FEB 21 2013

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

PRINTED: 02/15/2013
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
	345315	A. BUILDING _______ B. WING _______	02/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND ACRES NURSING AND REHABILITATION CENTER	1170 LINKHAW ROAD LUMBERTON, NC 28358

(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 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 and staff interviews, the facility failed to follow physician ' s orders to initiate a bowel protocol for Resident #29 on two occasions when the resident had not had a bowel movement for 3 days for 1 of 11 Residents (Resident #29) whose bowel movement records were reviewed. The findings included: The hospital Discharge Summary dated 12/05/12 showed that the resident had a diagnosis of Severe Clostridium Difficile Colitis followed by Ileus versus Partial Small Bowel Obstruction. The Discharge Summary read: " For her ileus and partial small bowel obstruction, we will continue her laxatives and stool softeners. " Resident #29 was admitted to the facility on 12/05/12 and had diagnoses that included Alzheimer's Disease and Severe Clostridium Difficile (resolved) Colitis followed by Ileus versus Partial Small Bowel Obstruction. The resident ' s admission orders dated 12/05/12 included Colace (a stool softener) twice a day and Miralax (a laxative) once a day.	F 309	Highland Acres 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. Highland Acres response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Highland Acres reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and /or any other administrative or legal proceeding.	2/18/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	2/20/13

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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	345316	A. BUILDING ______ B. WING ______	02/08/2013

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F 309	Continued From page 1 The Admission Minimum Data Set (MDS) Assessment dated 12/12/12 showed that the resident was severely cognitively impaired, was totally dependent on staff for toileting and was incontinent of bowel and bladder. The physician ' s standing orders for Resident #29 included an order for Milk of Magnesia (a laxative) 30 milliliters if no bowel movement in 3 days and to give Dulcolax (a laxative) 10 milligram suppository if no response from the Milk of Magnesia in 24 hours. The physician ' s order was to give a soap suds enema if no response obtained from the Dulcolax Suppository 2 hours after administration. a. A review of the resident ' s Bowel Movement Record for December 2012 showed daily documentation at least once per shift for 3 shifts of the resident ' s status regarding bowel movements. The record showed that the resident did not have a bowel movement on 12/05/12, 12/6/12, 12/7/12, 12/8/12 or 12/9/12. According to the Medication Administration Record (MAR) the resident received the Colace and Miralax as ordered but did not receive additional medications according to the physician ' s standing orders. There was no documentation in the nursing progress notes that the physician ' s standing orders were initiated The Director of Nursing (DON) stated in an interview on 02/07/13 at 11:58 AM that the ward secretary prints off a bowel sheet daily and notes if a resident has not had a bowel movement in 3 days and gives the sheet to the nurse on second shift and that nurse initiates the bowel protocol.	F 309	On 2/7/13 Resident #29 was assessed by the Director of Nursing for any signs or symptoms related to abdomen distention, bowel sounds and no bowel movements in three days or greater. Resident #29 bowel regimen was reviewed by MD and new orders obtained for Resident # 29 for new bowel regimen. A 100% audit was conducted on 2/7/13 by the Director of Nursing using the census sheet in regards to any residents that had not had a BM in three days or greater. For all residents that had not had a bowel movement in three days or greater they were assessed by the Director of Nursing and given medications per standing orders or physician order. In services training for all licensed nurseswas conducted on 2/7/13 by the Staff Facilitator focusing on: • Process of generating a BM List • Following physician orders • Checking BM sheets daily • Documentation on BM sheets daily • If no BM in three days, initiating BM protocol per standing order or follow physician order. • Completion and documentation of bowel assessments, i.e. Bowel sounds, firmness of abdomen, tenderness, loose stools, or emesis.	

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F 309	Continued From page 2 The DON stated that she keeps a copy of the bowel sheets but could not find one for Resident #29 for the month of December 2012. The DON stated that the bowel protocol should have been initiated on 12/08/12 when the resident had not had a bowel movement for 3 days. The DON was observed to review the MAR and stated that the bowel protocol had not been initiated. Nurse #1 stated in an interview on 02/07/13 at 4:23 PM that on week days the ward secretary gives the nurses a bowel sheet around 3:00 PM and if a resident has not had a bowel movement in 3 days the nurse initiates the bowel protocol. The Nurse stated that on the weekend the nurses have to check the sheets themselves to see if the bowel protocol needed to be initiated. Nurse #2 stated in an interview on 02/08/13 at 8:27 AM that the nurses get a bowel list every day during the week around 3:00 PM and if the resident is on the list the nurse initiates the bowel protocol. The Nurse stated that the nurses started working 12 hour shifts in December 2012 and did not recall if she received a bowel list for the resident during that time. b. The resident ' s Bowel Movement Record for December 2012 showed that the resident did not have a bowel movement on 12/22/12, 12/23/12, 12/24/12 or 12/25/12. According to the Medication Administration Record the resident received the Colace and Miralax as ordered but did not receive additional medications according to the physician ' s standing orders. There was no documentation in the nursing progress notes that the physician ' s standing orders were initiated.	F 309	The Staff Facilitator, MDS Nurses, QI Nurse and Treatment Nurse will monitor and assess resident bowel patterns daily utilizing the BM record to include Resident #29. The Staff Facilitator, MDS Nurses, QI Nurse and Treatment Nurse will monitor the documentation of BM medication, effectiveness of BM medications, and documentation of bowel assessments utilizing the QI tool to include Resident #29 for monitoring bowel movement three times per week for four weeks, then weekly for four weeks, and monthly for two months. All newly hired licensed nurses will be trained on monitoring bowel function during orientation by the Staff Facilitator to include the process focusing on the following: • Process of generating a BM List • Following physician orders • Checking BM sheets daily • Documentation on BM sheets daily • If no BM in three days, initiating BM protocol per standing order or follow physician order. • Completion and documentation of bowel assessments, i.e. Bowel sounds, firmness of abdomen, tenderness, loose stools, or emesis.	

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F 309	Continued From page 3 The Director of Nursing (DON) stated in an interview on 02/07/13 at 11:58 AM that the ward secretary prints off a bowel sheet daily and notes if a resident has not had a bowel movement in 3 days and gives the sheet to the nurse on second shift and that nurse initiates the bowel protocol. The DON stated that she keeps a copy of the bowel sheets but could not find one for Resident #29 for the month of December 2012. The DON stated that the bowel protocol should have been initiated on 12/25/12 when the resident had not had a bowel movement for 3 days. The DON was observed to review the MAR and stated that the bowel protocol had not been initiated. Nurse #1 stated in an interview on 02/07/13 at 4:23 PM that on week days the ward secretary gives the nurses a bowel sheet around 3:00 PM and if a resident has not had a bowel movement for 3 days the nurse initiates the bowel protocol. The Nurse stated that on the weekend the nurses have to check the sheets themselves to see if the bowel protocol needed to be initiated. The Nurse stated that she could not remember if she got a bowel sheet or if she initiated the bowel protocol for the resident when she worked on December 24th and 25th of 2012. Nurse #2 stated in an interview on 02/08/13 at 8:27 AM that the nurses get a bowel list every day during the week around 3:00 PM and if the resident is on the list the nurse initiates the bowel protocol. The Nurse stated that the nurses started working 12 hour shifts in December 2012 and did not recall if she received a bowel list for the resident during that time.	F 309	Staff nurses will monitor and assess resident bowel patterns daily utilizing the BM Record to include Resident #29. All residents noted not to have had a bowel movement within three days will be given medication per standing orders or physician order The findings of the QI monitoring tools will be forwarded to the QI committee by the Director of Nursing for review monthly for the identification of trends, development of action plans as indicated, and to determine frequency of continued QI monitoring. The monitoring tool will be integrated on the facility QI program. The monitoring tool will be reviewed for effectiveness and revised as necessary.	

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	345315	A. BUILDING 01 - MAIN BUILDING 01 MAR 22 2013 B. WING	03/06/2013

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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 facility is Type V protected construction utilizing North Carolina Special locking arrangements, and is equipped with an automatic sprinkler system.	K 000	Highland Acres 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. Highland Acres response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Highland Acres reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and /or any other administrative or legal proceeding.	
K 012 SS=D	CFR#: 42 CFR 483.70 (a). 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: Based on the observations and staff interviews on 3/6/2013 the following Life Safety item was observed as noncompliant, specific findings include: There was unsealed penetrations in the rated ceiling of the sprinkler riser room where the riser enters the ceiling in the room.	K 012	K 012 The ceiling in the sprinkler riser room has been repaired ensuring that there are no unsealed penetrations in the ceiling. The facility has been inspected by the Maintenance Staff ensuring that there are no other locations in the facility that have unsealed penetrations in the ceiling. An audit tool has been implemented to ensure that the facility ceiling remains free of any unsealed penetrations in the ceiling. The audit tool will be conducted daily x7, weekly x3, monthly x 2 then quarterly thereafter by the Maintenance Staff or a representative appointed by the Administrator. 10 locations in each area as identified on the audit tool will be inspected during each audit.	3/19/2013
K 029 SS=E	CFR#: 42 CFR 483.70 (a) 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	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	3/19/13

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K 029	Continued From page 1 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: Based on the observations and staff interviews on 3/6/2013 the following Life Safety item was observed as noncompliant, specific findings include: There was unsealed penetrations in the rated ceiling of the main Electrical / Boiler room around the sprinkler head in front of the main switch gear. CFR#: 42 CFR 483.70 (a)	K 029	K029 The ceiling in the main electrical / boiler room has been repaired ensuring that there are no unsealed penetrations in the ceiling. The facility has been inspected by the Maintenance Staff ensuring that there are no other locations in the facility that have unsealed penetrations in the ceiling. An audit tool has been implemented to ensure that the facility ceiling remains free of any unsealed penetrations in the ceiling. The audit tool will be conducted daily x7, weekly x3, monthly x 2 then quarterly thereafter by the Maintenance Staff or a representative appointed by the Administrator. 10 locations in each area as identified on the audit tool will be inspected during each audit.	3/19/2013
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on the observations and staff interviews on 3/6/2013 the following Life Safety item was observed as noncompliant, specific findings include: The sprinkler head in the 500 hallway storage room has paint over spray on the heat element. CFR#: 42 CFR 483.70 (a)	K 062	K062 The sprinkler head located in the 500 hall storage room that was identified with overspray located on the heating element has been replaced with a new sprinkler head. The facility has been inspected by the Maintenance Staff ensuring that there are no other sprinkler heads in the facility that have any type of overspray located on or around the heating element of the sprinkler head. An audit tool has been implemented to ensure that the sprinkler heads in the facility remain free of any type of overspray on or around the heating element. The audit tool will be conducted daily x7, weekly x3, monthly x 2 then quarterly thereafter by the Maintenance Staff or a representative appointed by the Administrator. 10 sprinkler heads in each area as identified on the audit tool will be inspected during each audit.	3/19/2013