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

APR 20 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345397	A. BUILDING _____ B. WING _____	03/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHORELAND HLTH CARE & RETIREME	200 FLOWER-PRIDGEN DR WHITEVILLE, NC 28472

(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
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews and observations, the facility failed to put interventions in place to prevent falls for 1 of 3 sampled residents. (Resident # 40) Findings include: Resident # 40 was admitted to the facility on 7/8/2009 with diagnoses of Difficulty in Walking, Muscles Weakness, Altered mental status, Cellulites of leg, Depression, Osteoarthritis, Parkinson's and Pacemaker. Resident # 40's annual Minimum Data Set (MDS) dated 7/5/2010 indicated the resident had a fall in the past 31-180 days. The Resident Assessment Protocol (RAP) dated 7/5/2010 documented "Resident has a long history of occasional falls." Resident # 40's care plan last updated 3/16/2011, indicated the resident's problem as being at risk for falls due to history of falls." The approaches for the falls included "Report any change in condition, bed in lowest position and bed pad alarm when in bed." Review of the facility's Resident Incident Report	F 323	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F 323 **Corrective Action for Resident Affected:** 4/13/11 For Resident #40 the following fall interventions were put in place: dyscem placed in wheelchair 3/18/11 by Support Nurse, urine checked for UTI 3/21/11 by Support Nurse, wing mattress put on bed 3/21/11 by Maintenance and Staff Development Coordinator, auto-lock breaks on wheelchair by Maintenance 3/22/11, high-low bed ordered 3/25/11 by Administrator and care plan reviewed and updated by Care Plan Coordinator and Staff Development Coordinator on 3/23/11.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sum Mullen LNHA — TITLE: 4/1/11 — (X6) DATE

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

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F 323	Continued From page 1 dated date 12/27/2010, documented the resident "found facing bed with Knees on the floor and elbows and upper body on bed." The Incident report further indicated "the resident had alarms but were not sounding." The intervention was "staff to make sure alarms is turned on at all times." Review of the facility 's Resident Incident Report dated 1/4/2011, documented "Resident was observed sitting on floor next to her bed. " The incident report further indicated "the alarm was sounding at the time of incident." The intervention was "staff to try to respond more quickly to sounding alarms." Review of the facility's Resident Incident Report dated date 1/6/2011, documented the resident "found sitting on floor beside bed with back against bed." The intervention was "staff to answer alarms quickly." Review of the facility's Resident Incident Report dated date 1/24/2011, documented the resident was "observed sitting on floor beside bed facing roommate without injuries." The intervention was "staff to make sure all alarms are turned on when resident is in the bed or her wheel chair to prevent future falls." Review of the facility 's Resident Incident Report dated date 2/23/2011, documented "Resident was attempting to get out of bed without assistance. Found sitting on floor beside bed. Observed sitting on floor next to her bed." The intervention was "staff to try to respond more quickly to sounding alarms to try to prevent incident."	F 323	**Corrective Action for Resident Potentially Affected:** All resident's who have fallen are at risk for the alleged deficient practice. A falls review meeting was held by the Quality of Life Team on 3/17/11 and all residents who have fallen in the past 6 months were reviewed for appropriate interventions and the need for any additional interventions. Any additional interventions recommended will be put in place by Staff Development Coordinator and Falls Nurse by 4/13/11. **Systemic Changes:** A falls intervention box containing various fall prevention items such as bed alarms, chair alarms, dyscem, gripper socks, floor strips, TABS, and wander guard was placed at the nurses station by the Staff Development Coordinator for staff to have access to and initiate when a resident falls if indicated. An in-service was conducted on 3/25/11, 3/28/11, 3/29/11 and 3/31/11 by the Staff Development Coordinator. Those who attended were all RN's and LPN's, FT, PT, and PRN. In-service done with Staff Development Coordinator and Falls Nurse, 3/18/11 on falls interventions by Nurse Consultant. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included: location and content of the falls intervention box and when to initiate items from the falls box to assist in preventing future falls and the proper procedure to follow. This information has been integrated into the standard orientation training and in the required in-service refresher courses	

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F 323	Continued From page 2 During the interview on 3/16/2011 at 11:00 AM, Nurse # 1 reported the resident was confused and had several falls in the past last month. Nurse #1 further reported the intervention put in place was the best the facility could do to prevent the resident from falling from the bed. Nurse #1 was asked why the intervention was not changed but only mainly indicated staff was to respond more quickly to sounding alarms. Nurse # 1 answered that it was difficult for the staff to reach the resident on time when the alarm sounded. During the interview on 3/16/2011 at 2:00 PM, the Director of Nursing (DON) reported she will make sure in the future the facility uses a different intervention any time the resident had a fall and document the intervention in the Resident's Incident Report.	F 323	for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **Quality Assurance** The Staff Development Coordinator will monitor this issue using the "QA Monitor Falls Review" for making sure appropriate and timely interventions are put in place for residents who fall. This will be completed weekly x 4 weeks then monthly x 2 months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. Monitoring began on 3/23/11 and will continue through 6/11 and longer, if necessary.	

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K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Surveyor: 26594 Based on observation on Thursday 4/14/11 between approximately 10:15 AM and 2:00 PM the following was noted: 1) The area around the sprinkler heads and eschusion plate were not properly sealed in order to maintain the required rating of the ceiling. 42 CFR 483.70(a)	K 012	Correction Action: All areas around sprinkler heads are sealed in order to maintain the required rating of the ceiling. Potential Affect: All residents have the potential to be affected by this alleged deficient practice. Systemic Changes: All sprinkler heads were checked and those not properly sealed were sealed with the required sealant. Monitoring: Maintenance Director will monitor sprinkler heads when he performs the monthly building inspection and report to QOL committee. Date of Completion: 4/20/11	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Surveyor: 26594 Based on observation on Thursday 4/14/11 between approximately 10:15 AM and 2:00 PM the following was noted:	K 025	Correction Action: The holes/penetrations in the smoke wall in the attic area on 100 hall were sealed using the required sealant to maintain the fire resistive rating of the smoke barrier. Potential Affect: All residents have the potential to be affected by this alleged deficient practice. Systemic Changes: Sealant was placed around the penetrations to ensure a tight seal was present and that the deficient practice does not occur again. Monitoring: Maintenance Director will monitor smoke barrier penetration when he performs the monthly building inspection and report to QOL committee. Date of Completion: 4/15/11	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan Bullock LNHA | TITLE: Administrator | (X6) DATE: 4/28/11

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K 025	Continued From page 1 1)The smoke wall in the attic area on 100 Hall had holes and/or penetrations that were not sealed in order to maintain the required rating of the wall. 42 CFR 483.70(a).	K 025		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 26594 Based on observation on Thursday 4/14/11 between approximately 10:15 AM and 2:00 PM the following was noted: 1) The dry storage room in the kitchen did not close, latch and seal when checked. 2) The one laundry room corridor door was found wedged open and the other laundry room corridor door did not close, latch and seal when checked. 42 CFR 483.70(a)	K 029	Correction Action: Dry storage room door in kitchen repaired. Wedge removed from laundry room door. Laundry room corridor door repaired. Potential Affect: All residents have the potential to be affected by this alleged deficient practice. Systemic Changes: Dry storage room door and laundry room corridor door was repaired to close, latch and seal. Laundry room staff in-serviced on "Self Closing Doors" on 4/27/11 and 4/28/11. Monitoring: Maintenance Director will monitor self closing doors and doors closing, latching and sealing monthly on Monthly Building Inspection. Date of Completion: 5/6/11	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	Correction Action: Staff in-serviced on the use and function of the two master override switches for the mag lock doors. Potential Affect: All residents have the potential to be affected by this alleged deficient practice.	

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K 038	Continued From page 2 This STANDARD is not met as evidenced by: Surveyor: 26594 Based on observation on Thursday 4/14/11 between approximately 10:15 AM and 2:00 PM the following was noted: 1) When question the staff at the nurse station on 100 Hall were one of two master override switches for the mag lock doors was located were not familiar with its use and function on unlocking the mag lock door to the facility. 42 CFR 483.70(a)	K 038	Systemic Changes: An in-service was held on 4/21/11, 4/26/11, 4/27/11, and 4/28/11 on use and function of the two master override switches for the mag lock doors to the facility. Monitoring: Staff Development Coordinator will monitor staff by asking 10 staff weekly for one month, the function and use of the mag locks and then monthly for 2 months. Date of Completion: 5/29/11	
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Surveyor: 26594 Based on observation on Thursday 4/14/11 between approximately 10:15 AM and 2:00 PM the following was noted: 1) Upon review of Fire Alarm Documentation it	K 052	Correction Action: Smoke head sensitivity inspection will be completed yearly. Potential Affect: All residents have the potential to be affected by this alleged deficient practice. Systemic Changes: Sunland Fire Protection, Inc. will perform a smoke head sensitivity test yearly in accordance with NFPA 70 National Electrical Code and NFPA 72. Monitoring: Maintenance Director will monitor this yearly for testing to be completed. Date of Completion: 5/29/11	

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K 052	Continued From page 3 was found that a smoke head sensitivity inspection and/or report has not been conducted in the last two years. 42 CFR 483.70(a)	K 052		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Surveyor: 26594 Based on observation on Thursday 4/14/11 between approximately 10:15 AM and 2:00 PM the following was noted: 1) On 300 and 400 Hall exits the exterior roofs were not sprinklered. (Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in depth per NFPA 13 section 5-13.8.1.) 42 CFR 483.70(a)	K 056	Correction Action: Sprinklers will be installed under exterior roofs on 300 and 400 hall exits. Potential Affect: All residents have the potential to be affected by this alleged deficient practice. Systemic Changes: Sprinklers will be installed under exterior roofs exceeding 4 foot in depth. Monitoring: Maintenance Director will monitor 300 and 400 hall exterior sprinklers when he performs the monthly building inspection and report to QOL committee. Date of Completion: 5/29/11	
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96	K 069	Correction Action: Negative pressure in kitchen repaired. The two kitchen doors close, latch and seal properly. Kitchen exhaust hoods exhaust fumes properly from the environment. Potential Affect: All residents have the potential to be affected by this alleged deficient practice.	

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K 069	Continued From page 4 This STANDARD is not met as evidenced by: Surveyor: 26594 Based on observation on Thursday 4/14/11 between approximately 10:15 AM and 2:00 PM the following was noted: 1) The kitchen is operating under a sever negative pressure resulting in two of the doors to the kitchen not able to close, latch and seal and the negative pressure is also preventing the kitchen exhaust hoods not able to properly exhaust fumes from the environment. 42 CFR 483.70(a)	K 069	Systemic Changes: The kitchen fan on the roof was re-wired to prevent negative pressure in the kitchen. Kitchen exhaust hood was repaired so fumes are properly removed from the environment. Two kitchen doors were repaired and close, latch and seal properly. Monitoring: Maintenance Director will monitor pressure in the kitchen, doors closing, latching and sealing properly and exhaust hoods exhausting fumes properly when he performs the monthly building inspection and report to QOL committee. Date of Completion: 4/26/11	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Surveyor: 26594 Based on observation on Thursday 4/14/11 between approximately 10:15 AM and 2:00 PM the following was noted: 1)Documentation for monthly load test was conducted without recording percent rated load or temperature rise. A load bank test had not been completed within the past year. NFPA 99 3-4.4.2 Record keeping. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained	K 144	Corrective Action: Percent rated load and temperature rise was added to the monthly documentation for the generator testing. A load bank test will be completed yearly. Potential Affect: All residents have the potential to be affected by this alleged deficient practice. Systemic Changes: The generator was exercised with loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes for a total of 2 continuous hours. Monthly documentation was changed to reflect percent rated load and temperature rise.	

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K 144	Continued From page 6 and available for inspection by the authority having jurisdiction. NFPA 110 6-4.2 (1999 edition) generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: (a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating (b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. NFPA 110 6-4.2.2 (1999 edition) Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPPS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. (load bank testing) 42 CFR 483.70(a)	K 144	Monitoring: Maintenance Director will monitor this yearly for load bank testing and document monthly on the percent rated load and temperature rise. Date of Completion: 5/4/11	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Surveyor: 26594 Based on observation on Thursday 4/14/11 between approximately 10:15 AM and 2:00 PM the following was noted: 1) The normal power/utility light on the automatic	K 147	Corrective Action: The normal power/utility light on the automatic transfer switch is repaired. Potential Affect: All residents have the potential to be affected by this alleged deficient practice.	

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K 147	Continued From page 6 transfer switch was not operational at the time of the survey. 42 CFR 483.70(a)	K 147	Systemic Changes: The power/utility light was repaired using the proper light on the automatic transfer switch. Monitoring: Maintenance Director will monitor this monthly on his monthly preventive maintenance report. Date of Completion: 4/25/11	