STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345036	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 8/16/2014

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

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F 159	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS

Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.

The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)

The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.

The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.

The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to notify residents who received Medicaid benefits or their responsible parties (RP) when the residents' accounts were within $200.00 of exceeding the resource limit of $2000.00 for 2 (residents # 90 & # 114) of 3 residents' accounts reviewed. The findings include:
A review of the Patient Fund Account page of the Admission Handbook revealed item 4 which read in part, "Should Medicaid recipient's personal funds reach $200 less than the SSI (Social Security Income) resource limit, the facility will notify them in writing."
1. A record review of the Resident Trust Fund Statement revealed resident #90, who was receiving Medicaid benefits, had a beginning balance on 7/1/14 of $1,834.31 with an ending balance of $1,878.34 on 7/31/14. During an interview with the business office assistant on 8/15/14 at 2:40 PM she stated she did not notify the

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

The above isolated deficiencies pose no actual harm to the residents

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F 159	Continued From Page 1 resident or their assigned RP when the account balance was $1,800.00 or more. She added that when the monthly statements were prepared to be mailed that the account balance would be observed and then she would notify the resident or their RP. She stated, "They have 30 days to get the reserve down." 2. A record review of the Resident Trust Fund Statement revealed resident #114, who was receiving Medicaid benefits, had a beginning balance on 7/1/14 of $1,975.19 with an ending balance of $2,007.72 on 7/31/14. During an interview with the business office assistant on 8/15/14 at 2:40 PM she stated she did not notify the resident or their assigned RP when the account balance was $1,800.00 or more. She added that when the monthly statements were prepared to be mailed that the account balance would be observed and then she would notify the resident or their RP. She stated, "They have 30 days to get the reserve down."
F 160	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to convey the residents' personal funds to the residents' estates within 30 days of the death of the resident for 2 (residents #83 & #265) of 3 residents reviewed for conveyance of personal funds. The findings include: The business office assistant provided copies of the computerized resident fund accounts for review. 1. Resident #83 expired on 6/17/14. Review of the computerized Resident Trust Fund Statement revealed the ending balance and a copy of the check written to the resident's estate for that amount was dated 7/29/14. An interview with the business office assistant on 8/15/14 at 2:45PM revealed that the funds should be dispersed within 30 days. 2. Resident #265 expired on 2/3/14. A review of the Resident Trust Fund Statement revealed the ending balance and a copy of the check written to the resident's estate for that amount was dated 3/14/14. An interview with the business office assistant on 8/15/14 at 2:45PM revealed that the funds should be dispersed within 30 days.
F 247	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and record review, the facility failed to notify a resident in advance of receiving a new roommate for 2 of 2 residents (Residents #41 and #115) reviewed for notification

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of change in roommates.

The findings included:

1. Resident #41 was admitted to the facility on 12/28/11. Her most recent Minimum Data Set, dated 6/23/14, indicated she was cognitively intact.

During an interview on 8/11/14 at 11:21 AM, Resident #41 stated that she did not get advance notification when she got a new roommate. The resident said she usually found out she was getting a roommate when the nursing assistant came in to get the new roommate's bed ready.

During an interview on 8/14/14 at 10:09 AM, the Social Worker indicated that if a resident was being transferred to a different room in the facility, the facility focused on ensuring the move was agreeable for the resident being moved. The Social Worker said the resident already living in the room was notified shortly before the move.

An interview was conducted with the Director of Nursing (DON) on 8/14/14 at 10:37 AM. The DON indicated she and the Assistant Director of Nursing (ADON) generally did the room assignments, discussing who might be a good match based on room temperature preferences and cognition as examples. The DON explained whoever went in to set up the room for the incoming resident - it could be a nursing assistant, the nurse or me - would tell the resident who was already living in the room that they were getting a roommate. The DON said she would like the 2 residents to try the new living arrangement for a while before entertaining any complaints from the established resident.

2. Resident #118 was last readmitted to the facility on 2/24/12. His most recent Minimum Data Set, dated 6/11/14, indicated he was moderately cognitively impaired.

During an interview on 8/12/14 at 11:21 AM, Resident #118 indicated he was given no notice prior to a change in roommates.

During an interview on 8/14/14 at 10:09 AM, the Social Worker indicated that if a resident was being transferred to a different room in the facility, the facility focused on ensuring the move was agreeable for the resident being moved. The Social Worker said the resident already living in the room was notified shortly before the move.

An interview was conducted with the Director of Nursing (DON) on 8/14/14 at 10:37 AM. The DON indicated she and the Assistant Director of Nursing (ADON) generally did the room assignments, discussing who might be a good match based on room temperature preferences and cognition as examples. The DON explained whoever went in to set up the room for the incoming resident - it could be a nursing assistant, the nurse or me - would tell the resident who was already living in the room that they were getting a roommate. The DON said she would like the 2 residents to try the new living arrangement for a while before entertaining

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any complaints from the established resident.

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483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interview, the facility failed to develop a comprehensive care plan for pressure ulcer treatment and prevention for 1 of 4 residents (Resident #168) reviewed for pressure ulcers.

The findings included:

1. Resident #168 was admitted to the facility on 5/2/14. Diagnoses included end stage renal disease, anemia, congestive heart failure and abnormal glucose. The resident received hemodialysis.

The hospital discharge summary dated 5/2/14 indicated Resident #168 had moderate protein calorie malnutrition, atrophy of quadriceps (large muscles of the upper leg) and ambulatory dysfunction due to deconditioning.

Wound Assessment Reports dated 5/2/14 revealed Resident #168 had a stage 2 pressure ulcer on the sacrum and another on the left buttocks.

An admission interim care plan dated 5/2/14 included a problem with skin integrity related to open areas on sacrum and left buttock.

The admission Minimum Data Set (MDS), dated 5/9/14, indicated Resident #168 had moderate cognitive impairment, no resistance to care, required extensive assistance of 2 people for bed mobility, was not ambulatory and had two stage 2 pressure ulcers. The Care Area Assessment (CAA) for pressure ulcers referred the reader to the CAA for Urinary Incontinence and Indwelling Catheter. The Analysis of Findings in

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the CAA included: "Urinary Incontinence/Pressure Ulcers: (name of Resident #168) presents with frequent incontinence and requires staff assist with toileting and pericare after incontinence. She is receiving physical/occupational therapies in hopes of improving her mobility and self care. She is at risk for increased incontinence due to her impaired mobility and weakness. She is also at risk for skin breakdown due to the above mentioned. Staff will monitor her skin for any changes and report them to the MD (physician), RD (dietician), RP (responsible party) and treatment nurse. Treatments will be provided as needed/ordered. Licensed nurse will perform a skin check weekly as scheduled." The Care Plan Considerations section of the CAA included, "Will proceed to care plan."

The care plan (undated) revealed no indication that Resident #168 had pressure ulcers. The care plan (undated) included under "Problem Onset": "Turning and repositioning program to assist with prevention of skin breakdown and for comfort". The goal read, "Resident will not have any skin breakdown during this assessment period." Approaches included, "Monitor for any skin breakdown and notify the charge nurse, Nurse to evaluate program quarterly and/or PRN (as needed), Provide encouragement/assist as needed, Turn and reposition Q (every) 2 hours and/or PRN both in the bed and the chair daily".

Weekly Wound Assessment Reports dated 5/21/14 revealed Resident #168 was found to have suspected deep tissue injury to both heels. (Per the National Pressure Ulcer Advisory Panel, a suspected deep tissue injury is a "purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear.") The Report indicated the physician and responsible party were notified; an air mattress was placed and the resident was to wear protective boots (padded ankle high fabric boots to minimize pressure on heels and ankles) while in bed. The care plan was not updated to include the suspected deep tissue injury to the heels.

Weekly Wound Assessment Reports dated 5/28/14 revealed signs of deep tissue injury (DTI) to the right heel had resolved, but the left heel DTI remained. Additional intervention included "heels to be floated." Neither the care plan nor the care guide was updated.

During an interview on 8/15/14 at 11:05 AM, MDS Nurse #1 indicated residents admitted with pressure ulcers should be care planned for actual pressure ulcers. MDS Nurse #1 indicated the treatment nurse notified the MDS nurses when a new pressure ulcer developed and they also received copies of all new physician orders so care plans and care guides can be updated immediately. MDS Nurse #1 stated she did not know why Resident #168's comprehensive care plan did not include pressure ulcers or deep tissue injury.

During an interview on 8/16/14 at 12:38 PM, the Director of Nursing (DON) indicated pressure ulcers should have been care planned for Resident #168. The DON stated Resident #168 was at high risk for pressure ulcers due to existing pressure ulcers, incontinence, dependence on staff for bed mobility and on dialysis. The DON said she depended on the MDS nurses to write and update comprehensive care plans.