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 _____	C 04/09/2015

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 000	INITIAL COMMENTS No deficiencies were cited from the complaint investigation survey of 4/9/2015. Event ID# XGNU11. Intake NC00102096.	F 000		
F 156 SS=C	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,	F 156		4/28/15

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

Electronically Signed | 04/28/2015

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 156	Continued From page 1 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	F 156		

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F 156	Continued From page 2 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. This REQUIREMENT is not met as evidenced by: The facility failed to post the correct contact information for the state agency for 98 of 98 residents residing in the facility. Findings included: On 4/7/15 at 9:00 AM, observation of posted state contact information revealed the state agency posted as the Division of Facility Services (DFS) instead of the Division of Health Service Regulation (DHSR) and the contact number was incorrect. On 4/9/15 at 1:13 PM, the number posted was called and the number was not for the Nursing Home Section of the DHSR. On 4/9/15 at 1:20 PM, the facility administrator stated that she was responsible for the posting of contact information for advocacy groups including the state agency and that the postings were reviewed and updated as she received updated information from the regional long-term care ombudsman. She reported that she did not verify accuracy of information from the ombudsman's office and felt that if she got the information from the ombudsman, it would be accurate and reliable. The administrator stated that it was ultimately the facility's responsibility to ensure	F 156	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 dates indicated. F 156 SS= C Corrective Action for Resident Affected No specific resident is identified. See corrective actions described below. Corrective Action for Resident Potentially Affected All residents residing in the facility have potential to be affected by this alleged deficient practice. State Ombudsman contact information was updated and posted on 4/10/15. Social Worker	

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F 156	Continued From page 3 accuracy of the information posted.	F 156	in-serviced on updating State Agency contact information on 4/10/15. Systemic Changes Social Worker in-serviced on 4/10/15 on verifying correct information with Ombudsman. Administrator or Social Worker will verify contact information no less than annually by contacting Ombudsman for updates and calling posted numbers to verify they reach correct agencies. Quality Assurance Administrator or Social Worker will verify contact information no less than annually by contacting Ombudsman for updates and calling posted numbers to verify they reach correct agencies. If contact information is found to be incorrect, it will be updated immediately.	
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews, the facility failed to ensure trash was contained in the outside trash compactor. Findings included: On 4/9/2015 at 11:36 AM, an observation was made of the trash compactor outside the facility, and it was noted that there were soiled gloves	F 372	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	4/28/15

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F 372	Continued From page 4 laying on the ground. There were 9 gloves in the immediate area of the compactor and other gloves and trash laying on the ground. There was also a dead mouse on the ground two feet from the sidewalk that is beside the trash compactor. On 4/9/2015 at 11:50 AM, two dietary aides were interviewed, and both stated they tied up the trash before they took it out. On 4/9/2015 at 11:55 AM, the cook was interviewed and stated that she took her trash out herself, tied up the bag, and put a lid on it. On 4/9/2015 at 12 noon in an interview, the Director of Housekeeping stated that his staff was supposed to wear gloves, tie up the trash bag, which is in the rolling container and wheel it to the large trash compactor. The bag was to be put into the compactor along with the gloves. On 4/9/2015 at 12 noon, in an interview, the Administrator stated the expectation was staff would make sure all trash would be placed in the compactor and not left on the ground.	F 372	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 dates indicated. F 372 SS= C Corrective Action for Resident Affected No specific resident is identified. See corrective actions described below. Corrective Action for Resident Potentially Affected All residents residing in the facility have potential to be affected by this alleged deficient practice. All gloves and trash were removed on 4/9/15 by Environmental Services Director. A sign was placed on dumpster by Environmental Services Director on 4/9/15 reminding all staff to ensure that all gloves and trash are placed inside dumpster. Systemic Changes All Dietary employees were in-serviced by Dietary Manager and Housekeeping employees were in-serviced by and Environmental Services Director, on proper garbage disposal on 4/24/15. Environmental Services Director to monitor dumpster area daily as part of daily rounds and correct improper handling when observed. Quality Assurance Daily monitoring will be completed daily by Environmental Services Director or	

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F 372	Continued From page 5	F 372	designee for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life-QA committee and corrective action initiated as appropriate. The QOL/QA committee is the main quality assurance committee. This regularly scheduled weekly meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, and Dietary Manager. The Medical Director will review during the Quarterly QA Meeting.	