PRINTED: 02/13/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
×	A	345159	B. WIN			00/06	
	OVIDER OR SUPPLIER			14	EET ADDRESS, CITY, STATE, ZIP CODE 410 EAST GASTON ST INCOLNTON, NC 28092	02/02	2/2012
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 157 SS=J	consult with the resid known, notify the resid or an interested famil accident involving the injury and has the pointervention; a signific physical, mental, or p deterioration in health status in either life the clinical complications significantly (i.e., a nexisting form of treatment); or a decist the resident from the §483.12(a). The facility must also and, if known, the resor interested family mentange in room or rospecified in §483.15 resident rights under regulations as specifithis section. The facility must receive address and photological representative of the section. This REQUIREMENT by: Based on observation physician interviews	iately inform the resident; ent's physician; and if dent's legal representative y member when there is an eresident which results in tential for requiring physician cant change in the resident's sychosocial status (i.e., an, mental, or psychosocial reatening conditions or i); a need to alter treatment due to adverse commence a new form of sion to transfer or discharge facility as specified in promptly notify the resident sident's legal representative member when there is a commate assignment as (e)(2); or a change in Federal or State law or ited in paragraph (b)(1) of incompare the resident's per interested family member. It is not met as evidenced ons, staff interviews, and record reviews facility		157	This Plan of Correction is the center's creallegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreeme provider of the truth of the facts alleged of set forth in the statement of deficiencies. correction is prepared and/or executed so it is required by the provisions of federal. Resident #1 no longer resides in the Licensed Nurses #2, #3 and #4 white identified as primary care provide assessment interventions and notified clinical changes with resident individually in-serviced/re-educated Staff Development Coordinator (Staff Development Coordinator (Staff Development Refusal of Failure to Follow MD orders. The Staff Development Coordinator (Staff Develo	of correction in by the in conclusions. The plan of obely because and state law. The facility. The facility in the facility in the facility. The facility is the facility in the facility. The facility is the facility in th	2/23/12
LABORATORY	aller M	SUPPLIER REPRESENTATIVE'S SIGNATURE	•	E	Executive Director	J	(X6) DATE

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QEUX11

RECEIVED
Facility ID: 923312

If continuation sheet Page 1 of 43

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	OF DEFICIENCIES CORRECTION	(X1) TROVIDE TOOLY		(X3) DATE SURV COMPLETED			
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	OVIDER OR SUPPLIER NURSING CENTER INC			14	EET ADDRESS, CITY, STATE, ZIP CODE 110 EAST GASTON ST INCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	059932	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 157	combative behaviors insulin at bedtime, constick blood sugars are pressures daily for the fourteen (14) sample. Immediate Jeopardy Resident #1 continue behaviors and refuse subcutaneously at boout of compliance at of D (an isolated def potential for more the immediate jeopardy) systems are put in put The findings are: Resident #1 was ad diagnoses including dementia, hypertensided weakness. The most recent qua (MDS) dated 12/20/short and long term	ne physician of continued , resident refusal of Lantus ontinued refusals of finger nd failed to document blood aree days for one (1) of red residents. (Resident #1). began on 1/19/12 when red to exhibit combative red Lantus Insulin 25 units redtime. The facility remains a lower scope and severity riciency, no actual harm with ran minimal harm that is not red to ensure monitoring of red lace. mitted on 6/28/11 with runcontrolled type II diabetes, resion, and a stroke with left (L) marterly Minimum Data Set red minimal in memory and no impairment in memory and no impairment	F	157	This Plan of Correction is the center's creallegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreeme provider of the truth of the facts alleged set forth in the statement of deficiencies correction is prepared and/or executed set it is required by the provisions of federal. Data results will be reviewed and at the facility monthly Performant Improvement (PI) Committee Me months with a subsequent plan of as needed. The Director of Nurses responsible for overall compliance.	of correction on the by the or conclusions. The plan of olely because and state law. analyzed ceeting for 3 correction is is	2/23/12
4	also indicated Resid symptoms directed extensive assistanc dressing and hygier only with eating, wa	decision making. The MDS dent #1 had no behavioral toward others, required e by staff for transfers, ne, required set up assistance is incontinent of bowel and per and lower extremity side.		n#			
		an orders dated 6/28/11 or Lantus insulin 14 units					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345159	B. WING		C 02/02/2012		
	OVIDER OR SUPPLIER NURSING CENTER INC			14	EET ADDRESS, CITY, STATE, ZIP CODE 410 EAST GASTON ST INCOLNTON, NC 28092	02/02	12012
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F 157	subcutaneously daily Amaryl 2 milligrams of diabetes mellitus. A review of physician revealed an order to units subcutaneously A review of physician revealed an order to 17 units to 20 units su and increase Finger shreakfast each morni evening. A review of laborator indicated a hemoglot overall view of how the controlled or out of codiabetes) was 11.9 pless than 7 percent). A review of physician revealed an order to units daily at bedtime. A review of a physician revealed an order to units daily at bedtime. A review of a physician revealed an order to units daily at bedtime. A review of a physician revealed an order to units daily at bedtime. A review of a physician revealed an order to units daily at bedtime. A review of a physician revealed an order to units daily at bedtime. A review of a physician revealed an order to units daily at bedtime. A review of a physician revealed an order to units daily at bedtime. A review of a physician revealed Resconfusion. "Patient here ordered last three patient with multiple in the patient with	at bedtime for diabetes; brally before breakfast for orders dated 9/06/11 increase Lantus insulin to 17 daily at bedtime. Forders dated 11/8/11 increase Lantus insulin from ubcutaneously at bedtime stick Blood Sugars to before ing and before supper each or an	F	157			

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F 157	6:30 PM revealed an pressure daily; finger fasting each morning x 2. Chest x-ray positives due to increase A review of the Medi Record (MAR) dated #1 refused finger stick A review of the MAR Resident #1 refused 6:00 AM. A review of a physicity 1/19/12 revealed "parefusing meds." Blo nursing staff. "Demei strokes." A review of nurse's in PM stated Resident #1	orders dated 1/17/12 at order to check blood stick blood sugars daily - ; CBC; CMP; Blood Cultures teroanterior (PA) and lateral ed confusion.	F	157			
	stated Resident #1 re subcutaneously. The	dated 1/19/12 at 9:00 PM efused Lantus 25 units ere was no documentation in physician was called.				2	
	Resident #1 refused attempted to feed restated the resident w	ote dated 1/20/12 stated meal and a nursing assistant sident. The notes further as spitting out food, refused ger stick blood sugar and all					

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	OVIDER OR SUPPLIER	140100		14	EET ADDRESS, CITY, STATE, ZIP CODE 410 EAST GASTON ST INCOLNTON, NC 28092	1 0210	2/2012	
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F 157	stated Resident #1 resubcutaneously. A review of the MAR Resident #1 refused 6:00 AM. A review of nurse's new pm and signed by Liver was performed this a vital signs were docutemperature 101.0, perspiration's 20. Oxywas 95% on room ai was noted, resident and warm to the touch the resident had not shift and the nurse we take oral medications consciousness. A review of laborator 2:41 PM revealed ab follows: Glucose 822 70 -110 BUN 71 (critical valuations Creatinine 3.60 (critical valuations 1.20) White Blood Cell 23.10.8 Total Protein 8.6 (high SGOT 53 (high) nor Calcium 10.6 (high) Carbon Dioxide 17 (dated 1/20/12 at 9:00 PM afused Lantus 25 units dated 1/21/12 revealed finger stick blood sugars at otes dated 1/21/12 at 3:30 N # 5 stated a venipuncture fiternoon on Resident #1 and imented as follows: oulse 154, BP 138/87, gen saturation percentage r, bilateral lung congestion was very difficult to arouse ch. The notes further stated eaten or taken any fluids this ras unable to get resident to so due to decreased level of by reports dated 1/21/12 at conormal laboratory values as a conormal range 7 - 18 cal value) normal range 0.50 7 (high) normal range 4.8 - gh) normal range 8.5 - 10.1 low) normal range 21 - 32 positive with streptococcus	F	157				

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	OVIDER OR SUPPLIER NURSING CENTER INC	¥		1	REET ADDRESS, CITY, STATE, ZIP CODE 410 EAST GASTON ST INCOLNTON, NC 28092	-	
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F 157	time revealed Reside emergency medical states altered mental status infection and diabetic complication of diabetody produces very his sepsis and underlying white blood cell coun rapid heart rate with renal failure and a lar stroke. During an interview of stated she was told of shift nurse on 1/21/12 or take her medicated days. She stated she room immediately aft room later in the mor respond, moved her wouldn't talk to her. call the physician bed blood drawn first. She blood on the resident the laboratory and the critical values. She physician's answerin #1 to the hospital on 3:00 PM. During an interview of LN #3 she stated she evening 1/20/12 that	r form dated 1/21/12 with no ant #1 was transferred by services to the hospital. I history and physical dated sident #1 was admitted with with possibilities including set tes that occurs when the high levels of blood acids); g infection with elevated ts and urinary tract infection; fever and dehydration; acute rge new acute left sided on 1/30/12 at 1:15 PM LN #1 during report from a night 2 Resident #1 did not drink ons for the last couple of e did not go to Resident #1's ter report but went to her ming and the resident did not right (R) arm slightly and She explained she did not cause she wanted to get the ne further stated she drew that around noon and sent it to be laboratory called back with explained she called the g service and sent Resident 1/21/12 at approximately on 1/30/12 at 3:10 PM with the was concerned on Friday Resident #1 was still her medications. She	F	157			

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F 157	Resident #1 refused and stated she report nurse to keep an eye something did not see During an interview of physician stated Reshypertension, diabeted stated he was not awainsulin doses on 1/19 unaware of the reside behaviors and confus should have told him doses, continued refusugars and continued combativeness. He stated insulin do refusals of finger stick have ordered for their sugar or he would have hospital. During an interview of LN #4 she stated she during the night shift was very noncompliate physically and verbal tried to draw blood wand she tried to do a the resident wouldn't not call the physician to the day shift on Sawas unable to draw thad refused her medians.	call the physician after ther Lantus insulin at bedtime and off to the night shift on the resident because are right. In 1/31/12 at 8:35 AM the ident #1 had very volatile as and recent strokes. He had a trace of the missed Lantus insulinguistic continued combative sion. He further stated staff about missed Lantus insulinguistic of finger stick blood disconfusion and a stated if he had known about asses and the continued in to do a finger stick blood are sent the resident to the sent 1/31/12 at 8:49 AM with the was Resident #1's nurse on 1/20/12 and the resident and, combative and was ally abusive. She stated she fork but she couldn't get it finger stick blood sugar but let her. She verified she did a during her shift but reported a furday morning 1/21/12 she he blood and the resident ications and finger sticks.	F	157			

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F 157	she did not receive a nurses that morning approximately 11:00 nurse with drawing b resident "was not ale her room. She state resident's vital signs she was focused on She further stated Rowhen they drew her took the blood to the critical values to the the resident was sen During an interview of Director of Nurses (Inursing staff to notify resident refused insuphysician when a recombative behaviors should document information of the physician state would have been verified his answering any calls from the faresident while he was The Administrator wo Jeopardy on 1/31/12. The facility provided compliance which in	e day on 1/21/12. She stated report from the night shift and she saw Resident #1 at AM on 1/21/12 to assist a lood. She stated the end at all" when she went into dishe did not check the or call the physician because getting the blood drawn. esident #1 was very sick blood. She explained she laboratory and they called facility within the hour and at to the hospital. On 1/31/12 at 9:00 AM the DON) stated she expected of the physician when a continued and confusion and they formation in the nurse's notes. Interview on 1/31/12 at 10:25 ated an elevated blood sugar representation. He stated he ag service had not received cility after he saw the last in the facility on 1/19/12. The day of the might shift the stated he ag service had not received cility after he saw the last in the facility on 1/19/12. The day of the might shift the stated he ag service had not received cility after he saw the last in the facility on 1/19/12. The day of the might shift the stated he ag service had not received cility after he saw the last in the facility on 1/19/12.	F	157			

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F 157	facility to the hospital related to changes in of Finger Stick Blood routine insulin doses, Physician of continue status decline, as evivalues. On January 31, 2012 identified as primary interventions and not changes for Resident individually in-service Development Coordin processes. Notification: Nurresponsible party regmedications, diagnost changes in condition. Use of the 24-Ho in Condition Book: Id resident's conditions identify type of change follow up validation bwith acute change in Resident Refuse orders: Notification oparty, nursing, and of members when resided while also profuse. Condition Change expectations on comshift: Nurses will utilicommunication tool tadministration for changes in condition tool tadministration for changes.	on January 21, 2012, behavior, resulting in refusal Sugar (FSBS), refusal of and lack of notification to d change in condition and denced by critical laboratory , three (3) nurses were providers in the assessment, ification regarding clinical # 1. These nurses were d/educated by the Staff nator (SDC) on the following reses will notify physician and arding, refusal of tic procedures, and/or our Report Resident Change entifies acute changes in by utilizing check marks to ge, narrative if indicated, and y check mark of action taken	F	157			

OLIVILIY	OT ON WILDIOANL &	VILDICAID SERVICES				T CIVID NO.	. 0000 0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SUR COMPLETE	
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F 157	identified as complete Protocols for Phy Provision of resource recognition, identificat intervention, and doc relevant information r in Condition. The Medical Director of Nursing Services a Coordinator conducte Improvement (PI) me address Resident #1' hospitalization. The Committee deter analysis the change if was related to the de orders, and Physician refusal of medication clinical decline that w Based on this root ca developed a "Perforn 1/31/2012 to provide prevent re-occurrence Notification: Nur responsible party reg medications, diagnos changes in condition Use of the 24-He in Condition Book: Id resident's conditions identify type of chang follow up validation b with acute change in Resident Refusa orders: Notification of party, nursing, and o	the nurse's notes and and and on the 24 hour Report. Assician Notification: I guidelines for nurse's ation, assessment, amentation of pertinent and a related to Resident Change I Executive Director, Director and the Staff Development and the Staff Development and a Performance are an condition and armined through root cause an condition for Resident #1 lay in implementation of MD an notification of resident so, diagnostic testing, and are not readily identified. The ED and DNS anance Improvement" plan on the following interventions to be a reses will notify physician and arding, refusal of a stic procedures, and/or a cour Report Resident Change and a procedures are the changes in by utilizing check marks to ge, narrative if indicated, and by check mark of action taken	F	157			

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F 157	needed while also prefuse. Lab Protocol: Forders, scheduling la reports, review, reports follow up if indicated or inability to obtain a subsequent notification responsible party as Condition Change expectations on comshift: Nurses will util communication tool administration for chemology. Notification to play will be documented it identified as completed in the processes as Inserviced and education on the processes as Inserviced will be in mandatory inserviced modification for the processes as Inserviced will be in mandatory inserviced will be in mandatory inserviced in the processes and remaining inserviced will be in mandatory inserviced will be in mandatory inserviced in the conducted by the 2012 and thereafter. III. On 01/31/2012 initiated and will be administration and in communicate identification, assessmentification to MD are	acility process of receiving be draw, validating return ring and documentation with Documentation of refusals, diagnostic test with on to physician and indicated. Ge of a Resident and munication at change of ize the 24 hour report as a coother shifts and nursing anges in resident condition. In the nurse 's notes and ed on the 24 hour Report. It is and LPN's were cated by the ADNS and SDC described in Section "I" leekend nurses, and PRN g nurses who have not been eligible to work until this e training completed. In early hired licensed PN's) will be provided this employee orientation that will SDC effective January 31, the new 24-hour report was utilized by the nurses, nursing interdisciplinary team to ited changes in resident	F	157			

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F 157	residents identified or condition sheet for not Responsible Party, do assessment of the redaily. The resident's reviewed during more the Interdisciplinary to of concern related to of MD and Responsib The DNS/ADNS/Unit Supervisor will be result and resolution for any condition. IV. The Unit Manage Supervisors will audit re-admissions, and the resident conditions of will be responsible for of concerns with characteristic of these audit reviewed at the facilit Improvement (PI) memonths and then qual Immediate Jeopardy 4:00 P.M. with interview who confirmed they reconsible party whin condition, use of the Change in Condition	Manager/Weekend eview of medical records on in the 24 hour change in offication of MD and ocumentation, and sident, which will be done medical record will be ning meeting (Mon - Fri) and eam will address any areas documentation, notification ole Party. Manager/Weekend exponsible for identification of concerns on change of er, Shift and Weekend anew admissions, are 24 hour report for change on a daily basis. DNS/ADNS or identification and resolution onge in Resident condition/s. ts will be analyzed and oy's monthly Performance exeting monthly for six (6) orderly thereafter. was removed on 2/2/12 at ews of licensed nursing staff eccived inservice training on ong on duty.	F	157			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A A CONTRACTOR OF THE CONTRACT	LE CONSTRUCTION	(X3) DATE SUR'	
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F 157	the change of shift recondition and documents was completing documents were at the was completing documents. Consider the second of the secon	protocol, communication at garding resident change in entation of notification to the estable party in the nurses 24 Hour Reports and 2/2/12 revealed the ne nurse's station and staff mentation as in-serviced. 3RE/SERVICES FOR NG seceive and the facility must y care and services to attain est practicable physical, ocial well-being, in comprehensive assessment	F 157	This Plan of Correction is the center's creallegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreeme provider of the truth of the facts alleged a set forth in the statement of deficiencies. correction is prepared and/or executed so it is required by the provisions of federal. Resident #1 no longer resides in the Licensed Nurses #2, #3 and #4 whidentified as primary care provide assessment interventions and notifier clinical changes with resident individually in-serviced/re-educat Staff Development Coordinator (Sthe following policy and procedur Notification, Lab Protocol, Twent Hour Report/Change in Condition Resident Refusal of/or Failure to MD orders. The Staff Development Coordinator reeducated the Licensed Nurses to centers policy and procedure for and Responsible Party Notificatio in Condition, 24-Hour Report Boo Protocol, Resident Refusal of/or Follow MD orders (with an emphasion and the procedure of the protocol of the protocol of the service will be incorporate the new employee orientation protocols.	to of correction ont by the for conclusions. The plan of olely because and state law. The facility. The facility of the facility. The facility of the facility	2/23/12

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			B. WING		С	1
		345159			02/02	/2012
	OVIDER OR SUPPLIER NURSING CENTER INC		14	EET ADDRESS, CITY, STATE, ZIP CODE 110 EAST GASTON ST INCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	of D (an isolated define potential for more that immediate jeopardy) systems are put in plotted. The findings are: Resident #1 was added. The findings are: A review of physician revealed Lantus insuited aily at bedtime for containing are bedtime for containing are bedtime. The findings are sugars are sugars. A review of all pressure was 164/90 documentation in the was called. A review of nurse's revealed Resident #1 was 194/91. Blood (1) hour after blood given and blood pressure was 164/91 and blood pressure was 184/91. Blood (1) hour after blood given and blood pressure was 184/91. Blood (1) hour after blood given and blood pressure was 184/91. Blood (1) hour after blood given and blood pressure was 184/91. Blood (1) hour after blood given and blood pressure was 184/91. Blood (1) hour after blood given and blood pressure was 184/91. Blood (1) hour after blood given and blood pressure was 184/91. Blood (1) hour after blood given and blood pressure was 184/91. Blood (1) hour after blood given and blood pressure was 184/91. Blood (1) hour after blood given and blood pressure was 184/91. Blood (1) hour after blood given and blood pressure was 184/91.	ciency, no actual harm with an minimal harm that is not to ensure monitoring of ace. mitted to the facility on es including uncontrolled ientia, hypertension, and a ded weakness. In orders dated 6/28/11 illin 14 units subcutaneously diabetes; Amaryl 2 milligrams ist for diabetes mellitus; ins orally daily for blood 0.2 milligrams orally twice a re; Lopressor 150 milligrams blood pressure. There were to check finger stick blood sesion nurse's note dated revealed Resident #1's blood 0. There was no enurse's notes the physician inote dated 7/1/11 at 2:00 PM 1's blood pressure this AM pressure was rechecked one pressure medication was	F 309	This Plan of Correction is the center's creallegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreeme provider of the truth of the facts alleged of set forth in the statement of deficiencies. correction is prepared and/or executed so it is required by the provisions of federal. The DNS/ADNS/Unit Manager withrough record review 5 residents hour report for changes in residen condition, for physician and family notification 3 times weekly for foothen 2 times weekly thereafter to ongoing compliance in notification change of condition. Data results will be reviewed and at the facility monthly Performant Improvement (PI) Committee Memonths with a subsequent plan of as needed. The Director of Nurse responsible for overall compliance.	of correction on the by the or conclusions. The plan of the plan o	2/23/12

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURV COMPLETE	
		345159	B. WIN			02/02	; /2012
	ROVIDER OR SUPPLIER			14	EET ADDRESS, CITY, STATE, ZIP CODE 410 EAST GASTON ST INCOLNTON, NC 28092	J 02/02	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	nurse's notes the bloor the physician was A review of a physician 7/12/11 revealed the Minimum Data Set (Note to reports of anx not available for exart follow up visit next work a review of a nurse's resident was having physician was notified a review of a physician revealed to check find breakfast meal. A review of a vital signification of a physician was 146/84. A review of a physician 8/2/11 revealed Resident #was 146/84. A review of a physician sugars were flood and the pressures. A review of a physician revealed to increase or ally each day for expressures. A review of a physician revealed patients of a physician was notified to pressures.	od pressure was rechecked called. an's progress note dated physician was asked by MDS) staff to see resident iety and dementia. "Patient m at this time will evaluate at eek." anote dated 7/13/11 revealed periods of confusion and d. an's order dated 7/13/11 ger stick blood sugars before gn flow sheet dated 7/31/11 1's weekly blood pressure ian's progress note dated ident #1 was seen on routine	F	309			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		00 (1900) 1140-1150	A. BUII B. WIN			(100 La companya da 100 de 100 d
NAME OF PR	OVIDER OR SUPPLIER	345159		_	EET ADDRESS, CITY, STATE, ZIP CODE	02/02	2/2012
	NURSING CENTER INC			14	110 EAST GASTON ST INCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	130's/80's. Will plan from 14 units to 17 u A review of a physici revealed to increase subcutaneously daily A review of a nurse's Resident #1 was ext assistants, would no refused all care. A review of a nurse's Resident #1 was fou on floor. The notes clammy and difficult was 358. Vital signs follows: 136/76, puls notified and no new A review of a physic 11/8/11 revealed the up, staff concerned as high as 350. Cor in a range from 290-pressures are stable Lantus insulin and b A review of a physic revealed to increase to 20 units subcutar increase finger stick breakfast each morrevening.	the 240 range in the pressures were averaging to increase Lantus Insulin nits daily at bedtime. an's order dated 9/06/11 Lantus Insulin to 17 units at bedtime. anote dated 9/08/11 revealed remely agitated with nursing telt them change her and at let them change her and at let them change her and at let the resident was to arouse, her blood sugar at let were documented as se 72 and the physician was orders were received. It is progress note dated at patient was seen in follow about elevated blood sugars attinues to have blood sugars attinues to have blood sugars. It in the mornings. Blood at Will plan to increase	F	309			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII		CONSTRUCTION	1	C
		345159	D. 1711			02/0	02/2012
	OVIDER OR SUPPLIER NURSING CENTER INC			141	ET ADDRESS, CITY, STATE, ZIP CODE 0 EAST GASTON ST ICOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309	was 134/76. The most recent qua (MDS) dated 12/20/1 short and long term in cognition for daily also indicated Reside symptoms directed to extensive assistance dressing and hygien only with eating, was bladder and had uppimpairment on one set. A review of a nurse's PM revealed Reside drooping of the left (tongue was protruding resident's blood president's plood president's blood preside	arterly Minimum Data Set Indicated no impairment in memory and no impairment decision making. The MDS ent #1 had no behavioral oward others, required by staff for transfers, e, required set up assistance incontinent of bowel and over and lower extremity side. In the source of her face and her ang from her mouth. The source was documented as It's note dated 12/12/11 at 7:10 lood sugar was 416 then 382 and the resident was obeyital. In the source of the facility In the source of the facility In the source was no documentation in the	F	309			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	DING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345159	B. WIN	3		02/02/2012		
	OVIDER OR SUPPLIER			1410	TADDRESS, CITY, STATE, ZIP CODE EAST GASTON ST COLNTON, NC 28092			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 309	A review of laborator indicated a hemoglot overall view of how the controlled or out of or diabetes) was 11.9 pless than 7 percent). A review of a physici 12/27/11 revealed blewek range in 148-1 further stated the resewas severe, still understand the resewas severe, still understand to control. A review of a physici revealed to increase to 25 units daily at be 0.3 milligrams or ally pressure. A review of a physici revealed to obtain a sensitivity due to increase to 25 units daily at be 0.3 milligrams or ally pressure. A review of a physici revealed to obtain a sensitivity due to increase to 25 units daily at be 0.3 milligrams or ally pressure. A review of a physici revealed to obtain a sensitivity due to increase to 25 units daily at be 0.3 milligrams or ally pressure. A review of a physici revealed to obtain a sensitivity due to increased the urinaly urine was obtained. A review of laborator revealed the urinaly urine glucose 300 (revealed the	y results dated 12/21/11 bin A1C (a test to give an ne blood sugar levels are ontrol in individuals with ercent (normal range was an's progress note dated ood pressures over the last 50's/80-90's. The notes sident's high blood pressure ontrolled and her diabetes ian's order dated 12/27/11 Lantus insulin from 20 units edtime; increase Catapres to twice daily for blood ian's order dated 1/12/12 urinalysis and culture and reased confusion. s note dated 1/13/12 revealed d out catheterization was ent #1 and cloudy yellow ry results dated 1/13/12 sis had abnormal results of normal range 0-0.8) and a urmal range was no albumin ician's initials were laboratory results but they	F	309				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUIL	DING	·	(X3) DATE SUR COMPLETE	:D
		345159	B. WIN	G		02/02	2/2012
	OVIDER OR SUPPLIER	ıc		14	EET ADDRESS, CITY, STATE, ZIP CODE 110 EAST GASTON ST NCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 309	revealed "mixed be contamination." documented on the were not dated or A review of a nurse "late entry for 1/16 of any kind until 10 verbally and physically and physical	culture results dated 1/13/12 cacterial flora, probable The physician's initials were the laboratory results but they timed. e's note dated 1/17/12 revealed f/12." Resident #1 refused care 0:00 PM on this shift, was cally abusive toward staff, was the and refused to allow brief to 0:00 PM. e's note dated 1/17/12 revealed 0 PM" Resident #1 took all nner tray and poured them into the sheets up and yelled for a to change sheets. The sheets of the resident stated she poured use she didn't want it. sician's progress note dated increased confusion. "Patient tous decrease in level of the last ten days. Was alert the with decent memory and toused, unable to answer . Vital signs/blood sugar not the (3) days. Confusion on the lossible small stroke. Plan to	F	309			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345159	B. WIN	G			2/2012
	OVIDER OR SUPPLIER			141	ET ADDRESS, CITY, STATE, ZIP CODE 10 EAST GASTON ST NCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309	increased confusion. A review of a nurse's PM revealed Reside physically abusive to was notified. A review of a physic 7:40 PM revealed Hevery four (4) hours A review of a nurse's PM revealed Reside milligrams orally. A review of a nurse's "late entry for 1/18/1 reported Resident re 2:30 AM and demar her alone. At 5:00 Aprovide peri-care an refused Synthroid at There was no docur the physician was continued and the physician was continued	and lateral views due to s note dated 1/17/12 at 7:00 Int #1 was verbally and Iward staff and the physician Isan's order dated 1/17/12 at Isaldol 0.5 milligrams orally as needed for agitation. Is note dated 1/17/12 at 7:40 Int #1 received Haldol 0.5 Is note dated 1/19/12 revealed 2" a Nursing Assistant (NA) Isaldol dated 1/19/12 revealed 2" a Nursing Assistant (NA) Isaldol dated 1/19/12 revealed AM the NA was able to Isaldol dated 1/18/12 at 4:00 Isanote dated 1/18/12 at 4:00	F	309			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345159	A. BUII	DING	E CONSTRUCTION	COMPLETE COMPLETE COMPLETE	D
	OVIDER OR SUPPLIER			1	EET ADDRESS, CITY, STATE, ZIP CODE 410 EAST GASTON ST INCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 309	nursing staff. "Deme strokes." Change to A review of a physicia revealed "correction" intramuscularly every for agitation; discontinuorally and begin Cata and change weekly. A review of a nurse's PM revealed Resider was spitting them out care. There was no notes the physician variew of the MAR Resident #1 received intramuscularly at 5:00 A review of a nurse's PM revealed Resider refusing care and ware sident's blood president's blood president's notes the physician was nurse's notes the physician was notes the physician was nurse's notes the physician was noted to feed resident #1 refused attempted to feed resident was noted the resident was nurse's nurse's noted the resident was nurse's nur	od sugar "high" according to ntia with possible mini Catapres Patch." an's order dated 1/19/12 Haldol 5 milligrams orally or of four (4) hours as needed nue Catapres 0.3 milligrams apres patch 0.3 milligrams apres patch 0.3 milligrams are patch 0.3 milligrams and was combative during documentation in the nurses was called. dated 1/19/12 stated distance Haldol 5 milligrams 20 PM. a note dated 1/19/12 at 5:30 and #1 was screaming, as physically combative. The asure was documented as no documentation in the	F	309			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE S COMPLI	ETED
		345159	B. WING		02	C /02/2012
	OVIDER OR SUPPLIER		14	EET ADDRESS, CITY, STATE, ZIP CODE 10 EAST GASTON ST NCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	nurses notes the phy A review of the month record (MAR) dated were no blood presson 1/18/12, or 1/20/12 and order to check blood the MAR revealed do on 1/18/12 resident "medications; on 1/19 blood sugar check"; ostick for blood sugar "refused finger stick of fluids." A review of laborator and dated 1/21/12 at laboratory values as value) normal range BUN 71 (critical value Creatinine 3.60 (critical value) normal range BUN 71 (critical value) Creatinine 3.60 (critical value) normal range BUN 71 (critical value) Creatinine 3.60 (critical value) normal range BUN 71 (critical value) Normal range BUN	ras no documentation in the sician was called. Inly medication administration January 2012 revealed there ares documented on 1/17/12, according to a physician's pressures daily. In addition, acumentation by nursing staff refused blood sugar and 1/12 "refused finger stick for on 1/20/12 "refused finger check" and on 1/21/12 for blood sugar check and 1/21/12 for blood sugar chec	F 309			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SURV	
		345159	B. WIN	G		02/02	
	OVIDER OR SUPPLIER			14	EET ADDRESS, CITY, STATE, ZIP CODE 410 EAST GASTON ST INCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	percentage was 95% congestion was noted to arouse and warm party was notified and (DON) was notified. resident had not eated shift and the nurse we to take oral medication consciousness. A review of a transfer time indicated reside emergency medical standard with altered possibilities including ketoacidosis (a serior that occurs when the levels of blood acids infection with elevate urinary tract infection and dehydration; actor and dehydration; actor and dehydration; actor and the composition of the stated she usually we person that occurs when the levels of blood acids infection with elevate urinary tract infection and dehydration; actor and dehydration; actor actor and elevated she usually we person that occurs when the levels of blood acids infection with elevated with a blood glucosed greater than 500 the verified she sent Re 1/21/12 at approxim	20. Oxygen saturation on room air, bilateral lung d, resident was very difficult to the touch. A responsible d the Director of Nurses The notes further stated the en or taken any fluids this as unable to get the resident ons due to decreased level of r form dated 1/21/12 with no nt was transferred by services to the hospital. Il history and physical dated sident #1 was admitted to the mental status with g infection and diabetic us complication of diabetes body produces very high); sepsis and underlying ed white blood cell counts and n; rapid heart rate with fever ute renal failure and a large	F	309			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	:D
		345159	B. WIN	G		02/02	2/2012
	OVIDER OR SUPPLIER			14	EET ADDRESS, CITY, STATE, ZIP CODE 410 EAST GASTON ST INCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	4000	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	for a couple of days. the resident's room la resident did not resp arm slightly and wou stated she had been laboratory staff had to resident for several of She explained she dand sent it to the lab called back with critic checked Resident # rate was "really high documenting them in record. She further the responsible party the Director of Nurse LN #2 she stated shat Resident #1 on Trin the facility. She sand hitting when the physician examined her blood sugar and did not remember of She explained she sand she was still comedications, finger personal care. During an interview LN #3 she stated she	drink or take her medications She explained she went to ater in the morning and the ond but moved her right (R) Idn't talk to her. She further told nursing staff and tried to draw blood from the days but were unsuccessful. Irew the blood around noon oratory and the laboratory cal values. She stated she 1's vital signs and her heart " but she did not remember in the resident's medical stated she called the doctor, y and her supervisor called es (DON). on 1/30/12 at 2:20 PM with he asked the physician to look uesday 1/17/12 while he was stated the resident was kicking by went to the room. The the resident, LN #2 checked It was in the 200 range but hecking her blood pressure. Saw Resident #1 the next day mbative and refusing stick blood sugars and on 1/30/12 at 3:10 PM with he was concerned on Friday	F	309			
	abusive and refused Resident #1 had hig blood sugars. She	at Resident #1 was still Id her medications. She stated Igh blood pressure and high Explained she had called the Iweek and got an order for					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ultipl Lding	LE CONSTRUCTION	COMPLETE	(X3) DATE SURVEY COMPLETED	
		345159	B. WIN	G		C 02/02/2012		
	OVIDER OR SUPPLIER		•	14	EET ADDRESS, CITY, STATE, ZIP CODE 410 EAST GASTON ST INCOLNTON, NC 28092			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	2000	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 309	Haldol because Resi yelling. She further person attempted to 01/20/12 but was unreported off to the nigon the resident becaright. She further st became confused arwanted to take her because she had a hake it. During an interview Nursing Assistant (Nursing Assistant (Nursing Assistant (Nursing Assistant (Nursing Assistant (Nurse the resident reat 2:30 AM. She state to provide peri-care. During an interview physician stated Reshypertension, diabets stated he examined was in the facility and less pleasant. I about her blood pressure med He stated he was not insulin doses on 1/1 unaware staff were ordered the tests or of the continued refi sugars after he saw further stated staff's missed Lantus insulin her blood and continued refi	dent #1 was screaming and explained a laboratory draw the resident's blood on successful. She stated she ght shift nurse to keep an eye use something did not seem ated before the resident and combative she always blood pressure medicine headache when she didn't on 1/31/12 at 6:42 AM with IA) #1 she stated she sident #1 on 1/19/12 during explained she reported to the efused care at 12:30 AM and ated the resident allowed her on 1/31/12 at 8:35 AM the sident #1 had very volatile tes and recent strokes. He her during the last week she and she was distant, less alert He stated he was very worried source and one missed dose of lication was critical for her. On the aware of the missed Lantus 19/12 and 1/20/12, he was unable to draw blood after he in 1/17/12 and he was unaware usals of finger stick blood of the resident on 1/19/12. He should have told him about lin doses, the inability to draw	F	309				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		LE CONSTRUCTION	(X3) DATE SURV		
		345159	B. WIN	G		02/02		
LINCOLN NURSING CENTER INC				EET ADDRESS, CITY, STATE, ZIP CODE 410 EAST GASTON ST INCOLNTON, NC 28092				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 309	wanted her to stay as he thought she might stated if he had know doses and the continuous blood sugars he wou do a finger stick blood sent the resident to the During an interview of LN #4 she stated she during the night shift was very noncompliar physically and verbatiried to draw the blood and she tried to do a the resident wouldn't not call the physician to the day shift on Sawas unable to draw thad refused her med Director of Nurses (Innursing staff to notify resident refused blood should assess and in there was a significate and they should document of the physician stay would have been verified his answering any calls from the face.	ident's blood pressure and second as possible because thave another stroke. He was another stroke in about the missed insulinued refusals of finger stick lid have ordered for them to disugar or he would have	F	309				

STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345159	A. BUII B. WIN				2012
	OVIDER OR SUPPLIER	343135		14	EET ADDRESS, CITY, STATE, ZIP CODE \$10 EAST GASTON ST INCOLNTON, NC 28092	02/02/	2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	55	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 309	NA #2 she stated she 1/21/12 at lunch time her bed with her mot she was in a daze." looked pale, was not way she normally did not get out of bed all drew blood from both to pull away or fight. During an interview LN #5 she verified stated she saw Resi 11:00 AM on 1/21/12 blood on the resider "was not alert at all" room and she was vexplained she took than they called critic the hour. She stated check vital signs or she was helping the then she transported of the facility. During an interview NA# 3 she stated she sadent #1 on 1/22 was "really out of it" her and she did not she did not talk to the resident's vital signs the resident's vital signs the resident's vital signs the resident's brief chospital because it hospital because it the same transporter of the facility was "really out of it" her and she did not she did not talk to the resident's vital signs the resident's vital signs the resident's vital signs the resident's brief chospital because it was not all the resident's vital signs the resident's	on 1/31/12 at 12:55 PM with e saw Resident #1 on and she was sitting up in ath open and she "looked like She explained the resident talking and did not act the d. She stated the resident did day and when the nurse in arms the resident did not try her.	F	309			

STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI	JLTIPL	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NOTIFICAL	A. BUIL	DING		С	
		345159	B. WIN	G			/2012
	OVIDER OR SUPPLIER			14	EET ADDRESS, CITY, STATE, ZIP CODE MO EAST GASTON ST NCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	The facility provided compliance which in I. Resident # 1 wa 28, 2011. Resident facility to the hospital related to changes in of Finger Stick Blood routine insulin doses Physician of continustatus decline, as evalues. On January 31, 201 identified as primary interventions and not changes for Reside individually in-service Development Coord processes. Notification: Note that is the condition of the 24-bits in Condition Book: I resident's condition identify type of charfollow up validation with acute change in Resident Refusorders: Notification party, nursing, and	as informed of Immediate at 4:10 PM for Resident #1. a credible allegation of cluded: as admitted to facility on June #1 was transferred from al on January 21, 2012, behavior, resulting in refusal d Sugar (FSBS), refusal of s, and lack of notification to ed change in condition and oldenced by critical laboratory 2, three (3) nurses were of providers in the assessment, offication regarding clinical and #1. These nurses were official providers of the Staff linator (SDC) on the following curses will notify physician and official of ostic procedures, and/or and continued to the staff contin	F	309			

STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDFLANO	CONNECTION	IDENTIFICATION TO MELIN	A. BUI	LDING			
		345159	B. WIN	G		02/0	2/2012
	OVIDER OR SUPPLIER			141	ET ADDRESS, CITY, STATE, ZIP CODE 10 EAST GASTON ST NCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 309	Education to resident needed while also provides. Condition Change expectations on comshift: Nurses will util communication tool to administration for chondition to play will be documented it identified as completed in the protocols for Phoforesource guideline identification, assess documentation of perinformation related to Condition. The Medical Director of Nursing Services Coordinator conduct Improvement (PI) maddress Resident # hospitalization. The Committee determines and Physicial refusal of medication clinical decline that the Based on this root of developed a "Perfor 1/31/2012 to provide prevent re-occurrental Notification: Notification: Notifications, diagnochanges in condition	trifamily and documentation otecting resident right to ge of a Resident and munication at change of ize the 24 hour report as a to other shifts and nursing anges in resident condition. In the nurses notes and led on the 24 hour Report. It is for nurse's recognition, sment, intervention, and ritinent and relevant to Resident Change in the Staff Development led a Performance leeting on January 31, 2012 to the schange in condition and leave in condition for Resident #1 leave in implementation of MD an notification of resident leave, the ED and DNS mance Improvement" plan on the following interventions to ce. Lurses will notify physician and garding, refusal of leave in procedures, and/or	F	309			

STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	JLTIPL	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION TO MADE IN	A. BUII			С	
		345159	B. WIN	G		02/02/	2012
	OVIDER OR SUPPLIER NURSING CENTER INC			14	EET ADDRESS, CITY, STATE, ZIP CODE 410 EAST GASTON ST INCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	20062 0	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	resident's condition identify type of chan follow up validation with acute change ir Resident Refus orders: Notification party, nursing, and omembers when resi Education to resident needed while also prefuse. Lab Protocol: Forders, scheduling I reports, review, repefollow up if indicated or inability to obtain subsequent notifica responsible party at Condition Charexpectations on conshift: Nurses will ut communication for a Notification for will be documented identified as completed in the processes at In-service and educentification for the processes at In-serviced will be mandatory in-servity. There have been main in-serviced yanuary 31, anurses (RN's and I	dentifies acute changes in its by utilizing check marks to ge, narrative if indicated, and by check mark of action taken in condition. al of/or Failure to Follow MD of physician, responsible other interdisciplinary team dents refuse plan of care. Interdisciplinary team deceiving and documentation rotecting resident right to reacility process of receiving and draw, validating return orting and documentation with d. Documentation of refusals, diagnostic test with tion to physician and sindicated. In the indicated in the 24 hour report as a least to other shifts and nursing thanges in resident condition. In the nurses notes and leted on the 24 hour Report. In the nurses notes and leted on the 24 hour Report. Facility RN's and LPN's were ucated by the ADNS and SDC is described in Section "I" Weekend nurses, and PRN ing nurses who have not been	F	309			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		DNSTRUCTION	(X3) DATE S COMPLE	
		345159	B. WING	-		02	/02/2012
	ROVIDER OR SUPPLIER NURSING CENTER INC			1410 E	ADDRESS, CITY, STATE, ZIP CODE EAST GASTON ST DLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	be conducted by the 2012 and thereafter. III. On 01/31/2012 initiated and will be administration and it communicate identification to MD at critical lab values, a changes. The DNS/ADNS/Un Supervisor will do a residents identified condition sheet for Responsible Party, assessment of the reviewed during more the Interdisciplinary of concern related to MD and Responsible of Concern related to MD and Responsible of concern will be readmissions, and resident condition. IV. The Unit Mana Supervisors will au re-admissions, and resident conditions will be responsible of concerns with changes and reviewed at the fact Improvement (PI) months and then of Immediate Jeopara	the new 24-hour report was utilized by the nurses, nursing interdisciplinary team to fied changes in resident ent, intervention, and ind RP of event, progress, and resolution of identified it Manager/Weekend review of medical records on on the 24 hour change in notification of MD and documentation, and resident, which will be done is medical record will be orning meeting (Mon - Fri) and ream will address any areas to documentation, notification esponsible for identification entry concerns on change of eager, Shift and Weekend dit new admissions, and the 24 hour report for change on a daily basis. DNS/ADNS for identification and resolution enange in Resident condition/s. Utility 's monthly Performance meeting monthly for six (6)	F3	809			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		E CONSTRUCTION	(X3) DATE SURVI	
		345159	B. WIN	G		C . 02/02/2	2012
	OVIDER OR SUPPLIER			14	EET ADDRESS, CITY, STATE, ZIP CODE 10 EAST GASTON ST NCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	10000	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 312 SS=E	who confirmed they record reviews with nursing of expectations to not responsible party whim condition, use of the Change in Condition resident refusal of/or orders, the laborator the change of shift recondition and documents and responsible party whim condition and documents were at the was completing documents were at the was completed was completed as a completed was completed as a complete who is under the was completed as a complete was a complete who is under the complete was a complete was	eceived inservice training on ng on duty. Ing staff revealed awareness tify the physician and en a resident had a change ne 24 Hour Report Resident Book, actions required with failure to follow physician's y protocol, communication at egarding resident change in tentation of notification to the nsible party in the nurses 24 Hour Reports and en 2/2/12 revealed the he nurse's station and staff tementation as in-serviced. ARE PROVIDED FOR DENTS Inable to carry out activities of the necessary services to ion, grooming, and personal entity staff failed to change are soiled during incontinence allow proper technique during or four (4) of four (4) sampled		309	This Plan of Correction is the center's crallegation of compliance. Preparation and/or execution of this plandoes not constitute admission or agreem provider of the truth of the facts alleged set forth in the statement of deficiencies. correction is prepared and/or executed sit is required by the provisions of federa. Resident #3, #5, #7, and #8 is recomposed in the statement care. The Staff Development Coordinator (SDC) educated NA #4 and #5 regarding technique during incontinent care. The Staff Development Coordinator will re-educate the Nursing Assistants and proper technique is maintained to incontinent care. An incontinent competency will be performed be with the centers Nursing Assistants proper technique is maintained of incontinent care. The above inseincluded in the orientation programments of the proper technique is maintained of incontinent care. The above inseincluded in the orientation programments of the proper technique is maintained of incontinent care. The above inseincluded in the orientation programments of the proper technique is maintained of incontinent care. The above inseincluded in the orientation programments of the proper technique is maintained of incontinent care. The above inseincluded in the orientation programments of the proper technique is maintained of incontinent care.	n of correction ent by the or conclusions. The plan of solely because I and state law. ceiving of proper e. ator (SDC) stants to the providing care clinically the SDC ents to ensure during ervice will be	2/23/12

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURV	
		345159	B. WING			02/02/	(2012
	OVIDER OR SUPPLIER	340100		141	EET ADDRESS, CITY, STATE, ZIP CODE 10 EAST GASTON ST NCOLNTON, NC 28092	02/02	2012
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	:	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 312	The findings are: 1. Resident #3 was a diagnoses including turinary tract infection. The admission Minim 1/14/12 indicated mo and long term memo in cognition for daily resident required extactivities of daily livin bladder incontinence resident had an indivermoved after admis of bowel. During an observation 1/30/12 at 11:15 AM #5 entered Resident hands, and put on gremoved the resident saturated with liquid sheet on the bed. A rinse cleanser and versident's groin, downinside the labia and a plastic bag on the NA #5 turned the re NA #4 removed the bag and handed it to resident's buttocks surface of the towel on the resident, remember 1/2 and interview. During an interview.	admitted to the facility with hypertension, history of	F3	312	This Plan of Correction is the center's creallegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreeme provider of the truth of the facts alleged a set forth in the statement of deficiencies. correction is prepared and/or executed sit is required by the provisions of federal. The SDC, Assistant Director of N (ADNS) and Unit Manager (UM) monitor through direct observation incontinent care for 5 residents 2 weekly for four weeks then week ensure ongoing compliance. Data results will be reviewed and at the facility monthly Performant Improvement (PI) Committee Memonths with a subsequent plan of as needed.	of correction ent by the corrections. The plan of colely because and state law. Turses will on times ly x 4 to I analyzed ace eeting for 3	2/23/12

PRINTED: 02/13/2012 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		345159	B. WIN	G			
	ROVIDER OR SUPPLIER NURSING CENTER INC	8		14	EET ADDRESS, CITY, STATE, ZIP CODE 10 EAST GASTON ST NCOLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 312	resident she didn't hat the soiled towel becard other towels available shouldn't have used plastic bag to further. During an interview Staff Development Cocharge of infection of expectation when structure incontinence care, the use the clean side if stated if the towel with discard it into a plastic continue cleaning. During an interview Director of Nurses (expectation nursing front to back and diswhen it was soiled of further stated it was staff to remove a scand use it to clean at 2. Resident #5 was diagnoses including blood pressure and. The most recent que (MDS) dated 11/25 impairment in short moderate impairmed decision making. Tassistance by staff	ave enough towels and used ause she didn't have any le. She further stated she a soiled towel from the clean the resident. on 1/31/12 at 2:47 PM the Coordinator who was also in control stated it was her aff used towels during hey should turn it over and it was not soiled. She further as soiled, nursing staff should tic bag and use a clean towel the resident. on 1/31/12 at 3:05 PM the DON) stated it was her staff should always wipe from scard a towel or washcloth during incontinence care. She unacceptable for nursing biled towel from a plastic bag a resident. Is admitted to the facility with a gacute renal failure, high diabetes. Parterly Minimum Data Set was a clean towel of the condition o	F	312			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE S COMPLE	
		345159	B, WING		02	/02/2012
	OVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP COD 1410 EAST GASTON ST LINCOLNTON, NC 28092	ÞE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 312	1/30/12 at 11:53 AM #6 entered Resident hands and put on glo resident's brief that v wiped back and forth resident's perineal ar and down inside the NA #6 turned the res resident had a bowe wet towel and wiped and forth. The reside and NA #6 to turn or was placed on her. During an interview NA #5 she stated sh from front to back do didn't realize she ha the wet towel. During an interview Staff Development of charge of infection of expectation staff sho and should not wipe During an interview Director of Nurses (i expectation nursing front to back and dis when it was soiled of 3. Resident #7 was diagnoses including hypertension, diabe	Nurse Aide (NA) #5 and NA #5's room, washed their oves. NA #5 removed the vas saturated with urine and a across the top of the rea, inside the left (L) groin perineal area. NA #5 and sident to her (L) side and the I movement. NA #5 took a the resident's buttocks back ant was assisted by NA #5 in her back and a clean brief on 1/30/12 at 11:35 AM with the had been taught to wipe uring incontinence care and d wiped back and forth with on 1/31/12 at 2:47 PM the Coordinator who was also in control stated it was her buld clean from front to back	F3	12		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL B. WING	DING	CONSTRUCTION	(X3) DATE S COMPLE	
	OVIDER OR SUPPLIER	343100		1410	ADDRESS, CITY, STATE, ZIP CODE EAST GASTON ST COLNTON, NC 28092		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 312	(MDS) indicated impterm memory and woognition for daily derequired total assisted daily living and was and frequently incorport of the property of the propert	nairment in short and long as moderately impaired in acision making. The resident ance by staff for activities of always incontinent of bladder	F	312			

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPL	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUI	LDING		С		
		345159	B. WIN	IG		02/02/2012		
NAME OF PROVIDER OR SUPPLIER LINCOLN NURSING CENTER INC			,	14	EET ADDRESS, CITY, STATE, ZIP CODE 410 EAST GASTON ST INCOLNTON, NC 28092			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 312	cleaning the resident During an interview Director of Nurses (I expectation nursing front to back and dis when it was soiled of the whole of the who	on 1/31/12 at 3:05 PM the DON) stated it was her staff should always wipe from scard a towel or washcloth during incontinence care. admitted to the facility with gurinary tract infections, xiety disorder. Inual Minimum Data Set 12 indicated no impairment in memory and no impairment by decision making. The extensive assistance by staff for ring. The MDS also indicated suprapubic catheter and was	F	312				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVI	D	
		345159	B. WIN	G		02/02/	2012	
NAME OF PROVIDER OR SUPPLIER LINCOLN NURSING CENTER INC (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	STREET ADDRESS, CITY, STATE, ZIP CODE 1410 EAST GASTON ST LINCOLNTON, NC 28092 ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFINE DEFICIENCY)		LD BE	(X5) COMPLETION DATE		
F 312	Staff Development C charge of infection or expectation when staincontinence care, the use the clean side if stated if the towel was discard it and use a cleaning the residen. During an interview of Director of Nurses (I expectation nursing front to back and discard it was soiled of 483.65 INFECTION SPREAD, LINENS. The facility must est Infection Control Prosafe, sanitary and control to help prevent the of disease and infection Control The facility must est Program under whice (1) Investigates, control the facility; (2) Decides what proshould be applied to (3) Maintains a reconcept of the control of the facility; (2) Preventing Spreadown (b) Preventing Spreadown (c) Preventing Spreadown	on 1/31/12 at 2:47 PM the coordinator who was also in ontrol stated it was her aff used towels during a tey should turn it over and it was not soiled. She further as soiled, nursing staff should clean towel to continue t. on 1/31/12 at 3:05 PM the DON) stated it was her staff should always wipe from scard a towel or washcloth during incontinence care. CONTROL, PREVENT ablish and maintain an		312	This Plan of Correction is the center's callegation of compliance. Preparation and/or execution of this pladoes not constitute admission or agreed provider of the truth of the facts alleged set forth in the statement of deficiencies correction is prepared and/or executed it is required by the provisions of federal Resident #3, #7, and #8 is received incontinent care. The Staff Development Coordinator (SDC) re-educated #5 regarding proper hand washind disposal of soiled linen during incare. The Staff Development Coordin will re-educate the Nursing Assistenters policy and procedure in incontinent care with an emphasional hand washing and disposal of soiled linen during incontinent care clinical committee with a specific content will be performed by the SDC we centers Nursing Assistants to enhand washing technique is main during incontinent care to included in the orientation of Nursing Assistants.	an of correction ment by the learn conclusions. The plan of solely because al and state law. Ting proper elopment NA #4 and and and and and acontinent lator (SDC) istants to the providing sis on proper biled linen. In a petency with the lasure proper attained de proper ove inservice	2/23/12	
		esident needs isolation to			tor runsing Assistants.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURV COMPLETE	D
		345159	B. WING			C 02/02/2012	
NAME OF PROVIDER OR SUPPLIER LINCOLN NURSING CENTER INC				14	EET ADDRESS, CITY, STATE, ZIP CODE 10 EAST GASTON ST NCOLNTON, NC 28092		,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(2000)	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 441	isolate the resident. (2) The facility must communicable disea from direct contact will tra (3) The facility must hands after each dire hand washing is indiprofessional practice. (c) Linens Personnel must han transport linens so a infection. This REQUIREMEN by: Based on observati record reviews facili gloves and wash ha incontinence care for residents observed (Resident #3, #7 and dispose of soiled lin residents (Resident The findings are: 1. During an observatives in the findings are: 1. During an observative in the findings and put the resident's pants with diarrhea. The	prohibit employees with a se or infected skin lesions with residents or their food, if insmit the disease. The require staff to wash their ect resident contact for which cated by accepted etc. If it is not met as evidenced it is not met as evidenced it is staff failed to remove and after providing or three (3) of four (4) during incontinence care ind metals as to properly the in one (1) of four (4)	F	441	This Plan of Correction is the center's creallegation of compliance. Preparation and/or execution of this plan does not constitute admission or agreeme provider of the truth of the facts alleged set forth in the statement of deficiencies. correction is prepared and/or executed sit is required by the provisions of federal. The SDC, Assistant Director of N (ADNS) and Unit Manager (UM) monitor through direct observation incontinent care for 5 residents 2 weekly for four weeks then week ensure ongoing compliance with handwashing and disposal of soil during incontinent care. Data results will be reviewed and at the facility monthly Performant Improvement (PI) Committee Memonths with a subsequent plan of as needed. The Director of Nurse responsible for overall compliance.	of correction ent by the corrections. The plan of colely because and state law. The plan of colely because and state law. The plan of colely because and state law. The plan of college and state law.	2/23/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1000 000	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLET	(X3) DATE SURVEY COMPLETED	
		345159 B. WING		C 02/02/2012				
NAME OF PROVIDER OR SUPPLIER LINCOLN NURSING CENTER INC				141	ET ADDRESS, CITY, STATE, ZIP CODE 10 EAST GASTON ST NCOLNTON, NC 28092			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 441	soiled towel into a pla Resident #3 was turn took the soiled towel handed it to NA #5 a buttocks with the soil placed it back into the soiled sheets off gloves still on, open resident's bedside ta cream and handed it gloves still on applied buttocks, put a clear touched the resident soiled gloves still on blanket and covered. During an interview NA #4 she stated she regloves when the were finished with in stated she didn't have refinished with in stated she didn't have refined and she did use. During an interview Staff Development of charge of infection of expectation staff she wash their hands aff care and before tour resident's room. During an interview.	Resident #3 and placed a astic bag on the bed. ned to her left side and NA #4 out of the plastic bag and nd she wiped the resident's led towel several times and e plastic bag. NA # 4 pulled the bed and with her soiled and the drawer of the ble and removed a tube of to NA #5. NA #5 with her d cream to the resident and 's sweater. NA #4 with her picked up the resident's	F	441				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		345159	B, WIN			C 02/02/2012	
NAME OF PROVIDER OR SUPPLIER LINCOLN NURSING CENTER INC				14	EET ADDRESS, CITY, STATE, ZIP CODE 410 EAST GASTON ST INCOLNTON, NC 28092	02/02	2/2012
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)		ULD BE	(X5) COMPLETION DATE
F 441	NURSING CENTER INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	441			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	***************************************	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING			(X3) DATE SURVEY COMPLETED	
8		345159	B. WIN	B. WING		C 02/02/2012		
NAME OF PROVIDER OR SUPPLIER LINCOLN NURSING CENTER INC				14	EET ADDRESS, CITY, STATE, ZIP CODE 410 EAST GASTON ST INCOLNTON, NC 28092	02/02		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 441	soiled or after they cand before they touch resident's room. 3. During an observation of the soiled side touching soiled gloves still on the resident and put on go plastic bag at the fool landed on top of the soiled side touching soiled gloves still on the resident and cover sheets and blanket, and placed it into the stated she should have the plastic bag on the plastic bag on the plastic bag on the stated she should have the plastic bag close changed her gloves brief off the resident anything clean. During an interview of the stated she should not have blanket. She further the plastic bag close changed her gloves brief off the resident anything clean.	ar hands when they were completed incontinence care thed anything clean in the action of incontinence care on Jursing Assistant (NA) #9 is room and washed her loves. She removed the provided incontinence care. In she assisted the resident is and resident had a incontinence care and the sed the soiled towel toward a lot of the bed and the towel resident's blanket with the the blanket. NA #9 with her placed a clean brief under locked up the soiled towel	F	441				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ing-congress	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345159	B. WIN	G		C 02/02/2012	
NAME OF PROVIDER OR SUPPLIER LINCOLN NURSING CENTER INC				STREET ADDRESS, CITY, STATE, ZIP CODE 1410 EAST GASTON ST LINCOLNTON, NC 28092			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 441	Director of Nurses (D expectation nursing s gloves and wash thei soiled or after they co and before they touch resident's room. The linen should always be bag and it was unaccommon the street of the	n 1/31/12 at 3:05 PM the	F	441			