STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345036	A. BUILDING _____ B. WING _____	C 09/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
W R WINSLOW MEMORIAL HOME	1075 US HIGHWAY 17 SOUTH ELIZABETH CITY, NC 27909

(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 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation of 9/19/13 Event ID # 8U1Z11.	F 000	WR Winslow Memorial Home submits this Plan of Correction (PoC) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this PoC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services (CMS), the State of North Carolina or any other entity; or (2) serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis. If the Provider meets the jurisdictional requirements, the Provider may be filling a request for an appeal before the U.S. Department of Health and Human Services Departmental	
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review the facility failed to continue utilizing new interventions to help prevent further weight loss for 1 of 5 sampled residents (Resident #249) who experienced weight loss. Findings included: Resident #249 was admitted to the facility on 06/18/13. The resident's documented diagnoses included protein calorie malnutrition, anorexia, fracture of the right hip, chronic anemia, and osteoporosis. Review of the resident's electronic medication administration record (MAR) revealed she was admitted on Marinol (appetite stimulant) 2.5 milligrams (mg) twice daily (BID) and a	F 325		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Wilkins | TITLE: Administrator | (X6) DATE: 9-30-13

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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F 325	Continued From page 1 multi-vitamin daily. The resident's weight record documented she weighed 119 pounds on 06/18/13. The resident's 06/25/13 Admission Minimum Data Set (MDS) documented the resident's cognition was moderately impaired, at a height of 61 inches she currently weighed 107 pounds, she had experienced a significant weight loss of 5% or more in the last month, and she was independent in eating with oversight by one staff member. On 06/26/13 the resident's care plan identified "Varied intake with potential for weight loss, dehydration" as a problem. Approaches to this problem included monitoring tolerance of a regular diet, offering appropriate substitutions, dietary/registered dietitian (RD) consults as needed, and discussion of preferences/dislikes with resident. The resident's weight record documented she weighed 105 pounds on 06/27/13. A 07/01/13 RD assessment documented Resident #249's intake of meals averaged 50%, and the resident reported she had little appetite/she was never a big eater/she was not a "picky eater"/her usual weight was 105 pounds/she experienced trouble chewing meats when her partial was not in. The RD recommended the resident's diet be changed to regular with chopped meats, and the resident start receiving a high calorie liquid supplement 60 cubic centimeters (cc) four times daily (QID). These recommendations were carried out via physician orders. In addition, on 07/01/13 dietary	F 325	Appeals Board to challenge the alleged deficiency cited in the HCFA-2567. Initially the Provider may exercise its limited rights to challenge the deficiency under the North Carolina Informal Dispute Resolution (IDR) process. F325 On 09/20/13, the DM started Resident #249 on the punch-like supplement. A chart audit of all residents was conducted comparing physician orders for supplements with the Dietary tray cards and chart documentation to ensure ordered supplements were being provided. The RD will notify Administration and Nurse Management of all Dietary Recommendations. The RD will complete the Dietary Order form with the recommendations and turn them in to the Dietary Manager.	10/16/13

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F 325	Continued From page 2 began providing yogurt on the resident's lunch and supper meal trays. The resident's weight record documented she weighed 104 pounds on 07/02/13, 100 pounds on 07/09/13 and 07/16/13, 97 pounds on 07/23/13, 96 pounds on 07/30/13, 94 pounds on 08/06/13, 90 pounds on 08/13/13, and 87 pounds on 08/20/13. A 08/21/13 physician order instructed the staff to hold the resident's high calorie liquid supplement due to loose stools. A 08/26/13 RD assessment documented Resident #249's meal intake now averaged 30%, and the resident had a 10.3% weight loss in the past month. A 08/26/13 physician order discontinued the QID use of the resident's liquid supplement (which presented with a milky appearance), and replaced it with a can of liquid supplement (which resembled a fruit punch) at each meal (three times daily). The resident's care plan was updated on 08/26/13 to reflect the punch-like supplement as a new intervention for weight loss. Resident #249's electronic August 2013 MAR documented the punch-like supplement was provided three times daily (TID) on 08/27/13 and 08/28/13, and was provided with breakfast on 08/29/13. Resident #249's electronic August 2013 MAR documented at 12:26 PM on 08/29/13 the resident refused her punch-like supplement at the	F 325	MDS will report any new physician orders to Administration and Nurse Management during the facility's daily meeting. The DM will bring the Dietary Forms that have been turned in to the department and tray cards to the facility's daily meeting to compare what has been ordered with the Dietary Forms received to ensure proper notification for supplements has been made to the Dietary Department. Nurse Management will monitor the above procedures and audit the resident's chart at each change in order to ensure it indicates supplements that have been ordered. This monitoring will be conducted for 6 months and then at the direction of the QA Committee. An in-service on these procedures was conducted for the Nurse Management, RD, DM, MDS and Administration employees.	

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F 325	Continued From page 3 lunch meal. The MAR then documented a discontinuation date of 08/29/13. Review of handwritten and electronic physician orders revealed no order to discontinue the use of this punch-like supplement. Review of the resident's MAR and tray slips revealed from 08/30/13 through 09/19/13 the resident only received a multi-vitamin daily, appetite stimulant, and yogurt on meal trays BID to address her continued weight loss. The resident's weight record documented she weighed 84 pounds on 09/03/13 and 83 pounds on 09/10/13. A 09/10/13 physician order placed Resident #249 on comfort measures. The resident's weight record documented she weighed 81 pounds on 09/17/13. The resident's 09/17/13 Significant Change MDS documented her cognition was severely impaired, at a height of 61 inches she currently weighed 81 pounds, she had experienced a significant weight loss of 5% or more in the last month, she was independent in eating with oversight by one staff member, and her diet was mechanically altered. Observation of resident #249 at the lunch meal on 09/18/13 (at 12:54 PM) and at the breakfast meal on 09/19/13 (at 8:38 AM) revealed the resident did not receive the punch-like supplement on her meal trays, and the punch-like supplement was not documented on her tray slips. The only nutritional supplement observed on the resident's meal trays was yogurt on the	F 325	Nurse Management will report findings of this monitoring to the facility's QA Committee at the regularly scheduled QA meeting. The results of these findings will be shared at the regularly scheduled QA Committee meeting which will evaluate and make any further recommendations for monitoring.	

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F 325	Continued From page 4 09/18/13 lunch tray. At 11:15 AM on 09/19/13 the dietary manager (DM) stated the dietary staff would be responsible for placing cans of the punch-like supplement on Resident #249's meal trays if the order for the product was communicated to them. She explained this information was communicated to dietary by completion of a Diet Order form or a Xerox copy of the physician order. The DM reported the nurse taking the physician order was responsible for completing the form or providing the copy of the order. After reviewing Diet Order forms and copies of physician orders, the DM stated dietary never received the required documentation to start Resident #249 on the punch-like supplement. At 11:23 AM on 09/19/13 the director of nursing (DON) stated the comfort measures put in place for Resident #249 only applied to checking with the family before sending the resident out to the hospital. She reported this resident was not "end of life", and should continue to receive her medication, supplements, and treatments. At 12:15 PM on 09/19/13, during a telephone conversation, the facility's RD stated the last time she assessed Resident #249 was on 08/26/13, and to her knowledge the resident was supposed to still be receiving the punch-like supplement TID with meals. She reported she had not obtained feedback from the direct care staff about the resident's intake or toleration of the punch-like supplement. According to the RD, if a supplement put in place to help prevent weight loss was discontinued, she expected the staff to let her know so that she might be able to replace it with an alternative.	F 325		

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

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F 325	Continued From page 5 At 2:23 PM on 09/19/13 the DON stated the RD or nurse could write orders for nutritional supplements. She explained the person writing the order was supposed to complete a Diet Order form if the supplement was to accompany meals, input the order into the computer system, and the supplement would appear on the electronic MAR. According to the DON, new orders, including those written for nutritional supplements, were reviewed in the morning meetings, and care plans were updated to reflect the changes/additions. The DON commented she was not really sure how or why Resident #249's punch-like supplement was discontinued in the electronic MAR. However, she stated her expectation was that if a nutritional supplement was discontinued, the responsible staff was to fax the physician or contact the RD so guidance could be provided on replacing the weight loss intervention.	F 325		

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	345036	A. BUILDING 04 - W.R WINSLOW MEMORIAL HOME INC. B. WING _____	10/31/2013

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K 000	INITIAL COMMENTS A. Based on observation on 10/31/2013 the facilityls type 111 protected , fully sprinkled and has delayed egress locking on the exit doors.	K 000	K 011 Facility maintenance repaired faulty latch on fire doors by Room 403 on 10/31/2013.	11/30/13
K 011 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2 This STANDARD is not met as evidenced by: A. Based on observation on 10/31/2013 the fire doors near room 403 failed to close and latch upon activation of the fire alarm. 42 CFR 483.70 (a)	K 011	All fire doors in facility were inspected 10/31/2013 for proper closing and latching. Facility maintenance staff in serviced on TAG K 011. Facility Maintenance will inspect all fire doors for proper closing and latching on a weekly basis for three months and then monthly thereafter. Administrator and or Assistant Administrator will inspect monthly, all fire doors for proper closing and latching. The Administrator and or Assistant Administrator will also review the weekly and monthly audits performed by the facility maintenance. The results of the monitoring will be reported to the facility's quarterly Quality Assurance (QA) Committee. The QA Committee will determine the need and frequency of further monitoring.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 10/31/2013 the door to the dry storage room in the kitchen failed to close and latch. 42 CFR 483.70 (a)	K 029	K 029 Facility maintenance installed a new door closer mechanism on 11/15/2013, and aligned door properly to ensure proper closing and latching.	11/30/13
K 051	NFPA 101 LIFE SAFETY CODE STANDARD	K 051		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
David Faulkner	Administrator	11/19/2013

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K 051 SS=E	Continued From page 1 A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6 This STANDARD is not met as evidenced by: A. Based on observation on 10/31/2013 only (1/2) one half of the strobes and horns in the facility worked on battery back-up. 42 CFR 483.70 (a)	K 051	K 029 All self-closing doors in the facility were inspected for proper closing and latching on 11/18/2013. Facility Maintenance will inspect all self-closing doors for proper closing and latching on a weekly basis for three months and then monthly thereafter. Administrator and or Assistant Administrator will inspect monthly, all self-closing doors for proper closing and latching. The Administrator and or Assistant Administrator will also review the weekly and monthly audits performed by the facility maintenance. The results of the monitoring will be reported to the facility's quarterly Quality Assurance (QA) Committee. The QA Committee will determine the need and frequency of further monitoring. K 051 On 10/31/2013, all six batteries for the fire alarm system were tested. Four of the six were found needing to be replaced. On 11/1/2013, those four batteries were replaced by facility maintenance. The fire alarm system on battery back-up was tested on 11/4/2013 with new	11/30/13

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		K 051	K 051 batteries to ensure all strobes and horns were functioning properly. The fire alarm system will be tested weekly for two months and monthly thereafter on battery back up to ensure all strobes and horns are functioning properly. The Administrator and or Assistant Administrator will jointly monitor with facility maintenance, on a monthly basis, the fire alarm system on battery back-up to ensure strobes and horns are functionally properly. The results of the monitoring will be reported to the facility's quarterly Quality Assurance (QA) Committee. The QA Committee will determine the need and frequency of further monitoring.	