FEB 2 1 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 CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SUI COMPLET	
	:	345315	B. WING	<del>, ,</del>	02/0	8/2013
	ROVIDER OR SUPPLIER  D ACRES NURSING AND	REHABILITATION CENTER	1	REET ADDRESS, CITY, STATE, ZIP CODE 170 LINKHAW ROAD .UMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD 8E	(X6) COMPLETION DATE
F 309 SS=D	provide the necessary or maintain the higher mental, and psychoso	NG eceive and the facility must y care and services to attain st practicable physical,	F 309	Highland Acres acknowledges r the Statement of Deficiencies ar proposes this Plan of Correction extent that the summary of findi factually correct and in order to compliance with applicable rule provisions of quality of care of r The Plan of Correction is submit written allegation of compliance	nd to the ngs is maintain s and residents.	2/18/2013
** /4.	by: Based on record revifacility failed to follow initiate a bowel protoc occasions when the removement for 3 days (Resident #29) whose were reviewed. The fith the hospital Discharge showed that the reside Severe Clostridium Ditleus versus Partial Singuished Severe Summary in partial small bowel ob her laxatives and stockness and stockn	bowel movement records ndings Included:  se Summary dated 12/05/12 ent had a diagnosis of lifficite Colitis followed by mall Bowel Obstruction. The read: "For her ileus and struction, we will continue of softeners."  mitted to the facility on gnoses that included and Severe Clostridium litis followed by Ileus versus obstruction.		Highland Acres response to this Statement of Deficiencies does a agreement with the Statement of Deficiencies nor does it constitut admission that any deficiency is Further, Highland Acres reserved to refute any of the deficiencies of Statement of Deficiencies throug Informal Dispute Resolution, for appeal procedure and /or any oth administrative or legal proceeding	te an accurate, s the right on this th	
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	<del> </del>	I 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 & MEDICARD SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SU COMPLET	
		345316	B. WING	3		02/0	8/2013
	OVIDER OR SUPPLIER  ACRES NURSING AND	REHABILITATION CENTER		1170	T ADDRESS, CITY, STATE, ZIP CODE D LINKHAW ROAD MBERTON, NC 28358		, , , , , , , , , , , , , , , , , , ,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	Т	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	resident was severely totally dependent on sincontinent of bowel a The physician's stand #29 included an order laxative) 30 milliliters it days and to give Dulco milligram suppository of Magnesia in 24 hour was to give a soap sure obtained from the Dulco after administration.  a. A review of the resident administration at least of the resident's statumovements. The recordid not have a bowel in 12/6/12, 12/7/12, 12/8/10 the Medication Administration the Medication Administration at the cordered but did not recaccording to the physical There was no docume progress notes that the orders were initiated.  The Director of Nursing interview on 02/07/13 assecretary prints off a before and gives the she days and gives the she	um Data Set (MDS) //12/12 showed that the cognitively impaired, was taff for toileting and was nd bladder.  ding orders for Resident for Milk of Magnesia (a f no bowel movement in 3 plax (a laxative) 10 if no response from the Milk rs. The physician 's order ds enema if no response colax Suppository 2 hours  dent's Bowel Movement 2012 showed daily t once per shift for 3 shifts its regarding bowel d showed that the resident novement on 12/05/12, //12 or 12/9/12. According to stration Record (MAR) the Colace and Miralax as seive additional medications cian's standing orders. Intation in the nursing e physician's standing	F3	09	On 2/7/13 Resident #29 was assessed by the Director of Nursing for any signs or symptoms related t abdomen distention, bowel no bowel movements in thr days or greater. Resident #2 bowel regimen was reviewed new orders obtained for Resident was conducted for new bowel regimen.  A 100% audit was conducted on 2/7/13 by the Director of Nursing using the census sh in regards to any residents that had not had a BM in three d greater. For all residents that had not had a bowel movem in three days or greater they assessed by the Director of B given medications per stand physician order. In services all licensed nurseswas conductors:  Process of generati Following physicia	sounds and ee 29 ed by MD and sident # 29 ed f eet that lays or et eent were Nursing and ing orders or training for ected on or focusing mg a BM List in orders ts daily BM sheets lays, initiating anding order order. cumentation its, i.e. Bowel f abdomen,	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLET	
		345315	B. WN			02/0	8/2013
HIGHLAN (X4) ID PREFIX	SUMMARY STA (EACH DEFICIENCY	REHABILITATION CENTER  ATEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC DESTRICTION OF THE PROPERTY OF T	ID PREF	1 L IX	LEET ADDRESS, CITY, STATE, ZIP CODE  170 LINKHAW ROAD  UMBERTON, NC 28358  PROVIDER'S PLAN OF CORRECTI  (EACH CORRECTIVE ACTION SHOUL  CROSS REFERENCED TO THE ADDRO	DBE	(X5) COMPLETION DATE
F 309	Continued From page The DON stated that is bowel sheets but coult #29 for the month of I stated that the bowel initiated on 12/08/12 v had a bowel movemer observed to review the bowel protocol had not Nurse #1 stated in an 4:23 PM that on week gives the nurses a bown and if a resident has rein 3 days the nurse in The Nurse stated that have to check the she bowel protocol needed.  Nurse #2 stated in an 8:27 AM that the nurse during the week around resident is on the list to protocol. The Nurse stated in an 8:27 AM that the nurse during the week around resident is on the list to protocol. The Nurse stated in the protocol. The Nurse stated in an 8:27 AM that the nurse during the week around resident is on the list to protocol. The Nurse stated in the call if she receive resident during that tin b. The resident 's Bow December 2012 show have a bowel movement 12/24/12 or 12/25/12. Medication Administrate received the Colace and did not receive addition to the physician's stated course in the resident in the resi	sc IDENTIFYING INFORMATION)  2 2  she keeps a copy of the d not find one for Resident December 2012. The DON protocol should have been when the resident had not not for 3 days. The DON was a MAR and stated that the it been initiated.  interview on 02/07/13 at days the ward secretary well sheet around 3:00 PM not had a bowel movement trates the bowel protocol. On the weekend the nurses ets themselves to see if the 1 to be initiated.  interview on 02/08/13 at the seg at a bowel list every day do 3:00 PM and if the ne nurse initiates the bowel ated that the nurses started in December 2012 and did and a bowel list for the ne.  Interview on 02/08/13 at the nurse initiates the bowel ated that the nurses started in December 2012 and did and a bowel list for the ne.	TAG		The Staff Facilitator, MDS Nurs Nurse and Treatment Nurse will and assess resident bowel patternutilizing the BM record to include Resident #29.  The Staff Facilitator, MDS Nurse QI Nurse and Treatment Nurse will monitor the document of BM medication, effectiveness medications, and documentation of bowel assessments utilizing the tool to include Resident #29 for monitoring bowel movement threat per week for four weeks, then we four weeks, and monthly for two All newly hired licensed nurses trained on monitoring bowel funduring orientation by the Staff Foto include the process focusing of following:  Process of generating a Following physician or Checking BM sheets da Documentation on BM daily If no BM in three days, BM protocol per standing or follow physician order Completion and document of bowel assessments, it sounds, firmness of abd tenderness, loose stools, emesis.	es, QI monitor ns daily de es, tation of BM ne QI ee times eekly for months. will be ction acilitator in the  BM List ders ily sheets initiating ng order er. entation e. Bowel omen,	

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		345315	B. WIN	G	<del></del> -	02/0	8/2013
	ROVIDER OR SUPPLIER  D ACRES NURSING AND	REHABILITATION CENTER		1	EET ADDRESS, CITY, STATE, ZIP CODE 170 LINKHAW ROAD UMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D ĐE	(X5) COMPLETION DATE
	The Director of Nursir interview on 02/07/13 secretary prints off a tif a resident has not hidays and gives the shift and that nurse in The DON stated that showel sheets but coul #29 for the month of E stated that the bowel printiated on 12/25/12 vinad a bowel movemer observed to review the bowel protocol had no Nurse #1 stated in an 4:23 PM that on week gives the nurses a bow and if a resident has no for 3 days the nurse in The Nurse stated that have to check the she bowel protocol needed stated that she could resident when seed that and 25th of 2012.  Nurse #2 stated in an 8:27 AM that the nurse during the week aroun resident is on the list the protocol. The Nurse stated the state of	at 11:58 AM that the ward at 11:58 AM that the ward bowel sheet daily and notes ad a bowel movement in 3 eet to the nurse on second titates the bowel protocol. She keeps a copy of the dinot find one for Resident becember 2012. The DON protocol should have been when the resident had not at for 3 days. The DON was a MAR and stated that the tit been initiated.  Interview on 02/07/13 at days the ward secretary well sheet around 3:00 PM of had a bowel movement itiates the bowel protocol, on the weekend the nurses at themselves to see if the lato be initiated. The Nurse not remember if she got a nitiated the bowel protocol she worked on December  Interview on 02/08/13 at the got a nitiated the bowel protocol she worked on December 2012 and did at a bowel list for the	F	309	Staff nurses will monitor and assert resident bowel patterns daily utilizing the BM Record to include Resident #29. All residents noted have had a bowel movement with days will be given medication per standing orders or physician order.  The findings of the QI monitoritools 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 mon The monitoring tool will be integrated on the facility QI program. The monitoring tool will be reviewer for effectiveness and revised as necessary.	de not to in three r ing itoring.	

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DEPARTMENT OF HEALTH	I AND HUMAN SERVICES
CENTERS FOR MEDICARE	& MEDICAID SERVICES
	(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 03/11/2013 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01 MAR 22 2013**IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION B. WING 03/06/2013\* 345315 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1170 LINKHAW ROAD HIGHLAND ACRES NURSING AND REHABILITATION CENTER LUMBERTON, NC 28358 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Highland Acres acknowledges receipt of the K 000 K 000 INITIAL COMMENTS Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in This Life Safety Code (LSC) survey was order to maintain compliance with applicable conducted as per The Code of Federal Register rules and provisions of quality of care of at 42 CFR 483,70(a); using the 2000 Existing residents. The Plan of Correction is submitted Health Care section of the LSC and its referenced as a written allegation of compliance. publications. This facility is Type V protected construction utilizing North Carolina Special Highland Acres response to this Statement of locking arrangements, and is equipped with an Deficiencies does not denote agreement with automatic sprinkler system. the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Highland Acres reserves the CFR#: 42 CFR 483.70 (a). right to refute any of the deficiencies on this K 012 NFPA 101 LIFE SAFETY CODE STANDARD K 012 Statement of Deficiencies through Informal SS=D Dispute Resolution, formal appeal procedure Building construction type and height meets one and /or any other administrative or legal of the following, 19.1.6.2, 19.1.6.3, 19.1.6.4, proceeding. 19.3.5.1 K 012 3/19/2013 The ceiling in the sprinkler riser room has been repaired ensuring that there are no This STANDARD is not met as evidenced by: unsealed penetrations in the ceiling. Based on the observations and staff interviews The facility has been inspected by the on 3/6/2013 the following Life Safety Item was Maintenance Staff ensuring that there are no observed as noncompliant, specific findings other locations in the facility that have Include: There was unsealed penetrations in the unsealed penetrations in the ceiling. rated ceiling of the sprinkler riser room where the riser enters the ceiling in the room. An audit tool has been implemented to ensure that the facility ceiling remains free of any CFR#: 42 CFR 483.70 (a) unsealed penetrations in the ceiling. K 029 NFPA 101 LIFE SAFETY CODE STANDARD K 029 The audit tool will be conducted daily x7, SS=E One hour fire rated construction (with 1/4 hour weekly x3, monthly x 2 then quarterly fire-rated doors) or an approved automatic fire thereafter by the Maintenance Staff or a extinguishing system in accordance with 8.4.1 representative appointed by the Administrator. and/or 19.3.5.4 protects hazardous areas. When 10 locations in each area as identified on the audit tool will be inspected during each audit. the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and

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

TITLE

STEPPHON

(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.

If continuation sheet Page 1 of 2

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OF IAIT	ING FOR MEDICARE	& MEDICAID SERVICES	<del></del>		<u> </u>
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVE COMPLETED
		345315	B. WING		03/06/201
	PROVIDER OR SUPPLIER  ND ACRES NURSING	AND REHABILITATION CENTE	- 1	STREET ADDRESS, CITY, STATE, ZIP CODE 1170 LINKHAW ROAD LUMBERTON, NC 28358	•
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO	) BE COMPLE
K 029	field-applied protecti	elf-closing and non-rated or ve plates that do not exceed outtom of the door are	K 02	The ceiling in the main electrical / boiler has been repaired ensuring that there are unsealed penetrations in the ceiling.  The facility has been inspected by the Maintenance Staff ensuring that there are other locations in the facility that have unsealed penetrations in the ceiling.	no 3713/28
	Based on the observed on 3/6/2013 the follow observed as noncominclude: There was urated ceiling of the maround the sprinkler is switch gear.  CFR#: 42 CFR 483.7	not met as evidenced by: vations and staff interviews wing Life Safety item was pliant, specific findings unsealed penetrations in the ain Electrical / Boller room nead in front of the main  70 (a) ETY CODE STANDARD	K 062	An audit tool has been implemented to enthat the facility ceiling remains free of an 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 Administr 10 locations in each area as identified on that audit tool will be inspected during each autic K062	y rator.
SS=D	Required automatic s continuously maintain condition and are insp	prinkler systems are ed in reliable operating	i voz	The sprinkler head located in the 500 hall storage room that was identified with overspray located on the heating element I been replaced with a new sprinkler head. The facility has been inspected by the Maintenance Staff ensuring that there are I other sprinkler heads in the facility that ha any type of overspray located on or around heating element of the sprinkler head.	nas
o coli s	Based on the observe in 3/6/2013 the follow bserved as noncomp iclude: The sprinkler	ot met as evidenced by: tilons and staff interviews ing Life Safety item was liant, specific findings head in the 500 hallway t over spray on the heat	The state of the s	An audit tool has been implemented to ensithat the sprinkler heads in the facility remains 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 Administrat 10 sprinkler heads in each area as identified the audit tool will be inspected during each audit.	in the







