

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

PRINTED: 06/10/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345137	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>JUN 24 2011</b> B. WING	(X3) DATE SURVEY COMPLETED  05/26/2011
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NAME OF PROVIDER OR SUPPLIER  SOUTH VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2221 RALEIGH ROAD ROCKY MOUNT, NC 27803
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F 159 SS=D	<p><b>483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS</b></p> <p>Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.</p> <p>The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)</p> <p>The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.</p> <p>The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the</p>	F 159	<p>"Submission of this response to the Statement of Deficiency by the undersigned does not constitute an admission that the deficiency existed and/or were correctly cited and/or require correction.</p> <p><b>F Tag 159</b></p> <p>Resident # 1 family came in, obtained a check, and bought a new TV for resident. This was on 5/26/11.</p> <p>All resident accounts were reviewed by the BOM and Regional AR person to ensure all resident trust accounts were at acceptable amounts. This was completed on 5/26/11.</p> <p>The Business Office Manager (BOM) will review weekly all resident trust funds. Any resident approaching \$1500,</p>	<p>6/7/11 6/23/11 aw</p>
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Freida Wright</i>	TITLE  <i>Administrative</i>	(X6) DATE  <i>6/26/11</i>
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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.

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F 159	<p>Continued From page 1</p> <p>resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident record review, facility record review, resident interview and facility staff interview the facility failed to notify 1 of 75 medicaid recipient residents with a trust account when they were within \$200.00 of their limit. (Resident #1)</p> <p>The findings included:</p> <p>A review of resident trust accounts was conducted on 5/26/11. During this review of resident trust accounts, Resident #1 was noted to have \$2, 381.18 as of 5/16/2011. Continued review revealed Resident #1 had \$2,209.33 in their account on 4/1/11. After a miscellaneous deduction and patient liability deduction on 4/8/11, Resident #1 remained with with \$2,042.58 in their trust account. With a Social Security deposit of \$427.00 on 5/12/11, and some other miscellaneous deductions, Resident #1 remained with \$2, 381.18 on 5/26/11 when the resident trust review was conducted. Resident #1 had been within \$200.00 of their limit since 4/1/11.</p> <p>An interview was conducted with the Business Officer Manager and the Regional Business Office Manager on 5/26/11 at 11:30 AM. During</p>	F 159	<p>their names will be given to Social Services. Social Services will contact the family regarding spending down of resident's resources.</p> <p>BOM will submit to the monthly QA meeting the results of this weekly audit for 2 months.</p>		

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F 159	Continued From page 2 this interview, the Regional Business Office Manager conveyed that Resident #1 was a medicaid recipient and that the resident or responsible party should have been notified of the account balance. The Regional Business Officer Manager stated the Social Worker would have notified the resident and or the responsible party of the residents account balance.  An interview was conducted with the Social Worker on 5/26/11 at 1:50 PM. During this interview the Social Worker stated she had not received notice of Resident #1's trust account balance until today (5/26/11). She stated she had contacted the responsible party for Resident #1 on 5/26/11 after the Business Office staff informed her of the balance, and they had a plan in place to spend money on a big screen TV and cable for the resident's room.  Resident record review revealed, Resident #1 was admitted to the facility on 11/19/10. Her beginning account balance on 12/6/10 was \$427.00. Resident #1 was assessed on her quarterly Minimum Data Set (MDS) assessment on 2/22/11 as interviewable.  An interview was conducted with Resident #1 on 5/26/11 at 5:40 PM. During this interview, Resident #1 stated that her daughter had left to go get her a TV from Walmart. She stated that she was not aware that she needed to spend any money from her account until staff notified her daughter today (5/26/11).	F 159	<b>F Tag 281</b>  Resident #6 had orders written for oxygen on May 24, 2011 and care plan updated on May 24, 2011.. Resident #7 received order for appetite stimulant on May 26, 2011. Resident #7 had order written on May 26, 2011 for oxygen use parameters. Care plan was then updated to reflect physician's orders.  All residents could be affected by this, so clinical records were audited for the above citations. This audit was done by DON/ADON/SDC and completed on June 8, 2011.  Nursing staff were re-educated by the ADON of the above citations on May 26, 2011. On June 6, 2011 at the All Staff Meeting, nurses were re-educated on physician orders for correctness,	6/23/11 J
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility	F 281		

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F 281	<p>Continued From page 3 must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews the facility failed to obtain a physician 's order for oxygen for 1 of 6 residents, (Resident #6), obtain a physician 's order for an appetite stimulant for 1 of 1 residents (Resident #7), and clarify an order for oxygen parameters for 1 of 6 residents (Resident #7). Findings include:</p> <p>1) Resident #6 was readmitted to the facility on 1/26/11 with the cumulative diagnoses of congestive heart failure (CHF), peripheral vascular disease (PVD), and shortness of breath.</p> <p>Record review did not reveal facility standing orders to administer oxygen.</p> <p>Record review of Resident #6 's Care Plan updated 4/20/11 did not reveal oxygen was being used as an intervention for an identified problem.</p> <p>Review of the most recent Quarterly Minimum Data Set (MDS) assessment dated 5/4/11 revealed Resident #6 had moderately impaired cognition, and received oxygen therapy.</p> <p>Record review of Nurses Notes dated 5/3/11, 5/5/11, 5/12/11, 5/14/11, 5/19/11, and 5/24/11 revealed Resident #6 received oxygen.</p> <p>Record review on 5/25/11 of Resident #6 's medical record did not reveal a physician 's order for oxygen.</p>	F 281	<p>oxygen parameters, oxygen assessment for saturation and transcription of orders.</p> <p>The DON/ADON will review at the daily clinical meeting all physician orders for correctness and will verify order transcription to MAR/TAR. Dietary recommendation will be reviewed by the Dietician with the DON/ADON upon exit and those recommendations brought to the daily clinical review meeting and addressed regarding follow through and completeness. This audit will be done 5 times a week for 2 months.</p> <p>Any discrepancies per nursing in orders or transcription will be re-educated by the DON/ADON of the correct procedure.</p>	

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F 281	Continued From page 4  During an observation on 5/25/11 at 8:18 AM Resident #6 was sitting in a wheelchair in his room with continuous oxygen being administered via nasal cannula at 3 liters per minute. Resident #6 appeared to be breathing without difficulty.  An interview was held on 5/25/11 at 8:20 AM with the Assistant Director of Nursing (ADON). She indicated Resident #6 had a physician 's order for oxygen before he went to the hospital. The ADON indicated Resident #6 was readmitted on 1/26/11. The ADON indicated there was not an admission physician 's order for Resident #6 to have oxygen when he was readmitted to the facility on 1/26/11. She indicated a physician 's order for oxygen had not been obtained since Resident #6 was readmitted on 1/26/11.  An interview was held on 5/26/11 at 3:55 PM with Nurse #4. Nurse #4 reviewed Resident #6 's medical record. He indicated there was not a written physician 's order for Resident #6 to receive oxygen.  An interview was held on 5/26/11 at 4:40 PM with the ADON. She indicated her expectation was a physician 's order would be obtained for a resident administered oxygen via nasal or tracheal oxygen, continuous or as needed (p.r.n.) oxygen.  2) Resident #7 was admitted to the facility on 5/20/10 with the cumulative diagnoses of dementia, seizure disorder, psychosis, aspiration pneumonia, and aphasia.  Review of the most recent Significant Change	F 281	The DON will bring the results of the audit to the monthly QA meeting for 2 months.	

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F 281	<p>Continued From page 5</p> <p>Minimum Data Set (MDS) assessment dated 3/25/11 revealed Resident #7 had severely impaired cognition, received oxygen, and was totally dependent for eating.</p> <p>a) Record review of a Dietary Progress Note dated 3/23/11 revealed Resident #7 had significant weight loss and had been discharged from Hospice services due to stabilization. The Registered Dietitian recommendations included a diet change to pureed with fortified foods, with nectar thick liquids, multivitamin (MVI) one tablet by mouth every day, magic cup with lunch and dinner, and a consult with medical doctor regarding the feasibility of an appetite stimulant.</p> <p>Record review of Physician ' s Telephone Orders for Resident #7 from 3/24/11 - 5/25/11 and the Physician Orders from 5/1/11 -5/25/11 did not reveal an order for an appetite stimulant.</p> <p>An interview was held on 5/26/11 at 8:30 AM with the ADON. She indicated the Registered Dietitian wrote recommendations on a form which was placed in the mailbox. The ADON indicated the Director of Nursing (DON) or ADON obtained the dietary recommendations from the mailbox and gave the order(s) to one of the four team members in the facility for follow up. The ADON indicated the dietary recommendations should be tracked and monitored to make sure the orders were obtained and on the resident ' s chart.</p> <p>b) Record review of the Physician ' s Orders dated 5/20/10 - 5/31/10 (last year) for Resident #7 revealed a hand written order for O 2 (oxygen) at 1 L/M (1 liter per minute) via NC (nasal cannula), titrate to maintain sats (saturation) @</p>	F 281			

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F 281	<p>Continued From page 6 (at)--- (parameters not identified).</p> <p>Record review of current Physician ' s Orders dated 5/1/11 -5/31/11 for Resident #7 revealed an order for O 2 at 1 L/M via NC to maintain sats at-- (parameters not identified).</p> <p>Record review of the Medication Administration Record dated 4/1/11 - 4/30/11 for Resident #7 revealed an order for O 2 at 1 L/M via NC to maintain sats at---(parameters not identified), with the date started as 5/21/10 (last year), and signed as done on the 7-3, 3-11, and 11-7 shifts. There were not any oxygen saturation percents written on any shifts.</p> <p>Record review of the Medication Administration Record dated 5/1/11 - 5/31/11 for Resident #7 revealed an order for O 2 at 1 L/M via NC to maintain sats at---(parameters not identified), with the date started as 5/21/10 (last year), and signed as done from 5/1/11 - 5/25/11 on the 7-3, 3-11, and 11-7 shifts, and for 7-3 shift on 5/26/11.</p> <p>Record review of the Medication Administration Record dated 5/1/11 - 5/31/11 for Resident #7 revealed there were only saturation percents written for all shifts on 5/9/11, 5/10/11, 5/11/11, and 5/12/11. There were only saturation percents written on the Medication Administration Record for Resident #7 on the 7-3 shift on 5/16/11, 5/17/11, 5/18/11, 5/20/11, and 5/21/11.</p> <p>During an observation on 5/25/11 at 8:30 AM Resident #7 was lying in bed receiving continuous nasal cannula oxygen at 1 liter per minute. Resident #7 appeared to be breathing without difficulty.</p>	F 281		
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F 281	Continued From page 7  An interview was held on 5/26/11 at 8:30 AM with the ADON. The ADON indicated if she was on the medicine cart she would write in a place to put the saturation rate (parameter) and signature (of the nurse). She indicated the physician's order should have at what percent the oxygen saturation was supposed to be maintained for the resident. She indicated her expectation was staff would proof the Medication Administration Record closely and write in an oxygen saturation percent and not just sign for saturation.  An interview was held on 5/26/11 at 4:40 PM with the ADON. She indicated her expectation was nurses would contact the physician for an order for an oxygen saturation parameter.	F 281	<b>F Tag 309</b>  Resident # 6 had diet order correction done on May 25, 2011, wound culture done May 25, 2011, vascular appointment was done on June 22, 2011, and prosthetic appointment on June 3, 2011.  All residents could be affected by this, so clinical records were audited for the above citations. This audit was done by DON/ADON/SDC and completed on June 6, 2011.  On June 6, 2011 at the All Staff Meeting, nurses were educated on Guidelines for Making Doctors Appointments and obtaining wound culture and documentation to MAR. Dietary Manager met with staff regarding dietary changes to tray card and	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on record review, observation, and staff interviews the facility failed to follow physician orders to schedule two physician consultant appointments, obtain a wound culture for a resident on isolation, and institute a diet change ordered by the physician for 1 of 9 residents (Resident #6). Findings include:	F 309		6/23/11 JW

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F 309	<p>Continued From page 8</p> <p>1) Resident #6 was readmitted to the facility on 1/26/11 with the cumulative diagnoses of congestive heart failure (CHF), shortness of breath, Diabetes Type II, left below the knee amputation, peripheral vascular disease (PVD), and end stage renal disease (ERSD).</p> <p>Review of the most recent Quarterly Minimum Data Set (MDS) assessment dated 5/4/11 revealed Resident #6 had moderately impaired cognition, pressure sores, and received oxygen therapy.</p> <p>a) Record review of a Care Plan updated 4/20/11 for Resident #6 revealed as a problem pain related to PVD.</p> <p>Record review of a Treatment Record dated 5/1/11 -5/31/11 for Resident #6 revealed an order, (with the start date of 1/27/11), for an enzymatic active micro debridement ointment and topical antibiotic ointment to be applied to the right lateral foot (right heel) wound daily. The Treatment Record dated 5/1/11 -5/31/11 for Resident #6 also revealed an order, (with the start date of 4/5/11), to clean the right outer ankle with wound cleanser (w/c), apply an antimicrobial wound dressing, and to also apply an antimicrobial wound dressing to the right 4th and 5th toes and cover all the areas with a sterile, self adherent, and conforming dressing.</p> <p>Record review of a Physician ' s Telephone Orders dated 5/5/11 for Resident #6 revealed to book an appointment with Vascular Surgery (re) PVD.</p>	F 309	<p>coverage when DM out of office. This was completed on June 20, 2011.</p> <p>The DON/ADON will review at the daily clinical meeting all physician orders for correctness and will verify wound culture orders transcription to MAR. This audit will be done 5 times a week for 2 months. The DON/ADON will review all consultant physician visits for orders and appointments. This audit will be done with each consultant visit for 2 months.</p> <p>Dietary Manager will assign cook on duty the responsibility for dietary order changes when DM out of office.</p> <p>Any discrepancies per nursing in obtaining wound cultures and documentation,</p>	
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F 309	<p>Continued From page 9</p> <p>Record review of the Wound / Skin Healing Records dated 5/23/11 for Resident #6 revealed the following: right heel Stage III pressure ulcer, 2.0 centimeter (cm) length x 2.0 cm width x 0.1 depth, right ankle Stage II pressure ulcer, 1.0 cm length x 0.2 cm width x 0.1 depth, right 5th toe Stage II pressure ulcer, 2.0 cm length x 2.0 width x 0.1 depth.</p> <p>Record review of Skin Condition Record dated 5/23/11 for Resident #6 revealed a non pressure ulcer 4th toe, 1.0 cm length x 1.0 cm width, and full thickness.</p> <p>An interview was held on 5/25/11 at 10:00 AM with the Central Supply scheduler responsible for scheduling appointments. The Central Supply scheduler reported she did not know anything about Resident #6 seeing a vascular doctor. She indicated the nurses were supposed to tell her if there was an appointment that needed to be scheduled for a resident. She indicated if the nurses did not tell her they left a written note under her office door or on the board at the South Station. The Central Supply scheduler indicated she checked the board at the South Station every morning for any notes.</p> <p>An interview was held on 5/25/11 at 10:35 AM with the Assistant Director of Nursing (ADON). The ADON indicated a copy of the order for a vascular surgeon consult for Resident #6 had not been taken off the chart. The ADON indicated a copy of the order for a vascular physician consultation for Resident #6 should have been taken off the chart and sent to the Central Supply scheduler. She indicated the Central Supply scheduler did not receive a copy of the physician '</p>	F 309	<p>and physician's appointments will be re-educated by the DON/ADON of the correct procedure.</p> <p>The DON will bring the results of the audit to the monthly QA meeting for 2 months.</p> <p>The DM will review in daily clinical meeting, dietary orders and continue with monthly chart audit. The DM will bring the results of the dietary audit to the monthly QA meeting for 2 months.</p>	
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NAME OF PROVIDER OR SUPPLIER  SOUTH VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2221 RALEIGH ROAD ROCKY MOUNT, NC 27803		
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F 309	<p>Continued From page 10</p> <p>s order for Resident #6 to have a vascular surgeon consultation.</p> <p>During an observation on 5/26/11 at 11:20 AM Nurse #4 removed the dressing from Resident #6 's right foot and ankle. Nurse #4 cleansed the right heel (right lateral foot), outer ankle, and 4th and 5th toe areas with wound cleanser. Nurse #4 applied an enzymatic active micro debridement ointment and topical antibiotic ointment to Resident #6 's right heel. Nurse #4 then applied antimicrobial wound dressing to Resident #6 's right outer ankle, and 4th and 5th toes. Nurse #4 the wrapped the areas with a sterile, self adherent, and conforming dressing.</p> <p>An interview was held on 5/26/11 at 11:50 AM with Resident #6 's physician. He indicated he had examined Resident #6 's foot today (5/26/11). The physician indicated Resident #6 was not healing with the speed he would want him to so he was sending him back to the vascular surgeon.</p> <p>An interview was held on 5/26/11 at 4:40 PM with the ADON. She indicated her expectation was the night nurse would review the resident chart(s) for orders for physician consultation(s). The ADON indicated the night nurses were to make sure everything was in place and send the information to the scheduler to coordinate.</p> <p>b) Record review of a Care Plan updated 4/14/11 for Resident #6 revealed as a problem potential for injury as a fall risk related to left lower prosthesis (used for) a left below the knee amputation. An intervention dated 5/19/11 revealed to not use the prosthesis until Resident</p>	F 309		

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F 309	<p>Continued From page 11</p> <p>#6 was re-evaluated by the prosthesis company</p> <p>Record review of Nurses Notes dated 5/19/11 for Resident #6 revealed the physician ' s office staff was called and informed Resident #6 had a sore area below the left knee with discoloration noted but without any open area. The Nurses Notes revealed Resident #6 complained of pain upon palpitation. The Nurses Notes revealed a request for an order to see the prosthesis company for fitting of Resident #6 ' s left prosthesis.</p> <p>Record review of a Physician ' s Telephone Orders dated 5/19/11 for Resident #6 revealed to discontinue use of prosthesis on left until seen and re-evaluated by the prosthesis company due to pressure below knee.</p> <p>An interview was held on 5/25/11 at 10:00 AM with the Central Supply scheduler responsible for scheduling appointments. The Central Supply scheduler reported she had been told about the 5/19/11 physician ' s order for Resident #6 to see the prosthesis company yesterday (5/24/11). She indicated she did not have a copy of the order. She indicated Nurse #3, the Wound Nurse, had told her on 5/24/11 to schedule the prosthesis appointment for Resident #6.</p> <p>An interview was held on 5/25/11 at 12:45 PM with Nurse #3 the Wound Nurse. She reported Resident #6 had a pressure area on the on bottom of the (left) stump and had hollered because (the area) was hurting. She indicated she had obtained an order from the physician to have Resident #6 seen by the prosthesis company.</p>	F 309			

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F 309	<p>Continued From page 12</p> <p>An interview was held on 5/26/11 at 4:40 PM with the ADON. She indicated her expectation was the night nurse would review the resident chart(s) for orders for physician consultation(s). The ADON indicated the night nurses were to make sure everything was in place and send the information to the scheduler to coordinate.</p> <p>c) Record review of a Care Plan updated 2/9/11 for Resident #6 revealed as a problem actual skin breakdown related to ulcer on the right heel with diagnosed methicillin resistant staphylococcus aureus (MRSA).</p> <p>Record review of Physician 's Telephone Orders dated 5/5/11 for Resident #6 revealed to re-culture wounds for culture and sensitivity (c/s) on Monday (5/9/11).</p> <p>Record review of Nurses Notes dated 5/5/11 revealed the physician assessed Resident #6 's wounds and discontinued all antibiotics previously ordered. The Nurses Notes revealed the physician ordered a re-culture (of wounds) for Resident #6.</p> <p>Record review of Nurses Notes dated 5/6/11 for Resident #6 revealed wounds as Stage III right heel, Stage II right 5th toe, Stage II right ankle, and 4th toe full thickness.</p> <p>Record review on 5/24/11 of Resident #6 's medical record did not reveal a laboratory report for a wound culture completed 5/9/11 - 5/24/11.</p> <p>An interview was held on 5/24/11 at 4:15 PM with the ADON. She indicated the wound culture ordered for Resident #6 on 5/5/11 had not been</p>	F 309		

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F 309	<p>Continued From page 13 done.</p> <p>During an observation on 5/25/11 at 8:30 AM an isolation cart was observed outside of Resident #6 's room.</p> <p>An interview was held on 5/26/11 at 4:40 PM with the ADON. She indicated her expectation was the night nurse would check the lab book to determine all labs had been acted upon and the results had been obtained.</p> <p>A telephone interview was held on 6/3/11 at 4:30 PM with the ADON. She indicated Resident #6 had been re-cultured in April 2011. She indicated Resident #6 was kept on isolation because he was not clear when re-cultured in April 2011. She indicated the May 2011 re-culture (5/9/11) was missed so Resident #6 had remained on contact isolation.</p> <p>d) Record review of a Care Plan updated 4/13/11 for Resident #6 revealed as a problem potential for alteration in nutritional status related to therapeutic diet, PVD, and ESRD.</p> <p>Record review of Physician 's Telephone Orders dated 4/20/11 for Resident #6 revealed to change the diet from a (reduced concentrated sweets (RCS), no added salt (NAS) regular, double meat) to a regular diet.</p> <p>Record review of a Diet Order Form dated 4/20/11 for Resident #6 revealed a diet change to a regular diet.</p> <p>During an observation on 5/25/11 at 8:30 AM Resident #6 was sitting in a wheelchair in his</p>	F 309		

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F 309	Continued From page 14 room. A staff member placed his breakfast tray on the over bed table in front of Resident #6. Resident #6 ' s breakfast tray included 2 sausage patties, scrambled eggs, and pancakes.  Review of Resident #6 ' s diet card, located on his breakfast tray, revealed the diet as RCS (reduced concentrated sweets), NAS (no added salt), and the texture as Regular, Double Meat.  An interview was held on 5/25/11 at 5:25 PM with the Dietary Manager. She provided a copy of Resident #6 ' s dietary sheet for breakfast and lunch which revealed the diet as RCS, NAS, and the texture as Regular, Double Meat. She indicated she had done a chart audit today and noticed Resident #6 ' s diet had changed and had made the correction. She reported she did monthly audits. She indicated a copy was given to dietary department when diet changes were made. She indicated she left on 4/21/11 and was gone for a week. She reported when she was away all dietary staff members were responsible for any dietary change(s). The Dietary Manager indicated the staff members would line out the current diet for each meal and write in the diet change on the (tray card). She indicated there was not a designated place to keep the dietary sheets. The Dietary Manager indicated when she returned to work she collected and went through all the diet sheets and made any changes. The Dietary Manager reported she did not know how Resident #6 ' s diet change was missed.	F 309	<b>F Tag 312</b>  Resident 4 had his fingernails trimmed and cleaned on May 24, 2011.  Any resident requiring assistance with nail care can be affected by this practice. Therefore, the IDT will review the care cards and preferences of each resident and update the aide care cards to reflect the level of assist needed with this care need. This was completed on June 15, 2011.  The DON/SDC in-serviced the nursing staff on June 6, 2011 regarding proper procedures for fingernail care and how to identify the level of assistance required by referring to the aide care cards.		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to	F 312		6/14/11 6/23/11 JW	

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F 312	<p>Continued From page 15 maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and family and staff interviews the facility failed to provide necessary services to maintain personal grooming for 1 of 5 sampled residents assessed as dependent for care, specifically regarding nail care (Resident #9).</p> <p>The findings included:</p> <ol style="list-style-type: none"> <li>Resident #9 was admitted on 1/28/2008 with a most re-admission date of 5/11/2011. His cumulative diagnoses included: Tachycardia, Anorexia, Chronic Skin Ulcer, Diabetes, Seizure Disorder and Depression</li> </ol> <p>His last Minimum Data Set (MDS) was a quarterly and was dated 4/18/2011. The MDS indicated Resident #9 memory was not intact and he was totally dependent on the facility staff to provide personal hygiene and grooming.</p> <p>A review of Resident #9 ' s care plan with an updated date of 4/18/11 indicated Resident #9 had a problem area of self-care deficits and he was unable to perform Activities of Daily Living (ADL ' s) due to Multi-infarct Dementia and Depression. The goal of this problem area was that Resident #9 would be groomed. The interventions of this problem area stated that staff would provide ADL care.</p>	F 312	<p>The Ambassadors will check resident nails on rounds and report any care needs to the charge nurse.</p> <p>The DON/ADON/SDC and charge nurses will review the nail care provided to 5-6 residents per day for 8 weeks. Any non-compliance will result in counseling.</p> <p>The result of the audits will be presented to the QA committee monthly for 2 months by the DON.</p>	

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F 312	<p>Continued From page 16</p> <p>A review of the Care Conference for Resident #9 dated 4/19/11 indicated he was dependent on staff for grooming and bathing.</p> <p>An observation of Resident #9 on 5/24/11 at 12:35 PM and 1:40 PM, revealed Resident #9 to have untrimmed and dirty fingernails. His nails had dark matter underneath his nail beds.</p> <p>An interview was conducted with Resident #9's responsible party (RP) on 5/25/11 at 12:15 PM. During this interview the RP stated " if it was not for you all being here, his nails would not be trimmed and cleaned ". The RP stated that she often has to request for staff to meet his grooming needs, and that the facility staff do not clean his nails everyday. The RP stated that his nails were trimmed and cleaned on the evening of 5/24/11 after the survey team entered the building.</p> <p>An interview was conducted with Nurse Aid #1 (NA) who reported routinely working with Resident #9, on 5/26/2011 at 2:45 PM. During this interview, the NA stated Resident #9 refused nail care on 5/24/11. She indicated she worked with Resident #9 on 5/24/11 and that when she bathed him, he refused nail care. She stated that they do not record baths or nail care anywhere in resident charts because all residents receive a bath daily and nail care is to be performed during bathing. She stated she reported Resident #9's refusal of nail care to the nurse in charge. NA#1 stated that Resident #9 is dependent upon the staff to clean his nails for him.</p> <p>An interview was conducted with the Licensed Practical Nurse #3 (LPN) on 5/26/11 at 2:50 PM.</p>	F 312	

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F 312	Continued From page 17 During this interview, the LPN indicated that refusals of nail care from Resident #9 would be documented on the staff assignment sheet and/or on the 24 hour report.  A review of the 24 hour report and staff assignment sheet for 5/24/11 for Resident #9 failed to reveal any documentation regarding him refusing nail care.  An interview with the Assistant Director of Nursing (ADON) was conducted on 5/26/11 at 3:30 PM. During this interview the ADON stated that she expects staff to provide nail care for Resident #9, and to report all refusals to the nurse in charge.	F 312	<b>F Tag 329</b>  Resident # 15 was a closed record.  All residents could be affected by this, so clinical records were audited for dual drug therapy and diagnosis with medication orders. This audit was done by DON/ADON/SDC and completed on June 6, 2011.	6/17/11	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329	On June 6, 2011 at the All Staff Meeting, nurse were in-serviced on dual drug therapy and diagnosis with medication orders.  The DON/ADON will review at the daily clinical meeting all physician orders for correctness and will verify order transcription to MAR/TAR, for dual drug	6/23/11 JW	

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F 329	<p>Continued From page 18 contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and pharmacist interview, the facility failed to ensure residents were free from duplicate therapy for 1 of 4 sampled residents receiving sedatives (resident #15), and failed to document an appropriate diagnosis for 1 of 15 sampled residents whose medications were reviewed (resident #15). Findings include:</p> <p>1. Resident #15 was admitted to the facility on 9/24/10 and readmitted on 2/4/11 and 3/31/11 with multiple diagnoses. Record review of the resident's clinical record revealed physician orders dated 2/7/11 for Restoril (temazepam) 15mg (milligram) at bedtime and orders dated 3/31/11 for Clonazepam 0.5mg at bedtime if needed for sleep. Restoril is a short-acting benzodiazepine agent used for the short-term treatment of insomnia. Clonazepam is a long-acting benzodiazepine agent with multiple indications that may be given for insomnia.</p> <p>Lexicomp's Drug Information Handbook, 14th edition, Warnings/Precautions for Restoril and clonazepam stated in part "use caution in the elderly...effects with other sedative drugs may be potentiated."</p> <p>Review of the resident's medication</p>	F 329	<p>therapy, and diagnosis with physicians orders. This audit will be done 5 times a week for 2 months.</p> <p>Any discrepancies per nursing in orders or transcription will be re-educated by the DON/ADON of the correct procedure.</p> <p>The DON will bring the results of the audit to the monthly QA meeting for 2 months.</p>

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F 329	Continued From page 19 administration records (MARS) revealed Restoril was given nightly and clonazepam was given on 4/11/11, 4/12/11, 4/23/11, 4/29/11, 5/2/11, and 5/3/11.  Record review of the physician's progress notes revealed no documentation of an assessment of the use of multiple sedatives.  Record review of the consultant pharmacist's progress notes revealed no documentation of an assessment of the use of multiple sedatives. An entry dated 4/22/11 read in part "Clonazepam Dx (diagnosis) - sleep Temazepam Dx - sleep."  In an interview on 5/26/11 at 5:48PM, the Assistant Director of Nursing (ADON) stated the consultant pharmacist reviewed the residents' records for duplicate therapy during the monthly medication regimen review. The ADON stated she expected the pharmacist to identify any duplicate medications and follow-up with the physician for evaluation.  In a telephone interview on 05/31/11 at 11:25AM, the Consultant Pharmacist stated she completed medication regimen reviews monthly, reported any irregularities to the attending physician and Director of Nursing, and documented her recommendations in the progress notes. The pharmacist stated resident #15 was admitted on Restoril, which was given scheduled, and clonazepam, given as needed only. She stated she had not made a recommendation regarding the use of two sedatives. The pharmacist stated she planned to monitor the clonazepam use before making any recommendations.	F 329		

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F 329	<p>Continued From page 20</p> <p>2. Resident #15 was admitted to the facility on 9/24/10 and readmitted on 2/4/11 and 3/31/11 with multiple diagnoses including congestive heart failure (CHF), coronary artery disease, myocardial infarction, and bradycardia. Record review of the resident's clinical record revealed physician orders dated 2/7/11 for Amiodarone 200mg daily. Amiodarone is an antiarrhythmic agent indicated for ventricular fibrillation or ventricular tachycardia. Amiodarone has unlabeled indications of atrial fibrillation and paroxysmal supraventricular tachycardia.</p> <p>Record review of the resident's clinical record revealed no documentation of an appropriate diagnosis for amiodarone.</p> <p>Record review of the physician's progress notes revealed no documentation of an appropriate diagnosis for amiodarone.</p> <p>Record review of the consultant pharmacist's progress notes revealed no documentation of an appropriate diagnosis for amiodarone. An entry dated 4/22/11 read in part "amiodarone - Dx CHF."</p> <p>In an interview on 5/26/11 at 5:48PM, the ADON stated the consultant pharmacist reviewed the residents' records for documentation of appropriate diagnoses during the monthly medication regimen review. The ADON stated she expected the pharmacist to identify medications without a diagnosis and request documentation from the physician.</p> <p>In a telephone interview on 05/31/11 at 11:25AM, the Consultant Pharmacist stated she completed</p>	F 329	

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F 329	Continued From page 21 medication regimen reviews monthly, reported any irregularities to the attending physician and Director of Nursing, and documented her recommendations in the progress notes. The pharmacist stated when residents were admitted, she checked the admission orders and discharge summary for supporting diagnoses. She stated she had not made a recommendation requesting a diagnosis for resident #15's amiodarone.	F 329	<b>F Tag 332</b>  Resident # 4 and 16 are receiving their medications according to center policy. Resident 17 is a closed record.		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, the facility failed to ensure a medication error rate less than 5% as evidenced by 3 errors out of 48 opportunities for error, resulting in an error rate of 6.25%, for 3 of 7 residents observed during medication pass (residents #4, #16, #17). Findings include:  1. Resident #4 was admitted to the facility on 5/30/06 with multiple diagnoses including congestive heart failure, myocardial infarction, and coronary artery disease. Record review of the resident's clinical record revealed physician orders dated 5/30/06 for Nitroglycerin patch 0.4mg (milligram) every morning, remove at bedtime. Nitroglycerin is a vasodilator used to prevent angina due to coronary artery disease.  Lexicomp's Drug Information Handbook, 14th	F 332	Any resident receiving medications could be affected by this practice. Therefore, nurse #1,2,3 and 4 were re-educated by the ADON on May 24, 2011 for non-compliance of the medication pass policy and medication pass audit was done by the Nurse Manger with Nurse #1,2,3 and 4 on June 16, 2011.  On June 6, 2011 the Administrator and DON reviewed with the Charge Nurses and Medication Techs the 5 Rights of Medication Administration.	6/17/11 6/23/11 aw	

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F 332	<p>Continued From page 22</p> <p>edition, Dosage Note read in part "tolerance often develops within 24-48 hours of continuous nitrate administration...tolerance is minimized by using a patch-on period of 12-14 hours and patch-off period of 10-12 hours."</p> <p>Observation of medication pass on 5/25/11 at 8:35AM revealed nurse #1 preparing to apply a nitroglycerin 0.4mg patch. Nurse #1 examined the resident's upper chest, removed a nitroglycerin patch from the right upper chest, and discarded it. Nurse #1 then applied the new patch to the resident's left upper chest.</p> <p>Record review of the resident's medication administration record (MAR) revealed instructions to remove the nitroglycerin patch at bedtime.</p> <p>In an interview on 5/25/11 at 8:36AM, Nurse #1 acknowledged the nitroglycerin patch she removed had been left on from the previous day. Nurse #1 stated "the patch was supposed to be removed at bedtime."</p> <p>In an interview on 5/25/11 at 5:33PM, Nurse #2 stated she had worked the evening shift on 5/24/11. Nurse #2 stated she was trained when hired and periodically regarding proper medication administration. The nurse stated she was aware the nitroglycerin patch for resident #4 was to be removed at bedtime. She stated the patch was usually removed each night and that it was an oversight on her part.</p> <p>In an interview on 5/26/11 at 5:08PM, the Assistant Director of Nursing (ADON) stated the staff was trained during their orientation. She stated the pharmacy provided in-services</p>	F 332	<p>Emphasis was be placed on Nitroglycerine patch application and removal, insulin injection time frames medications administered and medication documentation.</p> <p>Any nurse over 3% error rate will continue to have medication pass audits by nurse managers until less than 3 % error rate is reached</p> <p>Medication Pass Audits will be done by the Nursing Management team with the Charge Nurses and 2 times per week for the next 2 months.</p> <p>The DON will report the results of the medication pass audit to the monthly QA Committee for the next 2 months.</p>		

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F 332	<p>Continued From page 23</p> <p>periodically on proper medication administration. She stated medication pass observations were conducted by the pharmacist, Director of Nursing, and Staff Development Coordinator. Her expectation was for the staff to follow the physician's orders and remove the nitroglycerin patch at night.</p> <p>2. Resident # 16 was admitted to the facility on 12/31/09 with multiple diagnoses including diabetes. Record review of the resident's clinical record revealed physician orders dated 12/31/09 for Novolin R (Regular) inject 5 units subcutaneously 30 minutes before meals. Novolin R is a short-acting insulin product used for the treatment of diabetes.</p> <p>Lexicomp's Drug Information Handbook, 14th edition, read in part "Administration - regular insulin: should be administered within 30-60 minutes before a meal."</p> <p>Observation of medication pass on 5/25/11 at 9:04 AM revealed nurse #3 administered Novolin R insulin 5 units by injection in the resident's upper left arm.</p> <p>Record review of the resident's current MAR revealed administration times of 0800 (8AM), 1130 (11:30AM), and 1630 (4:30PM) for the Novolin R.</p> <p>In an interview on 5/25/11 at 11:05AM, Nurse #3 reviewed the MAR and acknowledged the Novolin R was not given before the meal. She stated the resident ate breakfast about 8:15AM that morning. Nurse #3 stated she usually gave the insulin after the meal since the resident often</p>	F 332		

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F 332	<p>Continued From page 24</p> <p>didn't eat all of his breakfast and had low blood sugars at times.</p> <p>In an interview on 5/26/11 at 5:08PM, the ADON stated the staff was trained during their orientation. She stated the pharmacy provided in-services periodically on proper medication administration. She stated medication pass observations were conducted by the pharmacist, Director of Nursing, and Staff Development Coordinator. Her expectation was for the staff to follow the physician's orders and administer medications at the correct time.</p> <p>3. Resident #17 was admitted to the facility on 3/7/11 with multiple diagnoses. Record review of the resident's clinical record revealed physician orders dated 3/14/11 for K-Dur (potassium chloride) 20 meq (milliequivalents) take 2 tablets by mouth once daily. K-Dur is a electrolyte supplement used for the treatment or prevention of hypokalemia.</p> <p>Observation of medication pass on 5/25/11 at 9:55AM revealed nurse #3 dissolved one K-Dur 20meq tablet in water and administered it to the resident with four ounces of juice.</p> <p>Record review of the resident's current MAR revealed two tablets of K-Dur were to be given.</p> <p>In an interview on 5/26/11 at 3:03PM, Nurse #3 stated she was trained during orientation when hired and received in-service training periodically. Nurse #3 stated she was observed by the hall or charge nurse and had completed a skills check-off list. She stated medication pass observations were conducted regularly by the</p>	F 332			



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F 371	Continued From page 26 The findings include:  During the kitchen observation on 5/25/11 at 11:15 AM insulated dome lids were observed stored on the drying rack. The interior surface of 10 of 60 insulated dome lids were observed with the inner layer of insulation, approximately 1/16 to 2/16 of an inch, peeling away from the lid edge.  During a second observation on 5/26/11 at 10:40 AM the dome insulated dome lids were in the same condition.  In an interview on 5/26/11 at 10:45 AM the Certified Dietary Manager stated, " I see what you mean, we can get new lids and throw out these worn out ones. "	F 371	<b>F Tag 428</b>  Resident # 15 is a closed record.  All residents could be affected by this, so clinical records were audited for dual drug therapy and diagnosis with medication orders. This audit was done by DON/ADON/SDC and completed on June 6, 2011.	6/23/11 ju
F 428 SS=O	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON  The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.  The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.  This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, and pharmacist interview, the facility failed to ensure the consultant pharmacist assessed duplicate therapy for 1 of 4 sampled residents receiving	F 428	On June 6, 2011 at the All Staff Meeting, nurses were in-serviced on dual drug therapy and diagnosis with medication orders. On June 20 and 22, Pharmacist reviewed clinical records for dual drug therapy and appropriate diagnosis.  The Pharmacist will email all recommendations to the DON. The DON will give copy of recommendations to SDC for pharmacy recommendation notebook.	

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F 428	<p>Continued From page 27</p> <p>sedatives (resident #15), and requested an appropriate diagnosis for 1 of 15 sampled residents whose medications were reviewed (resident #15). Findings include:</p> <p>1. Resident #15 was admitted to the facility on 9/24/10 and readmitted on 2/4/11 and 3/31/11 with multiple diagnoses. Record review of the resident's clinical record revealed physician orders dated 2/7/11 for Restoril (temazepam) 15mg (milligram) at bedtime and orders dated 3/31/11 for Clonazepam 0.5mg at bedtime if needed for sleep. Restoril is a short-acting benzodiazepine agent used for the short-term treatment of insomnia. Clonazepam is a long-acting benzodiazepine agent with multiple indications that may be given for insomnia.</p> <p>Lexicomp's Drug Information Handbook, 14th edition, Warnings/Precautions for Restoril and clonazepam stated in part "use caution in the elderly...effects with other sedative drugs may be potentiated."</p> <p>Review of the resident's medication administration records (MARS) revealed Restoril was given nightly and clonazepam was given on 4/11/11, 4/12/11, 4/23/11, 4/29/11, 5/2/11, and 5/3/11.</p> <p>Record review of the physician's progress notes revealed no documentation of an assessment of the use of multiple sedatives.</p> <p>Record review of the consultant pharmacist's progress notes revealed no documentation of an assessment of the use of multiple sedatives. An entry dated 4/22/11 read in part "Clonazepam Dx</p>	F 428	<p>The SDC will fax recommendations to physicians. The SDC will bring the notebook to daily clinical meeting for follow through and completeness.</p> <p>The DON/ADON will review at the daily clinical meeting the pharmacist recommendation notebook, all physician orders for correctness, and will verify order transcription to MAR/TAR, review for dual drug therapy, and diagnosis with physicians orders. This audit will be done 5 times a week for 2 months.</p> <p>Any discrepancies per nursing in orders or transcription will be re-educated by the DON/ADON of the correct procedure.</p>	

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F 428	<p>Continued From page 28 (diagnosis) - sleep Temazepam Dx - sleep."</p> <p>In an interview on 5/26/11 at 5:48PM, the Assistant Director of Nursing (ADON) stated the consultant pharmacist reviewed the residents' records for duplicate therapy during the monthly medication regimen review. The ADON stated she expected the pharmacist to identify any duplicate medications and follow-up with the physician for evaluation.</p> <p>In a telephone interview on 05/31/11 at 11:25AM, the Consultant Pharmacist stated she completed medication regimen reviews monthly, reported any irregularities to the attending physician and Director of Nursing, and documented her recommendations in the progress notes. The pharmacist stated resident #15 was admitted on Restoril, which was given scheduled, and clonazepam, given as needed only. She stated she had not made a recommendation regarding the use of two sedatives. The pharmacist stated she planned to monitor the clonazepam use before making any recommendations.</p> <p>2. Resident #15 was admitted to the facility on 9/24/10 and readmitted on 2/4/11 and 3/31/11 with multiple diagnoses including congestive heart failure (CHF), coronary artery disease, myocardial infarction, and bradycardia. Record review of the resident's clinical record revealed physician orders dated 2/7/11 for Amiodarone 200mg daily. Amiodarone is an antiarrhythmic agent indicated for ventricular fibrillation or ventricular tachycardia. Amiodarone has unlabeled indications of atrial fibrillation and paroxysmal supraventricular tachycardia.</p>	F 428	<p>Non-response to pharmacist recommendations will result in a phone call to physician's office by SDC.</p> <p>The DON will bring the results of the audit to the monthly QA meeting for 2 months.</p>		

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F 428	<p>Continued From page 29</p> <p>Record review of the resident's clinical record revealed no documentation of an appropriate diagnosis for amiodarone.</p> <p>Record review of the physician's progress notes revealed no documentation of an appropriate diagnosis for amiodarone.</p> <p>Record review of the consultant pharmacist's progress notes revealed no documentation of an appropriate diagnosis for amiodarone. An entry dated 4/22/11 read in part "amiodarone - Dx CHF."</p> <p>In an interview on 5/26/11 at 5:48PM, the ADON stated the consultant pharmacist reviewed the residents' records for documentation of appropriate diagnoses during the monthly medication regimen review. The ADON stated she expected the pharmacist to identify medications without an appropriate diagnosis and request documentation from the physician.</p> <p>In a telephone interview on 05/31/11 at 11:25AM, the Consultant Pharmacist stated she completed medication regimen reviews monthly, reported any irregularities to the attending physician and Director of Nursing, and documented her recommendations in the progress notes. The pharmacist stated when residents were admitted, she checked the admission orders and discharge summary for supporting diagnoses. She stated she had not made a recommendation requesting a diagnosis for resident #15's amiodarone.</p>	F 428		

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F 159 SS=D 483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS

Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.

The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the

F 159

"Submission of this response to the Statement of Deficiency by the undersigned does not constitute an admission that the deficiency existed and/or were correctly cited and/or require correction.

**F Tag 159**

Resident # 1 family came in, obtained a check, and bought a new TV for resident. This was on 5/26/11. *6/17/11*

All resident accounts were reviewed by the BOM and Regional AR person to ensure all resident trust accounts were at acceptable amounts. This was completed on 5/26/11.

The Business Office Manager (BOM) will review weekly all resident trust funds. Any resident approaching \$1500,

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Tricia Wreger</i>	TITLE <i>Administrative</i>	(X6) DATE <i>6/16/11</i>
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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.

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F 159	<p>Continued From page 1</p> <p>resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident record review, facility record review, resident interview and facility staff interview the facility failed to notify 1 of 75 medicaid recipient residents with a trust account when they were within \$200.00 of their limit. (Resident #1)</p> <p>The findings included:</p> <p>A review of resident trust accounts was conducted on 5/26/11. During this review of resident trust accounts, Resident #1 was noted to have \$2, 381.18 as of 5/16/2011. Continued review revealed Resident #1 had \$2,209.33 in their account on 4/1/11. After a miscellaneous deduction and patient liability deduction on 4/8/11, Resident #1 remained with with \$2,042.58 in their trust account. With a Social Security deposit of \$427.00 on 5/12/11, and some other miscellaneous deductions, Resident #1 remained with \$2, 381.18 on 5/26/11 when the resident trust review was conducted. Resident #1 had been within \$200.00 of their limit since 4/1/11.</p> <p>An interview was conducted with the Business Officer Manager and the Regional Business Office Manager on 5/26/11 at 11:30 AM. During</p>	F 159	<p>their names will be given to Social Services. Social Services will contact the family regarding spending down of resident's resources.</p> <p>BOM will submit to the monthly QA meeting the results of this weekly audit for 2 months.</p>		

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F 159	<p>Continued From page 2</p> <p>this interview, the Regional Business Office Manager conveyed that Resident #1 was a medicaid recipient and that the resident or responsible party should have been notified of the account balance. The Regional Business Officer Manager stated the Social Worker would have notified the resident and or the responsible party of the residents account balance.</p> <p>An interview was conducted with the Social Worker on 5/26/11 at 1:50 PM. During this interview the Social Worker stated she had not received notice of Resident #1's trust account balance until today (5/26/11). She stated she had contacted the responsible party for Resident #1 on 5/26/11 after the Business Office staff informed her of the balance, and they had a plan in place to spend money on a big screen TV and cable for the resident's room.</p> <p>Resident record review revealed, Resident #1 was admitted to the facility on 11/19/10. Her beginning account balance on 12/6/10 was \$427.00. Resident #1 was assessed on her quarterly Minimum Data Set (MDS) assessment on 2/22/11 as interviewable.</p> <p>An interview was conducted with Resident #1 on 5/26/11 at 5:40 PM. During this interview, Resident #1 stated that her daughter had left to go get her a TV from Walmart. She stated that she was not aware that she needed to spend any money from her account until staff notified her daughter today (5/26/11).</p>	F 159	<p><b>F Tag 281</b></p> <p>Resident #6 had orders written for oxygen on May 24, 2011 and care plan updated on May 24, 2011.. Resident #7 received order for appetite stimulant on May 26, 2011. Resident #7 had order written on May 26, 2011 for oxygen use parameters. Care plan was then updated to reflect physician's orders.</p> <p>All residents could be affected by this, so clinical records were audited for the above citations. This audit was done by DON/ADON/SDC and completed on June 8, 2011.</p> <p>Nursing staff were re-educated by the ADON of the above citations on May 26, 2011. On June 6, 2011 at the All Staff Meeting, nursing Guidelines for Making Doctors Appointments,</p>	6/19/11	
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility</p>	F 281			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345137	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  06/17/2011
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NAME OF PROVIDER OR SUPPLIER  SOUTH VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2221 RALEIGH ROAD ROCKY MOUNT, NC 27803
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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K 018  
SS=D

**NFPA 101 LIFE SAFETY CODE STANDARD**  
Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  
  
Roller latches are prohibited by CMS regulations in all health care facilities.

K 018

**K 018**  
It is the policy of South Village to be compliant in the Life Safety Code Standards for North Carolina.  
  
The Plant Operations Manager conducted a facility wide inspection of all doors in the center.  
  
The Plant Operations Manager repaired door latches on rooms 44, 47, 52, and 54. This was completed on June 20, 2011.  
  
The Plants Operation Manager will do door latch checks weekly for 8 weeks.  
  
Any latches requiring repair will be done at that time by the Plant Operations Manager.

6/27/11

K 051  
SS=D

This STANDARD is not met as evidenced by:  
A. Based on observation on 06/17/2011 the following doors failed to latch when closed ( 52,54,47 and 44).  
42 CFR 483.70 (a)  
**NFPA 101 LIFE SAFETY CODE STANDARD**  
A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in

K 051

This weekly report will be brought to the monthly QA meeting for 2 months by the Plant Operations Manager.

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

*Ireda Wright*

TITLE

*Administrator*

(X6) DATE

6/28/11

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

*ED*

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

PRINTED: 06/20/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345137	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  06/17/2011
NAME OF PROVIDER OR SUPPLIER  SOUTH VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2221 RALEIGH ROAD ROCKY MOUNT, NC 27803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 051	Continued From page 1 patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6  This STANDARD is not met as evidenced by: A. Based on observation on 06/17/2011 the fire alarm panel did not have an audible signal when the phone lines were disconnected. 42 CFR 483.70 (a)	K 051	<b>K 051</b>  It is the policy of South Village to be compliant in the Life Safety Code Standards for North Carolina.  Tyco Fire and Security ADT made service call June 17, 2011 and repaired the fire alarm panel to have an audible signal when the phone lines are disconnected.(See attached letter and invoice)  Plant Operations Director will make a visual inspection of the panel monthly during the fire drill. Any issues being addressed immediately with ADT.  Results of this inspection will be presented to the monthly safety meeting and reviewed monthly at the QA Committee Meeting for the next 3 months.	6/27/11	

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

PRINTED: 06/20/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345137	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED  06/17/2011
NAME OF PROVIDER OR SUPPLIER  SOUTH VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2221 RALEIGH ROAD ROCKY MOUNT, NC 27803	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 061 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>This STANDARD is not met as evidenced by: A. Based on observation on 06/17/2011 the tamper alarm on the valve for the pressure operated flow switch failed to sound an alarm due to the wires being disconnected. 42 CFR 483.70 (a)</p>	K 061	<p><b>K 061</b></p> <p>It is the policy of South Village to be compliant in the Life Safety Code Standards for North Carolina.</p> <p>Tyco Fire and Security ADT made service call June 17, 2011 and repaired the tamper alarm on the valve for the pressure operated flow switch. (See attached letter)</p> <p>Plant Operations Director will make a visual inspection of the panel monthly during the fire drill to ensure wires are connected. Any issues being addressed immediately with ADT.</p> <p>Results of this inspection will be presented to the monthly safety meeting and reviewed monthly at the QA Committee Meeting for the next 3 months.</p>	6/28/11

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

*Jude Wright*

TITLE

*Adrian Kiser*

(X8) DATE

6/28/11

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