accepted

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345472	A. BUILDING ______ B. WING ______	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWOOD NURSING AND RETIREME	180 SOUTHWOOD DRIVE BOX 708 CLINTON, NC 28328

(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 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 431	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 431 **Corrective Action for Resident Affected** No residents were identified in the 2567 to be affected. On April 4, 2013 three of the four medication carts were observed to have expired medications and not properly clean. **Corrective Action for Resident Potentially Affected** All residents have the potential to be affected by this practice. On April 17, 2013, cleaning all four medication carts was completed. This was completed by taking all medications out of the cart and disposing of dropped pills and wiping down the cart drawers and all sides. On April 18, 2013 all four carts were fully inspected for expired medications.	April 4, 2013 April 18, 2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 4/22/13

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.

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

PRINTED: 04/12/2013
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
	345472	A. BUILDING ____ B. WING ____	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWOOD NURSING AND RETIREME	180 SOUTHWOOD DRIVE BOX 708 CLINTON, NC 28328

(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 431	Continued From page 1 Based on observation and staff interview, the facility failed to discard expired drugs from, and safely store medications in carts on three (100 hall, 200 hall, and 400 hall) of four carts observed and checked. Findings include: On 4/7/2013 at 1:00 PM the 400 hall medication cart was observed to have one eight ounce canister of Benefiber powder with an expiration date of February 8, 2011. There were two loose tablets lying in the bottom of the drawer. In the top drawer were three Phenadoz suppositories with an expiration date of 3/2013. On 4/7/2013 at 1:20 PM the 200 hall medication cart was observed to have a container of Konsyl fiber laxative dated 3/2013. In the second drawer of the cart there were miscellaneous medications lying in the bottom of the drawer. Nurse #1 commented that they were pills that had been dropped and not picked up and thrown away. On 4/7/2013 at 1:40 PM the 100 hall medication cart was observed to have one sixteen ounce bottle of Iron Supplement Elixir with an expiration date of 3/2013. In the second drawer of the cart there were miscellaneous medications lying in the bottom of the drawer. Nurse #1 said " why didn ' t someone throw those away? " On 4/7/2013 at 2:00 PM, in an interview, Nurse #1 stated that the 11PM to 7 AM shift was responsible for inventory and for cleaning the carts. In an interview on 4/7/2013 at 2:20 PM, the administrator stated that her expectation was that the medication carts would be inventoried and	F 431	**Systemic Changes** A schedule of medication cart cleaning and checking expired medications has been established. This schedule requires one medication cart to be cleaned and inspected for expired medications weekly. On a weekly basis the DON will designate and assign a nurse to cleaning and checking for expired medications. On the following business day the SDC will check to ensure this process was completed according to facility expectations. Due to Southwood having 4 medication carts this will ensure each medication cart is properly inspected for cleanliness and expired medications each month. All nurses were in-serviced of this new procedure starting April 19, 2013. All nurses will have this in-service completed on or before April 24, 2013. Staff members that have not completed training by April 24, 2013 will not be allowed to work until this training is completed. **Quality Assurance** A Quality assurance audit will be completed by the Staff Development Nurse and will be reviewed weekly by use of the "QA Tool: Medications carts clean and inspected for expired medications". These items will be reviewed weekly times three months or until resolved by the QOL/QA committee. Reports of the audit will be given by the Director of Nursing to the weekly Quality of Life – QA committee and corrective action initiated as appropriate. The Quality of Life committee consists of the Director of Nursing, Administrator, Staff Development Coordinator, Dietary Manager, Wound Nurse, Minimal Data Assessments Nurse, Support Nurse and health Information management and meets weekly.	April 24, 2013 on-going July 29, 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345472	A. BUILDING ______ B. WING ______	04/04/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWOOD NURSING AND RETIREME	180 SOUTHWOOD DRIVE BOX 708 CLINTON, NC 28328

(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 431	Continued From page 2 cleaned on a regular basis.	F 431		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345472	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	04/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWOOD NURSING AND RETIREME	180 SOUTHWOOD DRIVE BOX 708 CLINTON, NC 28328

(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 Surveyor: 27871 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 protected construction, one story, with a complete automatic sprinkler system. Facility is using North Carolina State Building Code/special locking system. The deficiencies determined during the survey are as follows:	K 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	**K018** **Corrective Action for Deficient Practice** On 5/20/2013 the identified door in the employee break room was connected by magnet to the fire panel. In the event the fire panel is activated the magnet will disengage and the door will shut. Additionally a smaller trash can was placed in another location of the staff lounge. **Identify other issues having potential to affect residents by the same practice** All facility doors which are required to prevent the passage of smoke are free of impediment to closing the door. **Systemic Changes** The administrator and maintenance director will ensure all doors are free of impediment to closing the door. **Quality Assurance** The administrator and maintenance director will monitor doors during weekly environmental rounds. **K047** **Corrective Action for Deficient Practice** On 4/30/2013 the maintenance director fixed the exit sign identified and turned off the directional light as instructed by the life safety engineer.	5/20/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer P. LaMon	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.

GW

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345472	A. BUILDING 01 - MAIN BUILDING 01 B. WING ____	04/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWOOD NURSING AND RETIREME	180 SOUTHWOOD DRIVE BOX 708 CLINTON, NC 28328

(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 018	Continued From page 1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 11:30 am onward, the following item were noncompliant, specific findings include: door to staff dining room was being held open with trash can, preventing door from closing for smoke tight seal. 42 CFR 483.70(a)	K 018	**Identify other issues having potential to affect residents by the same practice** All other exit signs were inspected to ensure their directional sign is appropriately marked. **Systemic Changes** The administrator and maintenance director will ensure all directional signs are appropriately marked. **Quality Assurance** The administrator and maintenance director will ensure all directional signs are appropriately marked on weekly environmental rounds.	4/30/13
K 047 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 11:30 am onward, the following item were noncompliant, specific findings include: exit directional signs coming out of main lobby have directional arrows pointed in wrong direction to exit building. Also exit directional signs on 200 hall point in wrong direction. 42 CFR 483.70(a)	K 047	<u>K061</u> **Corrective Action for Deficient Practice** On 5/13/2013 a supervisor device was installed on the valve mentioned by the life safety engineer. On 5/14/2013 an electrician connected this valve to our fire alarm system. **Identify other issues having potential to affect residents by the same practice** All other valves were inspected and found to be in compliance. **Systemic Changes** The Maintenance director will ensure the sprinkler system contractor is contacted if a problem arises with the supervisor valves or any additional valves are discovered to need these devices. **Quality Assurance** The Maintenance director will ensure the sprinkler system contractor is contacted if a problem arises with the supervisor valves or any additional valves are discovered to need these devices.	5/14/13
K 061 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1	K 061	<u>K072</u> **Corrective Action for Deficient Practice** On 5/30/2013 all staff were in-serviced on ensuring if items are not being used to store them in the correct location. Additionally, all	

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

PRINTED: 05/02/2013
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
	345472	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	04/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWOOD NURSING AND RETIREME	180 SOUTHWOOD DRIVE BOX 708 CLINTON, NC 28328

(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 061	Continued From page 2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 11:30 am onward, the following item were noncompliant, specific findings include: accelerator valves connected to sprinkler system were not supervised to send signal to Fire Alarm Control Panel at time of survey. 42 CFR 483.70(a)	K 061	staff were in-serviced on the importance of keeping all corridors clear of obstruction in the event of evacuation. **Identify other issues having potential to affect residents by the same practice** All other areas of the facility were monitored for safe storage and pathway of exits. No issues were observed. **Systemic Changes** The maintenance director, staff development nurse and administrator on facility rounds will ensure the hallways are clear of obstruction for exits and items are being properly stored. **Quality Assurance** The maintenance director, staff development nurse and administrator on facility rounds will ensure the hallways are clear of obstruction for exits and items are being properly stored.	5/31/13
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 11:30 am onward, the following item were noncompliant, specific findings include: on all corridors transfer chairs, wheelchairs and hoyer lifts(med. cart with computer plugged into wall outlet for charging) were being stored on corridor reducing the width of corridor to exit discharge.	K 072	K147 **Corrective Action for Deficient Practice** On 5/1/2013the maintenance director went around to the rooms identified and removed the noncompliant multi-plug outlets. **Identify other issues having potential to affect residents by the same practice** All resident rooms were inspected by the respective supervisor for the assigned room to determine if these multi-plug outlets were in use. If these were discovered they were removed and the resident and/or family member notified. **Systemic Changes** This will be monitored by the supervisor assigned to each room on their weekly room rounds. **Quality Assurance** This will be monitored by the supervisor assigned to each room on their weekly room rounds any issues will be communicated to the maintenance director or administrator.	5/31/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345472	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	04/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWOOD NURSING AND RETIREME	180 SOUTHWOOD DRIVE BOX 708 CLINTON, NC 28328

(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 072	Continued From page 3 42 CFR 483.70(a)	K 072		
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: Surveyor: 27871 Based on observations and staff interview at approximately 11:30 am onward, the following item were noncompliant, specific findings include: rooms 103 and 207 were using un-rated multi plug outlet for TV and refrigerator for power. 42 CFR 483.70(a)	K 147		