of the Based on a compre- resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and o record; and residen drugs receive gradu behavioral intervent	onitoring; or without adequate se; or in the presence of nees which indicate the dose or discontinued; or any	F 3	329			
	by: Based on record reconsultant pharmad to ensure residents drugs, including du residents (Resident unnecessary drugs Resident #43 was a 08/30/2010 after a for a stroke and par diagnoses included resident ' s current orders included - C mouth every day (0	NT is not met as evidenced eview, facility staff, and cist interviews the facility failed were free from unnecessary plicate therapy for 1 of 6 #43) reviewed for . The findings included: admitted to the facility on hospitalization and treatment ralysis. The resident's depression. A review of the physician 's medication elexa 20 milligrams 1 by 2/18/2014) and Welbutrin 100 uth every day (01/07/2014) for			F329 Standard Disclaimer: This plan of correction is provided a necessary requirement of continued participation in the Medicare and Me program(s) and does not, in any ma constitute an admission to the validi the alleged deficient practice. Resident #43 has had medication re by physician as well as the On-Site clinician with the following documen noted: A GDR of Wellbutrin 100 mg AM and Celexa 20 mg po q AM is medically contraindicated at this tim	l edicaid inner, ty of eview tation po q	

Facility ID: 923313

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PRINTED: 08/05/2014

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			ON	<u>18 NO.</u>	APPROVEI 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (	COMF	E SURVEY PLETED
		345358	B. WING			07/1	) 1 <b>0/2014</b>
NAME OF I	PROVIDER OR SUPPLIER	L			TREET ADDRESS, CITY, STATE, ZIP CODE	•	
LOUISBI	JRG NURSING CENT	ER			02 SMOKETREE WAY OUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 329	Continued From pa	ige 8	F 3	29			
	depression.	-			will result in impairment of function a increased distressed behavior.	and	
	The resident's annual Minimum Data Set (MDS dated 04/14/2014 indicated the resident to be severely cognitively impaired and having a Basi Interview for Mental Status (BIMS) of 3 out of 1 The MDS also indicated the resident had an active diagnosis of depression and was receivin medications for depression. The resident's Care Plan dated 08/30/2010 with latest update on 02/04/2014 indicated the resident had a diagnosis of depression and was receiving the antidepressant medications Celex and Welbutrin. The facility 's goal was that the resident would have no acute signs of depressi as evidenced by no social withdrawal through th next review (90 days). The facility 's interventions included - administer medications as ordered, observe for signs/symptoms of side effects of medications and to notify the physicia				All pharmacy recommendations for p three months have been reviewed for appropriate follow up with no further variances identified. Monthly Pharmacy recommendation given to DON and/or designee for for up. The DON will review all pharma recommendations weekly with Pharm Recommendation Audit tool to ensure follow up until all monthly recommendations and responses ar accounted for. Pharmacy Consultant will ensure all recommendations are addressed due monthly Medication review. Variance be reported to Administrator for follo	or blow cy macy re re uring es will	
	seizures, tachycard report to also report encourage resident opportunities for re- concerns, refer to p and administer Cela A review of the con- documented month Reviews (MRRs) si- consultant pharmac the physician which dated 04/23/2014 to reduction (GDR) of Welbutrin. The phy- recommendation of	e for adverse reactions such a lia, agitation, confusion and t these to the physician, t to attend activities, provide sident to verbalize feelings and osychiatric services as needed, exa and Welbutrin as ordered. sultant pharmacist's ny Medication Regimen nce April 2013 indicated the cist made recommendations to n included a recommendation to conduct a gradual dose the resident's antidepressant visician reviewed the n 05/06/2014 and requested a be conducted prior to			The plan of correction for this allege deficient practice shall be included a addendum to the facilityJ s most rec Quality Assurance Committee meeti minutes. Additionally, the Administra DON and/or Clinical Coordinator sha report any episodes of non-compliar with Monthly Pharmacy Recommendations to Quality Assura Committee monthly for three months then quarterly thereafter.	as an eent ing ator, all nce ance	

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CENTER STATEMENT AND PLAN C NAME OF I LOUISBU	RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER JRG NURSING CENT	TEMENT OF DEFICIENCIES	A. BUILC B. WING	S S S S	C LE CONSTRUCTION S STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549 PROVIDER'S PLAN OF CORRECTION	FORM <u>OMB NO.</u> (X3) DAT COM 07/	: 08/05/2014 APPROVED .0938-0391 E SURVEY IPLETED C 10/2014
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION DATE
F 329	conducting a trial G consultant pharmad revealed a hand wr 's social worker wa consult request on " On Site " Psych s of Resident # 43 's Record (MAR) rever receive both Celexa depression, a duplit same diagnosis. A review of the consu- Medication Regime revealed there was the April 2014 's re There was no June documentation on t MRR chart review s Welbutrin GDR info at or being followed physician or the fact A review of a Consu- Communication to f 06/23/2014 was con- Request psych to a Antidepressant GD milligram every mod (It was noted this co- dated 2 months after which received no a communication she dated her review as form. On the side of the signature of the services worker wh The psychiatric services	DR. A review of the cist 's recommendation sheet itten note indicating the facility as aware of the psychiatric 05/07/2014 and would let the services know. Further review Medication Administration ealed the resident continued to a and Welbutrin for cation of medications for the sultant pharmacist 's monthly on Review (MRR) for May 2014 no mention or information of commended Welbutrin GDR. 2014 MRR or other the consultant pharmacist 's sheets to indicate the ormation was still being looked a up on from April 2014 by the cility 's DON. Wattant Pharmacist the Physician sheet dated inducted which indicated - iddress - RE: CMS F-329 R attempt - Welbutrin 100 rning (QAM). communication sheet was er the initial recommendation	F	329			

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		AND HUMAN SERVICES				FORM	: 08/05/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DAT CON	E SURVEY IPLETED
		345358	B. WING	i			C 10/2014
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LOUISB	URG NURSING CENT	ER			202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	function or increase A review of the con- recommendation to 43 dated 04/23/201 Pharmacist Commu- sheet dated 06/23/2 facility ' s DON on 0 DON could not stat the 2 months betwe Further review of R DON indicated ther the physician or the to indicate the phys made by the on site started a trial GDR documented the W contraindicated. Du could not find any 0 consultant pharmao #43 was receiving 2 diagnosis (depress by the consultant pharmao #43 was receiving 2 diagnosis (depress by the	age 10 ikely to result in impairment of ed distressed behavior. sultant pharmacist ' s the physician for Resident # 4 and the Consultant unication to the Physician 2014 was conducted with the 07/09/2014 at 9:05 a.m. The e why no action was taken for een 04/23/14 and 06/23/14. esident #43 ' s chart with the e was no documentation by e DON/consultant pharmacist ician reviewed the evaluation e psychiatric services worker, of the Welbutrin, or elbutrin GDR was medically uring the review the DON also documentation by the cists to indicate why Resident 2 medications for the same ion) and/or a recommendation harmacists to the physician for e resident's duplication of boument the physician ' s sician ' s progress notes, the /telephonic orders, and s Order Sheets (POS) for nd July 2014 was also facility ' s DON. There was no ne physician ' s progress s, or monthly POS ' s for those the physician was aware of atus per the consultant mmendation for the Welbutrin ysician was notified the	F	329			

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		AND HUMAN SERVICES					FORM	: 08/05/2014 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION		CON	E SURVEY IPLETED C
		345358	B. WING					0 10/2014
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE	E, ZIP CODE	_	
LOUISB	JRG NURSING CENT	ER			02 SMOKETREE WAY OUISBURG, NC 27549			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD O THE APPROPE	BE	(X5) COMPLETION DATE
F 329 F 428 SS=D	completed and the there was no docur indicate further acti taken for the GDR duplication of media On 07/09/2014 at 5 conducted with the expectation on ens pharmacists - #1 w Regimen Review m physician acted on recommendations t consults and indica indicated it was her contracted consulta a MRR every month facility and the physi follow up on all con recommendations a medications for a s 483.60(c) DRUG R IRREGULAR, ACT The drug regimen of reviewed at least of pharmacist. The pharmacist mu the attending physic nursing, and these	s worker 's consult was findings were reviewed. Also mentation by the physician to on would or would not be recommendation and/or cations Celexa and Welbutrin. 5:15 p.m. an interview was facility's DON concerning her uring the consultant ould conduct a Medication nonthly and #2 ensuring the all consultant pharmacist to include reviewing requested ting further action. The DON rexpectation that the ant pharmacists would conduct h for every resident in the sician would complete and sultant pharmacist and review for duplication or ingle diagnosis. EGIMEN REVIEW, REPORT		329				7/31/14

Facility ID: 923313

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORMA	08/05/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION (		PLETED
		345358	B. WING	i		C 07/1	, 0/2014
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LOUISBU	IRG NURSING CENT	ER			202 SMOKETREE WAY -OUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	consultant pharmac to ensure monthly M (MRR) were conduct last recertification s records reviewed for 43, 60, and 24). The 1. Resident #7 was 11/02/2005 and re-a resident's diagnose Hypertension, Coro Dementia, Coronary Degeneration disor dislocated shoulder indicated the reside for the listed diagno A review of the cons documented month Reviews (MRRs) in pharmacist conduct 4) during several m period and none in recertification perior have MRRs conduct pharmacist for resid last recertification), and December 201 On 07/09/2014 at 9 conducted with the missing MRRs. The the chart and also in entries or other doc	eviews, facility staff and cist interviews the facility failed Medication Regimen Reviews cted for each month since the urvey for 4 of 6 resident or unnecessary drugs (# ' s 7, he findings included: admitted to the facility on admitted on 04/06/2012. The s included a history of nary Artery Disease, Reflux, y Artery Bi-pass, Macular der, and a history of a . Resident # 7 ' s records on twas receiving medications oses. sultant pharmacist's ly Medication Regimen dicated the consultant ted multiple reviews (2, 3, or onths in the recertification other months of the d. The months noted to not cted by the consultant dent # 7 were April 2013 (after June 2013, October 2013, 3. :05 a.m. an interview was facility's DON concerning the e DON conducted a review of ndicated there were no MRR umentation by either of the	F	428	<ul> <li>F428</li> <li>Standard Disclaimer:</li> <li>This plan of correction is provided at necessary requirement of continued participation in the Medicare and Meprogram(s) and does not, in any ma constitute an admission to the validit the alleged deficient practice.</li> <li>Residents # 7, 43, 60, 24 have had 1 by Pharmacist Consultant for July 20</li> <li>All residents have had July 2014 MM Pharmacist Consultant.</li> <li>Pharmacist Consultant will assess e residentJ s drug regimen on a month basis per Pharmacy Policy and Procedure.</li> <li>The Director of Nursing/Clinical Coordinator and/or designee shall e compliance with MMR during end of month Physician Order Review. Anyidentified discrepancies shall be remediated.</li> <li>The plan of correction for this allege deficient practice shall be included at addendum to the facilityJ s most reconductionator and/or Clinical Coordinator shareport any non-compliance with MM policy and procedure identified to Question of the procedure of the proce</li></ul>	I edicaid inner, ty of MMR 014. MR by each hly each hly each hly each hly each ator, all R uality	
	facility 's consultan of April 2013, June	t pharmacists for the months 2013, October 2013, and he DON indicated she was in			Assurance Committee monthly for the months and then quarterly thereafter	hree	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	): 08/05/2014 APPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DA	TE SURVEY MPLETED
		345358	B. WING	;		07	C / <b>10/2014</b>
NAME OF I	PROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE		
LOUISB	URG NURSING CENT	ER			202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC 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 428	contact with the fac and they would be p information to indica conducted during th additional supporting provided by the DO for April 2013, June December 2013 we On 07/09/2014 at 1 conducted with the pharmacist. The pl why monthly Medica resident # 7 were n October, and Decen indicated she under every 30 days (which February as it only required to complet monthly basis, but a at the beginning of of the same month month to cover the MRR. The pharma unaware she had a MRR monthly per th On 07/09/2014 at 5 conducted with the expectation on ensi- pharmacists condur Regimen Review. expectation that the pharmacist would c every month for ever 2. Resident # 43 w	ility's consultant pharmacists possibly be sending supporting ate monthly MRRs were ne months indicated. No ig documentation was N/facility to indicate the MRRs 2013, October 2013, and ere conducted. :15 p.m. an interview was facility's consultant narmacist could not indicate ation Regimen Reviews for ot conducted for April, June, mber 2013. The pharmacist rstood they were to do a MRR ch could possibly skip had 28 days) and were not e the MRR on a calendar also thought they could do one the month and one at the end or close to the end of the following month's required cist indicated she was requirement to complete a	F	428			

		AND HUMAN SERVICES				FORM	08/05/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		345358	B. WING	i			C 10/2014
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LOUISBU	URG NURSING CENT	ER			202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428	Late effects of right Vascular Disease (I Failure (CHF), Atria Hypertension (HTN Glaucoma, Legal bl Multi-focal Dementi Muscular edema, H of Myocardial Infarce incontinence, Anxie Poor circulation. Re indicated the reside for the listed diagno A review of the con- documented month Reviews (MRRs) in pharmacist conduc 4) during several m period and none in recertification perior have MRRs conduc pharmacist for resid October 2013, and On 07/09/2014 at 9 conducted with the missing MRRs. Th the chart and also i entries or other doo facility ' s consultan of June 2013, Octo 2013. The DON ind with the facility's co would be possibly b information to indica conducted during the additional supporting provided by the DO	t sided Hemiplegia, Peripheral PVD), Congestive Heart al Fibrillation (A-Fib), I), Diabetes type 2 (DM II), lindness, Senile cataracts, ia, Coagulation deficit, Diabetic dypercholesterolemia, a history ct (MI), Urinary and bowel ety, Depression, Agitation, and esident # 43 ' s records ent was receiving medications oses. sultant pharmacist's hy Medication Regimen indicated the consultant ted multiple reviews (2, 3, or nonths in the recertification other months of the d. The months noted to not cted by the consultant dent # 43 were June 2013,	F 4	428			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/05/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345358	B. WING				C 10/2014
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LOUISBL	JRG NURSING CENT	ER			02 SMOKETREE WAY OUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	Continued From pa 2013 were conduct	ed.	F 4	28			
	conducted with the pharmacist. The pl why monthly Medic resident # 43 were October, and Dece indicated she under every 30 days (whic February as it only required to complet monthly basis, but a at the beginning of of the same month month to cover the MRR. The pharma unaware she had a MRR monthly per the On 07/09/2014 at 5 conducted with the expectation on ensi- pharmacists condu- Regimen Review. expectation that the pharmacist would of	harmacist could not indicate ation Regimen Reviews for not conducted for June, mber 2013. The pharmacist rstood they were to do a MRR ch could possibly skip had 28 days) and were not the MRR on a calendar also thought they could do one the month and one at the end or close to the end of the following month's required cist indicated she was requirement to complete a					
	02/05/2013. The re Chronic kidney dise Disease (ESRD) St Osteoarthritis, Aner Hypertension, Coro Dementia, Dizzines Gout, Reflux, Noctu	as admitted to the facility on esident's diagnoses included - ease, End Stage Renal age 5, Hypothyroidism, mia, Anxiety, Cellulitis, nary Artery Disease (CAD), s, a history of Leukocytosis, uria, Allergic Rhinitis, cholesteremia, Psychosis, and					

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		AND HUMAN SERVICES				FORM	08/05/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COM	E SURVEY IPLETED
		345358	B. WING	i			C 10/2014
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LOUISBI	URG NURSING CENT	ER			02 SMOKETREE WAY .OUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 428	a history of Purpura records indicated th medications for the A review of the con- documented month Reviews (MRRs) in pharmacist conduct 4) during several m period and none in recertification perio- have MRRs conduct pharmacist for reside (after last recertificat 2013, and Decemb On 07/09/2014 at 9 conducted with the missing MRRs. Th the chart and also i entries or other door facility ' s consultan of April 2013, June December 2013. T contact with the fact and they would be p information to indica- conducted during the additional supporting provided by the DO for April 2013, June December 2013 we On 07/09/2014 at 1 conducted with the pharmacist. The pf why monthly Medica- resident # 60 were	a of the skin. Resident # 60 ' s he resident was receiving listed diagnoses. sultant pharmacist's hy Medication Regimen idicated the consultant ted multiple reviews (2, 3, or nonths in the recertification other months of the d. The months noted to not cted by the consultant dent # 60 were April 2013 ation), June 2013, October er 2013. co5 a.m. an interview was facility's DON concerning the e DON conducted a review of ndicated there were no MRR cumentation by either of the t pharmacists for the months 2013, October 2013, and he DON indicated she was in cility's consultant pharmacists possibly be sending supporting ate monthly MRRs were he months indicated. No ng documentation was DN/facility to indicate the MRRs e 2013, October 2013, and	F 4	428			

Facility ID: 923313

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		AND HUMAN SERVICES				FORM	08/05/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345358	B. WING				C 10/2014
NAME OF I	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LOUISB	URG NURSING CENT	ER			02 SMOKETREE WAY OUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	indicated she under every 30 days (which February as it only required to complet monthly basis, but a at the beginning of of the same month month to cover the MRR. The pharma unaware she had a MRR monthly per th On 07/09/2014 at 5 conducted with the expectation on ensu- pharmacists condu Regimen Review. expectation that the pharmacist would of every month for ever 4. Resident # 24 w 11/25/2013. The re Altered mental state Leukocytosis, Card Chronic Hypotensic 24 ' s records indica medications for the A review of the con documented month Reviews (MRRs) in pharmacist conduc 4) during several m period and none in recertification perio have MRRs conduc	rstood they were to do a MRR ch could possibly skip had 28 days) and were not te the MRR on a calendar also thought they could do one the month and one at the end or close to the end of the following month's required acist indicated she was requirement to complete a he calendar. 5:15 p.m. an interview was facility's DON concerning her uring the consultant ct a monthly Medication The DON indicated it was her e contracted consultant conduct a monthly MRR for ery resident in the facility. vas admitted to the facility on esident's diagnoses included - us, Hypertension (HTN), liac Dysrhythmia (bradycardia), on, and Dementia. Resident # ated the resident was receiving	F 4	128			

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		AND HUMAN SERVICES				FORM	08/05/2014 APPROVED 0938-0391
STATEMENT	STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		345358	B. WING				C 10/2014
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
LOUISB	URG NURSING CENT	ER			202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	(after last recertifica 2013, and Decemb On 07/09/2014 at 9 conducted with the missing MRRs. Th the chart and also i entries or other door facility 's consultant of April 2013, June December 2013. T contact with the fact and they would be p information to indic conducted during th additional supportin provided by the DO for April 2013, June December 2013 we On 07/09/2014 at 1 conducted with the pharmacist. The pl why monthly Medic resident # 24 were October, and Dece indicated she under every 30 days (whic February as it only required to complet monthly basis, but a at the beginning of of the same month month to cover the MRR. The pharma unaware she had a MRR monthly per th	ation), June 2013, October er 2013. :05 a.m. an interview was facility's DON concerning the e DON conducted a review of ndicated there were no MRR sumentation by either of the t pharmacists for the months 2013, October 2013, and 'he DON indicated she was in ility's consultant pharmacists possibly be sending supporting ate monthly MRRs were he months indicated. No ag documentation was N/facility to indicate the MRRs 2013, October 2013, and ere conducted. :15 p.m. an interview was facility's consultant harmacist could not indicate ation Regimen Reviews for not conducted for April, June, mber 2013. The pharmacist rstood they were to do a MRR ch could possibly skip had 28 days) and were not the the MRR on a calendar also thought they could do one the month and one at the end or close to the end of the following month's required cist indicated she was requirement to complete a	F	128			

Facility ID: 923313

If continuation sheet Page 19 of 25

		AND HUMAN SERVICES				FORM	08/05/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345358	B. WING				_ 10/2014
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LOUISB	URG NURSING CENT	ER			02 SMOKETREE WAY OUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428 F 431 SS=D	conducted with the expectation on ensi- pharmacists condu- Regimen Review. expectation that the pharmacist would of every month for ever 483.60(b), (d), (e) II LABEL/STORE DR The facility must en a licensed pharmacion of records of receip controlled drugs in accurate reconciliat records are in order controlled drugs is reconciled. Drugs and biological labeled in accordan professional princip appropriate access instructions, and the applicable. In accordance with facility must store a locked compartment controls, and permi- have access to the The facility must pri- permanently affixed controlled drugs list Comprehensive Dri Control Act of 1976	facility's DON concerning her uring the consultant ct a monthly Medication The DON indicated it was her e contracted consultant conduct a monthly MRR for ery resident in the facility. DRUG RECORDS, UGS & BIOLOGICALS nploy or obtain the services of cist who establishes a system at and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically als used in the facility must be nee with currently accepted bles, and include the ory and cautionary e expiration date when State and Federal laws, the II drugs and biologicals in nts under proper temperature t only authorized personnel to	F 4				7/31/14

		& MEDICAID SERVICES	0.00			0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
			A. BUILDII			C
		345358	B. WING			10/2014
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LOUISBI	JRG NURSING CENT	ER		202 SMOKETREE WAY LOUISBURG, NC 27549		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETIO DATE
F 431	Continued From pa	aae 20	F 43	31		
	package drug distri	bution systems in which the ninimal and a missing dose can				
	by: Based on observation interviews the facility and other medication facility 's medication crash cart were pro- for 3 of 5 carts. The 1. On 07/07/2014 at conducted. During observation of the f storage closet acro- was conducted. In emergency crash of cart was observed in the out position at locking mechanism the unlocked position cart revealed medic sterile kits with medic being stored in the On 07/08/2014 at 8 was made of the fa storage closet and crash cart. The cart unlocked and the loc in the out positions indicating the locks observed to still hard	NT is not met as evidenced tions, record reviews, and staff ty failed to ensure prescription ons and lubricants in the on, wound care treatment, and operly stored and/or secured e findings included: a tour of the facility was the tour at 10:55 a.m. an facility 's unlocked oxygen ss from the nurse's station the closet the facility's eart was observed. The crash to have 2 locking mechanisms and the red dots on each (indicating the locks were in on) were visible. The crash cations and lubricants and dications and lubricants were cart. B:10 a.m. a second observation cility 's unlocked oxygen the unlocked emergency rt was observed to still be ocking mechanisms were still with the red dots showing were unlocked. The cart was ve the medications/lubricants cations/lubricants in the		<ul> <li>F431</li> <li>Standard Disclaimer:</li> <li>This plan of correction is provided necessary requirement of continuparticipation in the Medicare and program(s) and does not, in any mostitute an admission to the variath alleged deficient practice.</li> <li>All Medication/Treatment Carts and per Medication Storage policy and procedure.</li> <li>The Emergency crash cart no lon contains medications, lubricants, kits.</li> <li>All Licensed Nursing Staff / Medication Storage policy and procedure.</li> <li>All Licensed Nursing Staff / Medication Storage policy and procedure.</li> <li>Pharmacy Consultant will comple Medication Storage audits quarte submission to QA committee.</li> <li>The Director of Nursing, Clinical Coordinator and/or Administrator ensure compliance by completing</li> </ul>	ed Medicaid manner, lidity of re locked d ger sterile cation ne ocedure. nd ocedure. te rly for shall	

Facility ID: 923313

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/05/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		345358	B. WING				_  0/2014
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LOUISB	JRG NURSING CENT	ER			02 SMOKETREE WAY OUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	On 07/09/2014 at 1 was made of the far storage closet and f crash cart. The car unlocked and the lo in the out positions indicating the locks observed to still hav and sterile kit medie drawers. On 07/10/2014 at 1 was made of the ox unlocked emergend the facility's adminis observed to still be mechanisms were s the red dots showin unlocked. The cart medications/lubrica and the Administrat emergency crash c per the facility's poli A review of the facil procedure entitled N The policy and proc paragraph D on pag will be locked at all On 07/10/2014 at 9 conducted with the expectation, treatme secured while not in being used. The D	:35 p.m. a third observation cility 's unlocked oxygen the unlocked emergency t was observed to still be ocking mechanisms were still with the red dots showing were unlocked. The cart was ze the medications/lubricants cations/lubricants in the 0:15 a.m. a fourth observation cygen storage closet and the cy crash cart with the DON and strator. The cart was unlocked and the locking still in the out positions with g indicating the locks were was observed to still have the nts and sterile kit nts in the drawers. The DON or both indicated the art was supposed to be locked	F 4	31	Random Audit of Medication/Treatm Carts form on various shifts 3x weel and prn for 30 days and weekly ther to ensure compliance with Medicatio Storage policy and procedure. Any identified discrepancies shall be remediated. The plan of correction for this allege deficient practice shall be included a addendum to the facilityJ s most red Quality Assurance Committee meet minutes. Additionally, the Administr DON and/or Clinical Coordinator sha report any episodes of non-complian with Medication Storage policy and procedure identified to Quality Assu Committee monthly for three month then quarterly thereafter.	kly reafter on ed as an cent ing ator, all nce rance	

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		AND HUMAN SERVICES				FORM	08/05/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATI COM	E SURVEY PLETED
		345358	B. WING				C 10/2014
NAME OF F	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE		
LOUISBU	JRG NURSING CENT	ER			02 SMOKETREE WAY OUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 431	Continued From partial that the medication were to be locked were to be locked were be reassigned to the cart. 2. On 07/09/2014 a continuous observation wound care treatment by room 301. The posserved to be unlocked were and the locking mechanism was in dot on the locking mechanism was in dot on the locking mechanism was in dot on the locking mechanism was one pulled out displayin in the drawer (sever wound care ointme There was no wour cart. Facility reside were observed to we the unlocked/unatte 9:35 a.m. the woun of the cart was obsicome out of room 3 On 07/09/2014 at 9 conducted with the member. The facility member indicated s wound care treatmed 301 with the door care sident and forge prior to going into the facility 's wound care was support of the was sup	Ige 22 , treatment, and crash carts when not in use or the staff to the cart was out of sight of at 9:25 a.m. to 9:35 a.m. a ation was made of the facility's ent cart parked on the 300 hall wound care treatment cart was ocked as the locking the out position and the red nechanism was visible. Also of the middle drawer 's was g the prescription medications ral resident's prescription nts and other medications). Ind care staff member at the ents, family members, and staff valk, and/or wheelchair past ended wound care cart. At d care staff member in charge erved to open the door and 301. 2:35 a.m. an interview was facility 's wound care staff ity 's wound care staff she was not in sight of her ent cart as she was in room losed providing wound care to ot to close and lock her cart he resident 's room. The re staff member indicated she posed to close and lock the as not physically at the cart or	1	131			
	was out of sight of t						

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		AND HUMAN SERVICES				FORM	: 08/05/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	E SURVEY IPLETED
		345358	B. WING				C / <b>10/2014</b>
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
LOUISB	URG NURSING CENTI	ER			02 SMOKETREE WAY OUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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 431	procedure entitled M The policy and proc paragraph D on pag will be locked at all On 07/10/2014 at 9 conducted with the expectation for ensu- medication, treatme secured while not in being used. The Du aware of the facility that the medication, were to be locked w member assigned t the cart. 3. On 07/10/2014 at continuous observa- hall's medication ac the 200 hall across There was no staff and the cart was ob locking mechanism position and the rec mechanism was vis unlocked. Residen and /or wheel thems cart. At 7:40 a.m. the observed at the far resident's room and On 07/10/2014 at 7 conducted with the nurse indicated she and she should not facility's policies and	Medication Storage was made. cedure read in part in ge S-8: The medication carts times when not in use. :35 a.m. an interview was facility's DON concerning her uring medications stored in ent and crash carts were in view or the carts were not ON indicated that all staff were 's policies and procedures and , treatment, and crash carts when not in use or the staff to the cart was out of sight of at 7:35 a.m. to 7:40 a.m. ation was made of the 200 dministration cart located on from the women's bathroom. member attending the cart oserved to be unlocked as the was observed to be in the out	F	431			

Facility ID: 923313

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							PRINTED: 08/05/2014 FORM APPROVED DMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
345358		B. WING			C 07/10/2014			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
LOUISBURG NURSING CENTER			202 SMOKETREE WAY LOUISBURG, NC 27549					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 431	while at the end of t with the door closed A review of the facil procedure entitled I The policy and proc paragraph D on pag will be locked at all On 07/10/2014 at 9 conducted with the expectation for ens medication, treatme secured while not in being used. The D aware of the facility that the medication were to be locked v	the hall in a resident 's room	F	431				

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