STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	04/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTHCARE OF FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(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 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide proper perineal care to 1 of 1 (Resident #3) dependant residents whose care was observed. Findings included: The facility's policy entitled "Nursing: Perineal Care," revised 04/07, under #10 for females read: · "Separate labia then clean downward from the front to back with one stroke · Repeat using a clean part of the washcloth/wipe for each stroke. More than one washcloth/wipe may need to be used. · Rinse with clean washcloth, if applicable. · Pat and dry with towel. · Position patient/resident on side. · Clean rectal area from vagina to the anus with one stroke. · Repeat until area is clean using a clean part of the washcloth/wipe with each stroke. More than one washcloth/wipe may need to be used. · Pat dry with towel." Resident #3 was admitted to the facility on 02/08/13 with diagnoses of congenital hydrocephalus, spastic quadriplegia, neuropathy,	F 312	**ADL Care Provided for Dependent Residents.** **Corrective action for those residents affected.** Staff in now performing proper perineal care on resident #3. **Systemic Changes to Prevent Deficient Practice.** Staff has been in-serviced on proper perineal care procedure. Staff has performed a competency test. See Exhibit A. **How Corrective Action will be Monitored.** The DON or her designee will ensure perineal care is performed according to policy. This will be recorded on an audit tool. This will be observed 3 times weekly for 30 days. Then one time weekly for 30 days. See Exhibit B. **How Corrective action will be monitored.** DON, ADON, or Administrator will sign a weekly document to ensure the audits are completed. This will be in effect for ninety days and the findings will be brought to the monthly PI committee for follow up and review. See Exhibit C.	4-15-13 5-9-13 5-9-13 5-9-13

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

Larry Cobb — Administrator — 5-3-13

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	04/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTHCARE OF FARMVILLE	4361 SOUTH MAIN STREET FARMVILLE, NC 27828

(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 312	Continued From page 1 and pressure ulcer on right ishium. An admission Minimum Data Set (MDS) assessment completed on 02/15/13 identified Resident #3 as having memory problems and severe cognitive impairment. The assessment documented Resident #3 was dependant on staff for all activities of daily living and at risk for pressure ulcer development. Resident #3's care plan, dated 02/15/13 identified being dependant on staff to provide total assistance for activities of daily living. Approaches included to provide incontinent care/apply preventative moisture barrier to buttocks /perianal area. On 04/17/13 at 8:05AM during an observation of morning care, Nurse Aide (NA) #1 opened Resident #3's brief and rolled it down between her legs. NA #1 took the washcloth and placed liquid soap on the washcloth and washed Resident #3's perineal area in a circular motion several times. NA #3 looked at the washcloth and commented it was dirty, rinsed the same washcloth in the basin of water and reapplied more liquid soap and again washed the perineal area using a circular motion. NA #3 did not open the labia to cleanse Resident #3. NA #3 used a towel to dry the perineal area. NA#3, using the same washcloth and basin of water, then proceeded to add more soap to the washcloth and washed Resident #3's legs and feet. NA #1 rolled Resident #3 onto her right side and washed the buttocks area in a circular motion using the same washcloth and basin of water. NA#3 did not use a different section of the washcloth with the circular wipes. NA #3 used the towel to dry the	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	04/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTHCARE OF FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(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 312	Continued From page 2 buttocks area and then placed a clean brief under Resident #3's left side, rolled her to the left side and pulled the brief out and drew it up between her legs and fastened it on either side. NA #3 did not apply any moisture barrier. NA # 1 was not available for interview. In an interview with the Director of Health Services (DHS) and the Assistant Director of Health Services on 04/17/13 at 10:15 AM, they said the expectation was perineal care to be rendered to a female by their facility policy of cleansing the perineal area from front to back using a clean part of the washcloth with each stroke, opening the labia, and discarding the dirty washcloth after and changing the water before cleansing other areas. The DHS said NA #1 had been terminated that morning for an unrelated incident.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interview, the facility failed to follow physician	F 314	**Treatment/SVCS to Prevent/Heal Pressure sores** **Corrective action for residents affected.** Resident #3 had heel protectors applied according to physician orders.	4-15-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	04/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTHCARE OF FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(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 314	Continued From page 3 orders to provide preventative bilateral heel protector boots to 1 of 2 residents (Resident #3) reviewed at risk for pressure ulcer development. Findings include: Resident #3 was admitted to the facility on 02/08/13 with diagnoses of congenital hydrocephalus, spastic quadriplegia, neuropathy, and pressure ulcer on right ishium. An admission Minimum Data Set (MDS) assessment completed on 02/15/13 identified Resident #3 as having memory problems and severe cognitive impairment. The assessment documented Resident #3 was dependant on staff for all activities of daily living and at risk for pressure ulcer development. Resident #3 had 1 stage 4 pressure ulcer present on the right ishium on admission. A physician's verbal order, dated 02/08/13, read [type of bilateral heel protector boots] at all times. Review of a CNA (certified nursing assistant) Care Intervention Record (tool used for nurses aides to direct care) did not reflect the use of bilateral heel protector boots. Review of April 2013 Treatment Administration Record (TAR) read [type of bilateral heel protector boots] ay all times as an FYI (for your information). On 04/17/13 at 8:05 AM during an observation of morning care on Resident #3, when Nurse Aide (NA) #1 uncovered Resident #3 in preparation for her bath, there were no heel protector boots present on her feet. There were no open areas	F 314	**Systemic Changes to Prevent Deficient Practice.** All residents were observed to ensure heel protectors have been applied according to orders. DON and ADON has in-serviced Staff has on procedure for following physician orders for preventative bilateral heel protector boots. See Exhibit D. **How Corrective Action will be Monitored.** The DON or her designee will ensure the bilateral heel protector boots area applied per physician orders. This will be recorded on an audit tool. This will be observed two times a day for 30 days. Then 1 time a day for the next 30 days. See Exhibit E. **How Corrective action will be monitored.** DON, ADON, or Administrator will sign a weekly document to ensure the audits are completed. This will be in effect for ninety days and the findings will be brought to the monthly PI committee for follow up and review. See Exhibit F.	5-9-13 5-9-13 5-9-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING _____ B. WING _____	04/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTHCARE OF FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(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 314	Continued From page 4 observed on Resident #3's heels. After completion of care on Resident #3, NA applied regular socks to Resident #3's feet and covered her with the blankets. During a wound care observation to Resident #3's ishium area, on 04/17/13 at 4:10PM, completed by Nurse #1, Resident #3 was observed to have regular socks in place on both feet. In an interview with Nurse #1 on 04/18/13 at 10:00 AM, she said Resident #3 was to have bilateral heel protectors in place at all times. Nurse #1 said she was the person who should have checked to make sure they were in place. Nurse #1 said Resident #3 should have had the boots in place yesterday when she did wound care but she did not. On 04/18/13 at 10:20 AM, NA #2 raised the covers on Resident #3 and regular socks were observed in place on the resident's feet. In an interview with NA #2 on 04/18/13 at 11:32 AM, she said she usually cared for Resident #3. NA #2 said when Resident #3 was first admitted she had bilateral heel protector boots on but she had not seen them on in awhile. NA#2 said she would look on the Care Intervention Record located on the bulletin board in the resident ' s room for the information and it was not there.	F 314		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNEs AND NFs	PROVIDER # 345384	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: 4/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTHCARE OF FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345384	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 4/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTHCARE OF FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 156	Continued From Page 1

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview the facility failed to provide a resident/responsible party with a Medicare Provider Non-Coverage letter timely, for of 3 residents (Resident #33) whose letters were reviewed. Findings include:

A Medicare Provider Non-coverage letter reviewed on Resident #33 documented the last day of Medicare coverage was 02/21/13. There was a notation written on the letter that Resident #33's responsible party had been notified via telephone by the facility's Financial Counselor on 02/21/13 at 11:33 AM that coverage would end 02/21/13. The letter was signed by Resident #33's responsible party on 02/22/13.

In an interview with the facility's Financial Counselor on 04/17/13 at 11:08 AM, she said there should be at least a three day written notice given prior to the end of Medicare Part A coverage. After review of Resident #33's letter, the Financial Counselor said the resident/responsible party should have been notified prior to the end of the coverage date.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345384	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTHCARE OF FARMVILLE	4351 SOUTH MAIN STREET FARMVILLE, NC 27828

(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 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III (211) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements.	
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: 42 CFR 483.70(a) By observation on 5/7/13 at approximately noon the following fire alarm system was non-compliant, specific findings include, during testing of the facility fire alarm system and documentation indicated the batteries were dated 2/15/08, more than the required 5 year replacement date.	K 052	Corrective action to ensure that the Alarm system is in compliance. The backup batteries were replaced to meet suggested guidelines. Corrective action for those with Potential to be affected. Backup batteries will be inspected each month by Maintenance director to ensure they are still within the acceptable date per suggested manufacturer guidelines. Systemic Changes to Prevent Deficient Practice. Battery check has been added to monthly check list for Director of Maintenance to perform and replace if expired or not functioning. How Corrective Action will be Monitored. Administrator will view monthly to checklist to verify completed.	5-8-13 5-24-13 5-24-13 5-24-13

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

Lam Gee — Administrator — 5/17/13

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.