STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345363	A. BUILDING _____ B. WING _____	C 06/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESBYTERIAN HOME OF HAWFIELDS	2502 S NC 119 MEBANE, NC 27302

(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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to provide resident privacy during staff assisted toileting for 1 of 3 residents (resident #66).	F 164	DISCLAIMER RESPONSE PREFACE: Presbyterian Home of Hawfields Acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of Residents. The plan of correction is submitted as a written allegation of compliance. Presbyterian Home of Hawfields Response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Presbyterian Home of Hawfields reserves the right to refute any deficiency on this statement of deficiencies through informal dispute resolution, formal appeal, and/or other administrative or legal procedures.	07/12/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary H Kennedy — TITLE: Administrator — (X6) DATE: 7/6/12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345363	A. BUILDING _____ B. WING _____	C 06/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESBYTERIAN HOME OF HAWFIELDS	2502 S NC 119 MEBANE, NC 27302

(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 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to provide resident privacy during staff assisted toileting for 1 of 3 residents (resident #66).	F 164	**F 164** Presbyterian Home of Hawfields will continue to strive to ensure the right of Personal Privacy for the Residents' by re-educating staff on Personal Privacy. Resident #66 and in-house Residents will continue to have their Personal Privacy respected, to include Personal Privacy during Personal Care. Since all Residents have the potential to be included in this issue; the RNC's, MDS Coordinator or DON will conduct a retraining session and a visual review of incontinent care by Presbyterian Home of Hawfields staff to ensure Personal Privacy is respected. A QA Audit Tool will be used for 6 Residents, 3 times per week for one month and reviewed at least weekly by the DON, RN Consultant and/or Administrator.	07/12/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345363	A. BUILDING _____ B. WING _____	C 06/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESBYTERIAN HOME OF HAWFIELDS	2502 S NC 119 MEBANE, NC 27302

(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 164	Continued From page 1 Findings Include: Resident #66 was admitted to the facility on 01/11/2012 and had diagnoses which included Dementia, Alzheimer's disease, Congestive Heart Failure, history of left hip and femur fractures, Cellulitis to both lower extremities, Lower leg pain and a recent Compression fracture to the lumbar area. A review of the resident's Minimum Data Set (MDS) dated 04/13/2012 indicated the resident was, cognitively impaired, frequently incontinent of bowel and bladder, currently on a toileting program to manage incontinence, and needs limited assistance by at least 1 person to use the toilet. On 06/13/2012 at 10:10 a.m., an observation of resident #66's incontinent care by NA # 2 was conducted. During the incontinent care NA #2 undressed resident #66 from the waist down and transferred her from her Geri chair to the commode exposing her genital area. Resident #66's room mate was sitting in her wheelchair next to her bed (the A bed next to the bathroom door) facing the bathroom and had direct line of sight of resident #66 being undressed and placed on the commode and receiving incontinent care by NA #2. NA #2 made no attempt to pull the privacy curtain to block the room mate ' s view. An interview was conducted with NA #2 on 06/13/2012 at 10:20 a.m. The NA was asked why she had not provided any privacy for Resident #66 from the room mate as she had made no attempt to pull the privacy curtain to block the room mate ' s view. NA #2 then pulled the	F 164	**Cont. F 164** QA Committee will review the QA Action Plan once a month for 3 months and revise the action plan to ensure continued compliance. NA # 2 was terminated.	07/12/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345363	A. BUILDING _____ B. WING _____	C 06/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESBYTERIAN HOME OF HAWFIELDS	2502 S NC 119 MEBANE, NC 27302

(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 164	Continued From page 2 privacy curtain (resident already dressed and back on the Geri chair) and stated, " Is that good enough. " NA #2 was asked why she did not pull the curtain prior to getting resident #66 undressed but NA #2 would not respond.	F 164		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews and record reviews the facility failed to maintain the dignity of 1 of 3 sample resident by staff being rude to Resident # 17. Findings include: 1. Resident # 17 was admitted to facility on 4/5/2012 with diagnoses that included Muscle Weakness, Cerebrovascular Disease and Diabetes Mellitus. The most recent Minimum Data Set (MDS) dated 4/10/2012 indicated that resident #17's Brief Interview for Mental Status (BIMS) score was 15 (no short or long term memory problem). Resident #17 was independent with daily decision making. The same MDS revealed the Resident #17 required limited assistance with Activities of Daily Living (ADL) and the resident had no behavior problems. During an interview on 6/13/2012 at 4pm	F 241	**F 241** Presbyterian Home of Hawfields will continue to strive to ensure the Residents' dignity is respected in full recognition of his or her individuality. Copies of Resident Abuse and Neglect Policy and Procedures were issued to current employees for their re-review on 06/13/2012. This educational policy will continue to be included in the new employee orientation process and at least quarterly for current employees. Presbyterian Home of Hawfields will continue to thoroughly investigate all allegations of abuse and/or neglect. The Social Services Director will discuss Presbyterian Home of	07/12/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345383	A. BUILDING _____ B. WING _____	C 06/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESBYTERIAN HOME OF HAWFIELDS	2502 S NC 119 MEBANE, NC 27302

(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 241	Continued From page 3 Resident # 17 indicated she was asleep on 5/2/2012. Nurses Aide (NA # 1) came in jerking on her leg and removed a pillow that was under her legs and threw the pillow and it hit her in the face. Resident #17 indicated that NA # 1 was not supposed to treat residents like that and talked hateful to them. Resident #17 indicated that NA# 1 was rough and ugly to her. Resident #17 also indicated that NA # 1 told her that if she didn't like how she did it- that she could care for herself or tell her family to put her somewhere else. Resident # 17 indicated" that her feelings were hurt, this made her feel very bad and very upset. " During a review of the grievance log on 6/13/2012 revealed a concern dated 5/2/2012 which indicated resident #17, " stated, NA # 1 was rough and ugly with her claimed NA #1 hit her in her face with a pillow." The form revealed that the facility made a 24-hr initial report and 5-working day report of Resident Abuse to the state. That form revealed that the facility investigated this situation and the staff member was terminated. NA # 1 was called on 6/14/2012 at 11:30am for an interview no answer. During an interview on 6/14/2012 at 12:20pm, Nurse #1 revealed that NA # 1 indicated to her there was an incident with Resident # 17. Resident # 17 stated that NA#1 threw a pillow at her and hit her in the face. Nurse # 1 stated that NA # 1 informed her that if she had hit Resident # 17 on purpose it would have hurt worse. NA #1 stated to Nurse #1 that she told Resident # 17 that if she did not like the care that she gave, have your daughter take you some where else. Nurse #1 also indicated that during her interview	F 241	**Cont. F241** Hawfields' Abuse/Neglect Policies at the monthly Resident Council meetings (with the Residents permission) times 3 months. At that point, the Administrator and Social Services Director will reassess the continued discussion of policies at the Resident Council meetings. Presbyterian Home of Hawfields' Abuse/Neglect Policies will continue to be reviewed during the admission process and the orientation of new employees. The RNC or Social Services Director will interview at least 2 Residents per hall per week for one month to see if there are any Abuse/Neglect concerns. A QA Audit Tool will be used to document these interviews. The results of the Resident interviews will be reviewed at least weekly by the Administrator, DON and/or RN Consultant. The QA Committee will review the audit results every month for 3 months and revise the action plan	07/12/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345383	A. BUILDING _____ B. WING _____	C 06/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESBYTERIAN HOME OF HAWFIELDS	2502 S NC 119 MEBANE, NC 27302

(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 241	Continued From page 4 with Resident # 17, she reiterrated what the NA#1 had stated to her earlier. Nurse #1 stated that Resident # 17 felt that NA #1 threw the pillow on purpose. Resident # 17 stated NA # 1 came in her room and did not speak. Nurse # 1 told Resident # 17 that she would inform the RN Coordinator. During an interview on 6/14/2012 at 12:40pm RN Coordinator revealed that Resident # 17 reported to her that NA #1 hit her in the face with a pillow on purpose. Resident # 17 reported that NA#1 just came in, without saying good morning or any thing else, she started jerking the pillow out from under her feet and threw the pillow in her face. RN Coordinator also revealed that Resident # 17 stated that she was in fear of retaliation. RN Coordinator also indicated that she spoke with NA #1 concerning this incident. RN revealed that NA # 1 stated that she tossed the pillow to the top of the bed and the second pillow rolled off the first and landed on Resident #17's face. NA# 1 informed RN coordinator that she apologized to the Resident # 17 and asked if she was hurt. RN Coordinator stated that she later informed the Social Service Director of the incident because Resident # 17 requested to meet with SSD. During an interview with NA # 1 on 6/14/2012 at 1:30pm, indicated that she does not work at this facility any more. NA# 1 revealed that she wrote a statement to Director of Nursing. NA # 1 denied throwing the pillow at resident # 17 or telling Resident #17 that "if she does not like the way she provide care for her, do it your self or tell your daughter to place you some place else." During an interview with Social Services Director	F 241	**Cont. F241** to ensure continued compliance on this issue. NA #1 was Terminated.	07/12/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345383	A. BUILDING _____ B. WING _____	C 06/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESBYTERIAN HOME OF HAWFIELDS	2502 S NC 119 MEBANE, NC 27302

(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 241	Continued From page 5 (SSD) on 6/14/2012 at 3:45pm SSD stated that Resident #17 reported to her that this happened Tuesday morning Resident # 17 stated" she was sleeping. A person came in her room and started jerking things at the end of her bed. The person took a pillow that Resident # 17 used under her legs and threw it and it hit the Resident #17. Resident # 17 then opened her eyes and saw that the person was NA #1. Resident # 17 reported that NA #1 didn't say anything "Good Morning, time to get up,etc." Resident #17 reported that NA# 1 stated that "If you don't like how I do it- you can do it yourself or tell your family to put you somewhere else." Resident # 17 reported that NA # 1 told her she wass a professional. SSD stated that Resident # 17 stated that this was abuse and that NA # 1 should know how to treat people. SSD stated that Resident #17 reported that she told the RN Coordinator about this NA # 1 behavior. SSD stated to Resident # 17 that an investigation was taking place and a report will be sent to the State. SSD also stated that she informed Resident # 17 to tell other if they have concerns to please report them. SSD indicated that she would report this to the Administrator. During an interview with the Adminstrator and the Director of Nursing (DON) on 6/14/2012 at 4:15 pm, the Adminstrator stated "This facility has a zero tolerance for verbal abuse." The statement the NA # 1 made to that resident was very inappropriate.	F 241		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an	F 315	**F 315** Presbyterian Home of Hawfields will continue to strive to ensure	07/12/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345363	A. BUILDING _____ B. WING _____	C 06/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESBYTERIAN HOME OF HAWFIELDS	2502 S NC 119 MEBANE, NC 27302

(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 315	Continued From page 6 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on continuous observation, record review, and staff interviews the facility failed to implement interventions for 1 of 3 residents (resident #66) on toileting programs to prevent urinary incontinence. Findings Include: Resident #66's medical record indicated the resident had diagnoses which included Dementia, Congestive Heart Failure, history of left hip and femur fractures, Cellulitis to both lower extremities, and a recent Compression fracture to the lumbar area. A review of the resident's Care Plan dated 04/19/2012 revealed the resident had Activities of Daily Living (ADL) deficits which included, "Resident needs toileting program related to needing reminders/assistance to use toilet. Resident to be assisted to use toilet Q (every) 2 hours while awake as evidenced by (AEB) Care Tracker/observations X 3 months." The facility also indicated their interventions on the resident's care plan for this deficit to be, "Assist resident to toilet Q 2 hrs or more often while awake, Assist with toileting as needed, Record continent status	F 315	**Cont. F315** that our Residents with incontinence related issues will have their urinary interventions in place to strive to prevent urinary incontinence. Since all in-house Residents have the potential to be included in this issue, the RNC's, MDS Coordinator or DON will conduct a retraining session and a visual audit of incontinent care by Presbyterian Home of Hawfields staff. The RNC's (2) have re-assessed Resident #66 and other in-house Residents in regard to staff monitoring change to their urinary continence status. In-house Residents' identified as being continent, and capable of self toileting will continue with the process, and staff monitoring will continue. Residents that are continent or	07/12/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345363	A. BUILDING _____ B. WING _____	C 06/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESBYTERIAN HOME OF HAWFIELDS	2502 S NC 119 MEBANE, NC 27302

(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 315	Continued From page 7 on Care Tracker, Report any decline in continent status to Registered Nurse Coordinator (RNC)." A review of the resident's Minimum Data Set (MDS) dated 04/13/2012 indicated the resident was, "Cognitively impaired, frequently incontinent of bowel and bladder, currently on a toileting program to manage incontinence, and needs limited assistance by at least 1 person to use the toilet." The resident's Nursing Assistant's (NA) "Care Plan Flow sheets" for March, April, May, June 2012 indicated, "This resident is on a scheduled toileting program: Resident may or may not know when they have to go to use toilet so they are toileted at least every 2 hours (toileted during day and evening) Incontinence checks at night." On 06/13/2012 at 10:10 a.m., an observation of resident #66 ' s incontinence care by NA #2 was conducted. A continuous observation was made of the resident upon completion of the incontinent care through 1:00 p.m. (resident taken to and from dining room for lunch). During this continuous observation the resident was not observed assisted/taken to the bathroom/toilet. 06/13/2012 at 2:25 p.m. an interview with the facility's Ward Clerk/Data entry nursing assistant (NA #3) regarding the NA Kiosk Input from NAs (toileting) resident #66. A review of the Kiosk entries indicated only 1 toileting entry on 06/13/2012 on the 2nd shift (day shift) between 8:00 a.m. and 3:00 p.m. for resident #66 which was entered at 10:54 a.m. by NA #2. Further review of the Care Tracker data entries between 06/06-13/2012 for the toileting of resident #66	F 315	**Cont. F315** incontinent and require staff assistance will continue on a regular basis as indicated per Care Plan interventions but at least before and after meals, by the Nursing staff. Residents identified as being incontinent via their assessment will continue to be monitored on a regular basis as indicated per Care Plan interventions. Resident #66 and other in-house Residents that were assessed to need individualized interventions for urinary continence, the RNC's and MDS Nurse reviewed their Care Plans and Treatment Plans to revise interventions as determined per the assessment findings. The Care Plan Team will review the Resident's incontinence status and interventions on a regular basis but at least quarterly. The review process includes when there is a "significant change" per the Nursing Standard of Care	07/12/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345383	A. BUILDING _____ B. WING _____	C 06/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESBYTERIAN HOME OF HAWFIELDS	2502 S NC 119 MEBANE, NC 27302

(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 315	Continued From page 8 revealed the resident waited longer than the care planned 2 hours between toileting on the day/evening shifts as noted below: Date/Times toileted per electronic Care Tracker and resident ' s continent status 06/06/12 10:20 a.m. (resident incontinent) 2:34 p.m. (resident incontinent) 8:59 p.m. (resident continent) 06/07/12 10:52 a.m. (resident incontinent) 2:36 p.m. (resident incontinent) 5:26 p.m. (resident incontinent) 06/08/12 9:44 a.m. (resident incontinent) 3:05 p.m. (resident incontinent) 8:58 p.m. (resident continent) 06/09/12 9:37 a.m. (resident continent) 5:52 p.m. (resident incontinent) 06/10/12 10:18 a.m. (resident incontinent) 06/11/12 11:04 a.m. (resident incontinent) 2:52 p.m. (resident incontinent) 9:38 p.m. (resident incontinent) 06/12/12 10:12 p.m. (resident incontinent) 2:53 p.m. (resident continent) 9:57 p.m. (resident incontinent)	F 315	**Cont. F315** Guidelines, such as a change in their urinary status, the use of a Foley catheter, Resident's new diagnosis, etc. The RNC's will re-educate the nursing staff by July 12, 2012 related to the Resident's urinary system incontinence related interventions, Care Plan urinary logs to assist the staff with Resident specific interventions logs located in the C.N.A. Care plan Flow Book. The training program will be repeated at least yearly. We will continue to train all new employees about continence care. A QA Audit Tool will be used for 6 Residents, 3 times per week for one month and reviewed at least weekly by the DON, RN Consultant and/or Administrator. QA Committee will review the QA Action Plan once a month for 3	07/12/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345363	A. BUILDING _____ B. WING _____	C 06/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESBYTERIAN HOME OF HAWFIELDS	2502 S NC 119 MEBANE, NC 27302

(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 315	Continued From page 9 06/13/12 10:54 a.m. (resident incontinent) (Note - 06/09 &10/2012 care was provided by a staffing agency contracted with the facility) 06/13/2012 at 3:00 p.m. an interview was conducted with NA #2 (NA assigned to provide care on 06/13/2012 for resident #66). When asked if she had toileted resident #66 every 2 hours since the incontinence care observation was conducted NA #2 stated, "I checked the resident and she was dry, I don't have to put her on the toilet when she is dry or says she does not have to go to the bathroom." NA #2 was asked if she had toileted the resident prior to lunch or after lunch and NA #2 responded, "No, I only checked her after lunch and she was not wet and did not have a bowel movement so I didn't do anything else." An interview with the facility's Director of Nursing (DON) was conducted on 06/13/2012 at 3:05 p.m. The DON when asked about the facility's scheduled toileting program as indicated for resident #66 the DON stated, "I do not have any documentation covering our scheduled toileting program for the residents." The DON explained the toileting scheduled program to be: "Our scheduled toilet program is where the resident is gotten up every 2 hours and placed on the toilet. This is per the resident's care plan."	F 315	**Cont. F315** months and revise the action plan to ensure continued compliance. NA # 2 was terminated.	07/12/12

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
DRS	345363	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESBYTERIAN HOME OF HAWFIELDS	2502 S NC 119 MEBANE, NC 27302

(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 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III protected construction, and is utilizing North Carolina Special Locking arrangements . The facility is equipped with an automatic sprinkler system.	K 000	**DISCLAIMER** RESPONSE PREFACE: Presbyterian Home of Hayfields Acknowledges receipt of the statement of deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of Residents. The plan of correction is submitted as a written allegation of compliance. Presbyterian Home of Hayfields Response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Presbyterian Home of Hayfields reserves the right to refute any deficiency on this statement of deficiencies through informal dispute resolution, formal appeal, and/or other administrative or legal procedures.	
K 038 SS=E	CFR# 42 CFR 483.70 (a) 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 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 6/28/2012 the facility has an exit directional sign in the lounge room. This particular exit leads to an interior coourtyard that exits to the public way. This exit path is not a continuos non slick surface other than grass or soil. Note: There are two other required exits from the egress corridor for the lounge room and the lounge room does not require two remote exits. Note: There are two other doors from other rooms leading to the interior courtyard that are not exits through the courtyard, and are marked	K 038		

RECEIVED
JUL 11 2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary D Reynolds
TITLE: Administrator
(X6) DATE: 7/11/12

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

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
DRW	345363	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
THE PRESBYTERIAN HOME OF HAWFIELDS	2502 S NC 119 MEBANE, NC 27302

(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 000	INITIAL COMMENTS This Life Safety Code (LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III protected construction, and is utilizing North Carolina Special Locking arrangements . The facility is equipped with an automatic sprinkler system.	K 000	K 038 The directional sign marking the lounge door that leads to the interior courtyard has been changed to read "Not an Exit". This change was approved in writing by the Fire Marshall and a copy of their approval letter is included with this response.	06/29/2012
K 038 SS=E	CFR#: 42 CFR 483.70 (a) 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 This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 6/28/2012 the facility has an exit directional sign in the lounge room. This particular exit leads to an interior coourtyard that exits to the public way. This exit path is not a continuos non slick surface other than grass or soil. Note: There are two other required exits from the egress corridor for the lounge room and the lounge room does not require two remote exits. Note: There are two other doors from other rooms leading to the interior courtyard that are not exits through the courtyard, and are marked	K 038	Since all exit doors have to meet this same requirement, all other exit doors were inspected by the Maintenance Supervisor. All other doors were found to be in compliance. The Administrator verified that the exit sign to the courtyard from the lounge has been changed to read "Not an Exit". A QA Audit Tool will be used monthly by the Maintenance Supervisor and will be reviewed by the Administrator. The QA Committee will review the QA Action Plan monthly and revise the action plan to ensure continued compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (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

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345363	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESBYTERIAN HOME OF HAWFIELDS	2502 S NC 119 MEBANE, NC 27302

(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 038	Continued From page 1 as "Not an Exit". CFR# 42 CFR 483.70 (a)	K 038	**K 147** The Generator Maintenance Contractor has ordered repair parts for the switching mechanism that activates the generator, transfers the Life Safety Circuit to generator power and notifies the generator annuciator panel of the transfer to generator power.	08/12/2012
K 147 SS=E	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: Based on the observations and staff interviews on 6/28/2012 the following Life Safety item was observed as noncompliant with the generator annunciator panel, specific findings include: The generator annunciator panel did not give an indication that the generator was running and carrying the load for the Life Safety circuit when tested CFR# 42 CFR 483.70 (a)	K 147	Since the facility has a 400kw Generator that is activated by a 2500 AMP DPDT Switch that powers the entire facility upon partial/total loss of external power, this unit was tested during this survey and continues to be tested on a regular schedule as required. All other emergency generator functions performed as required. The Generator Maintenance Contractor will verify the proper operation of the Life Safety emergency transfer system. A QA Audit Tool will be used monthly by the Maintenance Supervisor and will be reviewed by the Administrator. The QA Committee will review the QA Action Plan Monthly and revise	

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345363	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE PRESBYTERIAN HOME OF HAWFIELDS	2502 S NC 119 MEBANE, NC 27302

(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 038	Continued From page 1 as "Not an Exit". CFR# 42 CFR 483.70 (a)	K 038	**Cont. K147** the action plan to ensure continued compliance.	08/12/2012
K 147 SS=E	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: Based on the observations and staff interviews on 6/28/2012 the following Life Safety item was observed as noncompliant with the generator annunciator panel, specific findings include: The generator annunciator panel did not give an indication that the generator was running and carrying the load for the Life Safety circuit when tested CFR# 42 CFR 483.70 (a)	K 147		