STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345161	A. BUILDING _____ B. WING _____	C 06/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERNETHY LAURELS	102 LEONARD AVENUE NEWTON, NC 28658

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation in this survey, event ID #PVFX11.	F 000	Preparation and execution of this plan of correction in no way constitutes an admission or agreement by Abernethy Laurels of the truth of the facts alleged in this statement of deficiency and plan of correction. In fact, this plan of correction is submitted exclusively to comply with state and federal law, and because the facility has been threatened with termination from the Medicare and Medicaid programs if it fails to do so. The facility contends that it was in substantial compliance with all requirements on the survey date, and denies that any deficiency exists or existed or that any such plan is necessary. Neither the submission of such plan, nor anything contained in the plan, should be construed as an admission of any deficiency, or of any allegation contained in this survey report. The facility has not waived any of its rights to contest any of these allegations or any other allegation or action. This plan of correction serves as the allegation of substantial compliance.	6/22/12
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	Prefix Tag: 157 It is the intent of this facility to immediately inform the resident; consul with the resident's physician; and if known, notify the resident's legal representative or an interested	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ben H. Harris — TITLE: NHA — (X6) DATE: 6/22/2012

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 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, staff and physician interview and record review, the facility failed to notify the physician of changes in level of alertness with low blood pressure and weight gain and loss for one (1) of five (5) sampled residents (Resident #244). The findings are: Resident #244 was admitted to the facility with diagnoses which included Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. The admission Minimum Data Set (MDS) dated 4/23/12 assessed Resident #244 as cognitively intact. 1. Review of nursing notes dated 5/22/12 revealed Resident #244's family member informed Licensed Nurse (LN) #3 at 12:20 PM that Resident #244 became unresponsive for a few minutes and needed assistance. LN #3 documented an assessment of Resident #244 which included placement of Resident #244 in a Trendelenburg position in response to a blood pressure measurement of 82/44. (In the Trendelenburg position, the body is supine with both feet elevated higher than the head by 15 to 30 degrees.) LN #3 documented Resident #244 was responsive when she entered into the room and a blood pressure taken at 1:30 PM was 100/60. There was no documentation of physician notification. Interview with LN #3 on 6/1/12 at 8:12 AM revealed she would notify a nursing supervisor	F 157	family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing for of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in 483.12(a). 1) Corrective action to be accomplished for those residents who have been affected by the alleged deficient practice. The physician was called on 5/31/2012 for clarification of orders on resident #244. New orders were issued that included weigh every Tuesday and Friday and the physician to review these weights on these same days. The Physician Notification Parameters have been updated on 6/21/2012 and reviewed with all Licensed Nurses to include notification of physician immediately of any sudden unresponsive episode of a resident.	6/22/12

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F 157	Continued From page 2 and not notify the physician. LN #3 explained she thought the nursing supervisor would notify the physician. LN #3 could not remember the name of the nursing supervisor notified on 5/22/12. Interview with LN #2, unit manager, on 6/1/12 at 8:15 AM revealed she was not aware of Resident #244's unresponsiveness and low blood pressure on 5/22/12. LN #2 reported she did not receive notification of the episode and the physician should have been notified. LN #2 explained physician notification would be documented in the nursing notes. Interview with the Assistant Director of Nursing (ADON) on 6/1/12 at 9:50 AM revealed she did not receive notification of Resident #244's unresponsiveness and low blood pressure on 5/22/12. Interview with the physician on 6/1/12 at 11:45 AM revealed notification was expected for Resident #244's drop in blood pressure and period of unresponsiveness Interview with the Director of Nursing (DON) on 6/1/12 at 2:10 PM revealed she expected either the staff nurses or nursing supervisors to notify the physician when a resident's condition changed. 2. Review of physician's orders dated 5/15/12 revealed direction for daily weights, chest x-ray, Lasix (to decrease fluid) 80 milligrams injection to be given now with the physician to check on 5/16/12. Review of a therapeutic left thorancentsis report	F 157	A Memo was issued to all licensed nurses on 6/20/2012 addressing notification parameters for weight changes to the Physician as noted in the Physician Notification Parameters. A new Nursing Internal 24 Hour Report Form was developed to include documentation of physician notifications and significant changes including weights, blood pressure changes allegations of abuse, falls, and infections. This form will be reviewed during the daily standup meetings. The ADoN will check the internal Nursing 24 Hour Reports at least weekly to ensure all MD notifications have occurred. The licensed nurses responsible for failing to notify the physician have both been counseled and re-educated. <u>2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice:</u> Record reviews and staff interviews verified there are no additional significant changes, including significant weight changes and/or unresponsive episodes requiring physician notification. All daily/weekly weights are being reported to the physician.	6/22/12

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F 157	Continued From page 3 dated 5/16/12 revealed successful withdrawal of 1800 milliliters of fluid. Review of the May 2012 Medication Administration Record (MAR) revealed daily documentation of Resident #244's weight measurements from 5/16/12 to 5/30/12. Resident #244's daily weight changes ranged from a loss of 13.8 pounds to a gain of 15.6 pounds. Review of Resident #244's clinical record revealed there was no documentation of physician notification of the weight changes. Interview with LN #1 on 5/31/12 at 11:03 AM revealed she would not notify the physician of weight changes because there was no specific direction. LN #1 explained she would report a significant weight change to the nursing supervisor. LN #1 was not able to provide a definition of a significant weight change. Interview with LN #2, unit manager, on 5/31/12 at 11:15 AM revealed she estimated a significant weight change would be 5 pounds in one day. LN #2 was not aware of Resident #244's weight changes and expected the licensed nurses to inform her or the physician. Interview with the Director of Nursing (DON) on 5/31/12 at 11:19 AM revealed the physician usually specified when notification was required. The DON explained she expected staff to request parameters when the order was obtained. Interview with the physician on 5/31/12 at 11:31 AM revealed she ordered the thorancentesis and her associate, who ordered the daily weights, was	F 157	3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. The Assistant Director of Nursing will audit medical records at least weekly to verify that significant condition changes are being reported appropriately and ensure continued compliance through September 2012. Continuous Quality Improvement (CQI) Quarterly Checklists have been updated for Charge Nurses and DoN for enhanced monitoring. These checklists will be reviewed during quarterly CQI meetings. 4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility's quality assurance system. These measures will be monitored by the Nurse Managers with oversight by the ADoN through the Quality Assurance process from the 24 Hour reports being completed daily. The Director of Nursing Continuous Quality Improvement (CQI) Checklist will report on the measures implemented to the Quality Assurance Committee which will monitor for effectiveness. The Committee will make further	6/22/12

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F 157	Continued From page 4 not available for interview. The physician explained she would expect facility staff either to inform the physician on a daily basis or request parameters. On 5/31/12 at 3:43 PM, the DON provided a physician's order dated 5/31/12 for staff to weigh Resident #244 on Tuesday and Friday and report these weights to the physician.	F 157	recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	Prefix Tag: 225 It is the intent of this facility to not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. This facility will ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source	7/3/2012

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F 225	Continued From page 5 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to submit the 24-Hour Initial Report and 5-Working Day Report to the Health Care Personnel Registry (HCPR) for one (1) of five (5) sampled investigations for allegations of abuse (Resident #244). The findings are: Resident #244 was admitted to the facility with diagnoses which included Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. The admission Minimum Data Set (MDS) dated 4/23/12 assessed Resident #244 as cognitively intact. Review of a social service progress note dated 4/28/12 revealed Social Worker (SW) #1 documented Resident #244's family member reported an allegation of verbal abuse. Review of the facility's investigations of alleged abuse from 5/2011 to 5/2012 revealed there was no submission of a 24 Hour Initial Report and a 5-Working Day Report of the 4/28/12 report of	F 225	and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures. This facility will have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. 1) Corrective action to be accomplished for those residents who have been affected by the alleged deficient practice. A thorough review of Resident #244's chart was completed by the Nursing Home Administrator (NHA) and Social Workers. A 24 hour and 5 day working report were completed for resident #244. It was not substantiated by the facility. The Nursing Home Administrator and Social Workers have reviewed the interpretive guidelines for Tag 225 and this facility's policy and procedure for abuse reporting. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: The administrator verified with staff that there were no other abuse	7/3/2012

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F 225	Continued From page 6 verbal abuse related to Resident #244. During an interview with SW #1 on 6/1/12 at 8:24 AM, SW #1 reported the Administrator should file the 24 Hour Initial Report and the 5-Working Day Report to the HCPR. SW #1 revealed the reports were not filed since there was no investigation conducted. Interview with the Administrator on 6/1/12 at 10:15 AM revealed SW #1 reported the verbal abuse allegation to him. The Administrator explained he submitted all reports and no reports were submitted to the HCPR.	F 225	allegations reported which needed investigation. Any and all future allegations of abuse will be thoroughly investigated and reported timely per this facility's policy. Each Nursing Unit in the Health Center has been educated to use the new investigation notebooks located at each Nurses Unit. These notebooks contain all forms and guidelines to consider and follow when allegations of abuse are reported.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on staff interviews, and record review, the facility failed to conduct an investigation of a verbal abuse allegation and failed to interview staff and residents during investigations of verbal abuse for three (3) of five (5) sampled verbal abuse allegations (Residents #12, #157 and #244). The findings are: Review of the facility's Abuse Prevention, Investigation and Reporting policy revised 2/12/04 revealed the facility's conduction of abuse	F 226	3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. A new notebook entitled Opportunities for Improvement was implemented on June 4, 2012. This notebook is a Grievance Log. This log will include all concerns communicated by residents, family members or staff. All staff have access to this notebook and the ability to log in concerns. The new Nursing Internal 24 Hour Report has been implemented to include abuse allegations and the initiation of the investigation. This will be reported by Nurse Managers in the daily standup meetings. All nurse managers have been educated to begin investigations timely and use a newly created	6/22/12

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F 226	Continued From page 7 investigations include consideration of interviews with the resident, interviews with staff members (on all shifts) having contact with the resident during the period of the alleged incident and a review of all circumstances related to the incident. 1. Resident #244 was admitted to the facility with diagnoses which included Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. The admission Minimum Data Set (MDS) dated 4/23/12 assessed Resident #244 as cognitively intact. Review of a social service progress note dated 4/28/12 revealed Social Worker (SW) #1 documented Resident #244's family member reported an allegation of verbal abuse. SW #1 documented the allegation could not be investigated since Resident #244 could not provide specific details of the staff member. Interview with SW #1 on 6/1/21 at 8:24 AM revealed she interviewed Resident #244 and the allegation was not investigated. Interview with the Administrator on 6/1/12 at 10:15 AM revealed SW #1 informed him of the allegation. The Administrator reported an investigation was not conducted. 2. Review of a 24 Hour Initial Report dated 10/28/11 and 5-Working Day Report dated 11/3/12 revealed Resident #12 alleged a nursing assistant spoke to her in a hateful manner. Resident #12 provided a staff name. Review of the facility's investigation revealed a written statement by the nursing assistant. There was no documentation of additional resident or staff	F 226	notebook with a checklist to consider and use when initiating an investigation. This checklist gives step by step instructions for staff to consider including completing head to toe assessments, environmental checks of the area where the allegation was made, and who to notify when an allegation is made. The notebook also includes forms to be used when gathering witness statements. The Continuous Quality Improvement (CQI) checklist was updated for the Administrator to enhance monitoring. This checklist will be reviewed during quarterly CQI meetings. 4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility's quality assurance system. These measures will be monitored by the Administrator through the Quality Assurance process. The Administrator will report on the measures implemented to the Quality Assurance Committee which will monitor for effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted on in a timely manner.	6/21/12

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F 226	Continued From page 8 interviews. The allegation was unsubstantiated. Interview with the Administrator at 10:20 AM on 6/1/12 revealed he and SW #1 conduct investigations together. The Administrator reported no other staff or residents were interviewed during the investigation. The Administrator explained Resident #12 was new to the facility at the time of the allegation. In his estimation, adjustment to the facility's rules caused the allegation and there was not a need to conduct a full investigation. 3. Review of a 24 Hour Initial Report dated 2/6/12 and 5-Working Day Report dated 2/10/12 revealed Resident #157's family member alleged observation of rude and condescending behavior by a named nursing assistant. Review of the facility's investigation revealed a written statement by the nursing assistant. There was no documentation of additional resident or staff interviews. The allegation was unsubstantiated. Interview with the Administrator on 6/1/12 at 10:23 AM about 2/12/12 revealed no other staff or resident interviews were conducted during the investigation.	F 226	Prefix Tag:226 It is the intent of this facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 1) Corrective action to be accomplished for those residents who have been affected by the alleged deficient practice. The named residents and or their family members as identified were interviewed as a follow up to the verbal abuse allegations. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: The administrator verified that there are no other abuse allegations requiring additional interviewing for the investigations. Forms have been created to help question residents and family members who report abuse to ensure thorough investigations are being completed for all allegations. This forms also include a Nurse assessment to be completed for physical abuse allegations.	6/22/12
F 279 SS=D	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	F 279		

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F 279	Continued From page 9 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 medical record review and staff interview the facility failed to develop a plan of care implementing measures to prevent a pressure ulcer related to a leg immobilizer and oxygen therapy for two (2) of thirty-eight (38) resident care plans reviewed, Resident #99 and Resident #244. The findings are: Resident #99 was admitted to the facility on 4/06/12 with the diagnoses of right tibial fracture, congestive heart failure and osteoporosis. Review of the Resident #99's most recent Minimum Data Set (MDS) for a significant change assessed her as being cognitively intact. Physician consult dated 4/12/12, revealed the following orders: 1.Observation and nonweightbearing on the right lower extremity. 2. Work on range of motion to full extension as well as flexion to tolerance. 3. Otherwise she will	F 279	3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. A Checklist Tool for investigations has been implemented to ensure compliance with established abuse investigation protocols. The internal Nursing 24 hour report form has been implemented as a means of communicating new allegations of abuse during the daily standup meeting. The CQI checklist has been updated for the administrator for enhanced monitoring and will be reviewed during quarterly CQI meetings.. 4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility's quality assurance system. These measures will be monitored by the Administrator through the Quality Assurance process. The Administrator will report on the measures implemented to the Quality Assurance Committee which will monitor for effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see	6/22/12

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F 279	Continued From page 10 remain in the knee immobilizer except for range of motion and bathing. Resident #99's Care Area Assessment (CAA) dated 4/17/12 read in part, "Hemoglobin of 8.9 adds to her risk and susceptibility to skin complications. Also to consider is the leg immobilizer she is currently wearing and the potential also for it to cause pressure/friction. She will need frequent repositioning in wheelchair and bed, routine checks for incontinence and toileting opportunities. Also regular skin checks for any indication of pressure and prompt intervention to prevent skin breakdown. This area will most likely prove the most challenging in what will be an extended period of limited mobility. Proceed to care plan." Review of Resident #99's care plan dated 4/20/12 revealed no focus on the leg immobilizer nor was the leg immobilizer mentioned. An interview was conducted on 6/01/12 at 2:10 PM with the LN #6, who worked with MDS assessments. She stated the unit manager is responsible for reading the CAA and then writing the care plan. She further stated the immobilizer should have been on the care plan because it would be a special care area. An interview was conducted on 6/01/12 at 2:15 PM with the Unit Manager. She reported she should have looked at the CAA prior to writing the care plan and the immobilizer should have been care planned. She could not offer an explanation why she did not mention the immobilizer in the care plan.	F 279	that recommendations are acted upon in a timely manner. Prefix Tag: 279 It is the intent of this facility to use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. 1) Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice. In-service review was conducted on 6/18/2012 by this facility's MDS Coordinator for Unit Manager RNs who are responsible for writing care-plans. This review stressed the importance of using the CAAs as a foundation for the development of individualized care-plans. The Care plans for residents #244 and #99 have been updated and reflect the CAAs. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: Unit Nurse managers reviewed all charts on their unit on 6/20/2012 to validate CAAs are reflected in all care plans.	6/22/12

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F 279	Continued From page 11 2. Resident #244 was admitted to the facility with diagnoses which included Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. Admission physician's orders dated 4/16/12 included continuous oxygen administration at 2 Liters per minute. Review of Resident #244's admission Minimum Data Set (MDS) dated 4/23/12 assessed Resident #244 as cognitively intact. The admission MDS listed Resident #244 required oxygen therapy and was short of breath when sitting or at rest. Review of the Care Area Assessment (CAA) for vision dated 4/26/12 revealed documentation of respiratory difficulty which required use of a Bi-level Positive Airway Pressure (BIPAP) machine with continued oxygen dependence. Review of the CAA for falls dated 4/26/12 revealed documentation of oxygen supplied via tubing which may pose a risk for falls. Review of the CAA for pain dated 4/26/12 revealed documentation Resident #244 reported fluid on the lungs caused pain. Review of Resident #244's care plan dated 4/30/12 revealed there was no documentation of Resident #244's respiratory status, BIPAP use and oxygen therapy. During an interview on 5/30/12 at 4:31 PM, Resident #244 explained she was received oxygen continuously. During this interview, Resident #244 appeared short of breath. Resident #244 reported she frequently felt out of	F 279	3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. The Care Plan Meeting/Participation Summary was updated on 6/20/2012 to reflect review of the Care Plan to ensure it is reflective of the CAAs during the Care Plan meeting. The CQI checklist for the MDS coordinator was updated to reflect enhanced monitoring and will be reviewed during quarterly CQI meetings.. 4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility's quality assurance system. These measures will be monitored by the MDS Coordinator with oversight by the Administrator through the Quality Assurance process. The MDS Coordinator will report on the measures implemented to the Quality Assurance Committee which will monitor for effectiveness for 6 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	6/27/12

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F 279	Continued From page 12 breath. Resident #244 received oxygen at 2 L/min via a nasal cannula. Interview with Licensed Nurse (LN) #1 on 5/31/12 at 11:03 AM revealed Resident #244 used continuous oxygen and was short of breath when resting. Interview with the Minimum Data Set Nurse #1 on 6/1/12 at 9:53 AM revealed she documented Resident #244's assessments on the CAAs and the unit manager developed the care plan. Interview with LN #2, the unit manager, on 6/1/12 at 11:55 AM revealed Resident #244's respiratory needs and oxygen therapy should have been address on the care plan. LN #2 reported the omission was an error.	F 279		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record reviews facility staff failed to provide nail care to one (1) of three (3) sampled residents observed for activities of daily living. (Resident #148) The findings are:	F 312	Prefix Tag: 312 It is the intent of this facility to carry out activities of daily living and provide services to maintain good nutrition, grooming, and personal and oral hygiene. 1) Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice. The necessary nail care was provided to resident #148. In-service	6/22/12

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F 312	Continued From page 13 A review of a facility policy titled "Fingernails/Toenails, Care of" dated 10/25/02 indicated nail care included daily cleaning and regular trimming. The following information should be reported to the staff/charge nurse and should be documented in the resident's medical record if abnormalities are noted: 1. The date and time the procedure was performed. 2. The name and title of the individual who performed the procedure. 3. The condition of the resident's nails and nail bed. 4. Any problems or complaints made by the resident related to the procedure. 5. If the resident refused the procedure, the reason(s) why. 6. The signature and title of the person recording the data. Resident #148 was admitted with diagnoses including high blood pressure, glaucoma, arthritis and anxiety. The most recent quarterly Minimum Data Set dated 4/12/12 indicated impairment in short and long term memory and moderate impairment in cognition for daily decision making. The MDS also indicated Resident #148 required extensive assistance by staff for personal hygiene and and was totally dependent on staff for bathing. A review of a care plan titled Activities of Daily Living (ADL's) dated 9/1/10 indicated a problem statement that Resident #148 needed moderate assistance with her ADL's due to cognitive impairment and impaired ambulation. The goals	F 312	education was conducted on each Unit for Nursing Assistants. Documentation is completed on the back of the Kardex for those residents who refuse a procedure including why the procedure was not completed. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: Compliance rounds were completed on each unit on 6/20-21/2012 to ensure all nails have been trimmed and cleaned appropriately. 3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. Charge Nurses from each hall will be responsible for weekly compliance rounds to ensure proper nail care has been provided and documented appropriately. The CQI checklist for Charge Nurse and CNA have been updated for enhanced monitoring and will be reviewed during quarterly CQI meetings.. 4) Facility's plan to monitor its performance so solutions are	6/22/12

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F 312	Continued From page 14 indicated the resident would assist with performing her ADL's for the next ninety (90) days as of 7/31/12. Approaches included to provide a bath or shower twice weekly and as needed, assist with dressing, grooming and oral care daily and allow resident to participate in care as much as possible. A review of a document titled "Resident Care Kardex" and undated for Resident #148 indicated under the section for grooming: "Nail Care (Clean as needed; Trim finger/toenails of non-diabetics prn (as needed); alert nurse if diabetic nails need trimming)." A review of a document titled "Bath Type Detail Report" revealed Resident #148 had a bath on 5/28/12 at 7:47 AM, a shower on 5/29/12 at 11:16 AM and a shower on 5/31/12 at 5:27 PM. During an observation on 05/30/12 at 8:57 AM Resident #148 was sitting in her wheelchair in her room with her hands resting in her lap and her fingernails on both hands were long and uneven with brown debris under the nails of both index fingers and both thumb nails. During an observation on 5/31/12 at 7:53 AM Resident #148 was sitting in her wheelchair in her room with her head bent forward and clutching her hands and fingers together and her fingernails on both hands were long and uneven with brown debris under the nails of both index fingers and both thumb nails. During an interview on 5/31/12 at 9:35 AM Nursing Assistant (NA) #1 stated nursing assistants usually did nail care for residents when	F 312	sustained and integrated into the facility's quality assurance system. These measures will be monitored by the Charge Nurse on each hall with oversight by the Administrator through the Quality Assurance process and completion of quarterly CQI checklists. The administrator will report on the measures implemented to the Quality Assurance Committee which will monitor for effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	6/27/12

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F 312	Continued From page 15 they had their shower or bath. During an interview on 5/31/12 at 10:00 AM with NA #2 she stated she was very familiar with Resident #148's care and the resident was cooperative with care and would let staff do whatever they needed to do for her. NA #2 verified Resident #148 received a shower twice per week on Tuesday and Thursday and a bath in between as needed. During an observation on 5/31/12 at 4:45 PM Resident #148 was sitting in her wheelchair in the hallway and had her hands resting on her lap. The fingernails on both hands were long and uneven with brown debris under the nails of both index fingers and both thumb nails. During an observation on 6/1/12 at 8:55 AM Resident #148 was sitting in her wheelchair in her room eating breakfast. The fingernails on both hands were long and uneven with brown debris under the nails of both index fingers and both thumb nails. During an interview on 6/1/12 at 10:36 AM with NA #2 she explained if she saw nail care needed to be done for a resident she did it but it was usually done during their shower or bath. She further explained the nursing assistants did not document when nail care was done or not done. NA #2 verified Resident #148's fingernails were long, several nails were broken off and there was brown debris under both index fingers and both thumb nails. During an interview on 6/1/12 at 10:57 AM the Nurse Manager explained residents had nail care	F 312		

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F 312	Continued From page 16 usually during their bath or shower and stated it was her expectation nails should be cleaned daily according to the facility policy. She further stated she could not provide documentation when Resident #148's nail care was done or not done because their documentation system did not provide a specific place for them to document nail care. During an interview on 6/1/12 at 3:24 PM the Director of Nursing (DON) stated it was her expectation nursing staff should follow the facility policy for nail care and resident's nails should be kept clean and trimmed. She further stated she expected nursing assistants to communicate with their charge nurse if they could not provide nail care to a resident and the charge nurse should document the information in the nurse's notes.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, medical record review and staff interviews the facility staff failed to implement care measures to prevent a pressure ulcer from developing for one (1) of four (4)	F 314	Prefix Tag: 314 It is the intent of this facility to ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing; prevent infection and prevent new sores from developing. 1) Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice. Resident #99 care plan was updated to reflect approaches to prevent additional pressure ulcers from developing. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice:	6/22/12

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F 314	Continued From page 17 residents reviewed with pressure ulcers, Resident #99. The findings are: Resident #99 was admitted to the facility on 4/06/12 with the diagnoses of right tibial fracture, congestive heart failure and osteoporosis. Resident #99's most recent Minimum Data Set for significant change dated 05/18/12 assessed her as being cognitively intact. The physical therapy initial assessment dated 4/7/12 was reviewed and read in part, "Precautions: non weight bearing right lower extremity, use knee immobilizer at all times, skin bruises and tears easily." Review of the Weekly Skin Assessment Detail Report completed by nursing dated 4/9/12 revealed there was no new skin problem. A Physician consult dated 4/12/12, revealed the following orders: 1.Observation and nonweightbearing on the right lower extremity. 2. Work on range of motion to full extension as well as flexion to tolerance. 3. Otherwise she will remain in the knee immobilizer except for range of motion and bathing. Resident #99's Braden Scale (scale used to assess risk for skin breakdown) dated 4/13/12 was scored at fourteen (14). Review of the Braden Scale revealed a score of twelve (12) or less represents high risk for skin breakdown. Review of the Weekly Skin Assessment Detail Report completed by nursing dated 4/16/12	F 314	All Residents with splints have been assessed for care measures to prevent pressure ulcers. Care plans have been reviewed to ensure they appropriately address factors contributing to risks of pressure ulcers. 3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. Care Traker's weekly skin assessment language has been clarified to read "New skin problems in last 7 days" instead of "New Skin problems." Charge Nurses will enter information daily on the new Internal Nursing 24 Hour Report which identifies any new skin issues for residents. A Standard Care Plan for residents at high risk for skin breakdown was implemented. Quality Improvement Action Team for Wound Care and Skin Assessments has been implemented beginning 6/21/2012. This Team consists of all Nurse Unit Managers, the Treatment Nurse, DoN, ADoN, and Dietary Director. This Team meets weekly to discuss all residents with wounds and their status to include improvement or decline. Interventions for improvement of wounds are considered as part of this meeting.	6/22/12

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F 314	Continued From page 18 revealed there were no new skin problems. Resident #99's Care Area Assessment (CAA) dated 4/17/12 read in part, "Hemoglobin of 8.9 adds to her risk and susceptibility to skin complications. Also to consider is the leg immobilizer she is currently wearing and the potential also for it to cause pressure/friction. She will need frequent repositioning in wheelchair and bed, routine checks for incontinence and toileting opportunities. Also regular skin checks for any indication of pressure and prompt intervention to prevent skin breakdown. This area will most likely prove the most challenging in what will be an extended period of limited mobility. Proceed to care plan." Review of physical therapy notes dated 4/19/12 read in part: "Today patient complained of right lower extremity pain and discomfort. Knee brace was strapped too tight. Physical therapy assistant (PTA) discovered an open blister at heel cord of right lower extremity and several blood blisters up lateral side of right lower extremity. Nursing notified and PTA (Physical Therapy Assistant) showed nursing areas." Review of nursing notes dated 4/19/12 read in part, "1 X 1 (one by one) centimeter (cm) dark red fluid filled blister noted on right lower lateral calf and 1 X 1 (one by one) cm dark red fluid filled blister noted on right lower posterior calf. Resident denies pain. No drainage noted from areas. Areas left open to air. Right leg immobilizer padded with a towel for protection of blisters." Review of physical therapy notes dated 4/20/12	F 314	The CQI checklist for CNA addresses skin breakdown, reporting responsibilities and skin care protocols for enhanced monitoring and will be reviewed during the quarterly CQI meetings. 4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility's quality assurance system. These measures will be monitored by Unit Nurse Managers, DoN, and ADoN with oversight by the Administrator through the Quality Assurance process. The Team will report on the measures implemented to the CQI Committee which will monitor for effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	6/22/12

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F 314	Continued From page 19	F 314		

read in part: "Blister areas on right lower extremity without dressing. Nursing notified again today and also shown the areas of interest."

Resident #99's care plan dated 4/20/12 indicated she was at risk for pressure ulcers due to immobility. The goal was she would not develop any pressure ulcers for ninety (90) days. Interventions included monitor skin daily with activities of daily living, bathe twice per wk and frequently reposition in bed and chair. There was no mention of the leg immobilizer in the care plan or the resident's leg wound.

Review of the Weekly Skin Assessment Detail Report completed by nursing dated 4/23/12 revealed there was no new skin problem.

Review of the Nursing Discharge Summary dated 4/30/12, revealed Resident #99 was discharged to the hospital emergency room. This form completed prior to the resident being sent to the hospital, read in part, "Skin Conditions: left upper arm skin tear." There was no mention of the wound on Resident #99's right lower leg. The discharge summary was signed by the Unit Manager.

An interview was conducted on 6/1/12 at 8:38 AM with Licensed Nursed (LN) #4 who is a certified wound nurse. She stated that the resident came here because she had a right tibial fracture. She stated the resident went back to the hospital and when she returned from the hospital she had a wound on her right lower leg. She reported the wound measured 15 X 3.6 cm. She stated she had not seen the resident prior to her readmission to the facility on 5/3/12. She further reported that

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F 314	Continued From page 20 an immobilizer has to be taken off everyday and the skin inspected. She specified necrosis can develop with that type of fracture. She stated checking the skin is a standard of care. An interview was conducted on 6/1/12 10:26 AM with Physical Therapy Assistant (PTA) #1. She stated that on 4/19/12 while providing range of motion exercises for Resident #99 she felt her leg was wet and saw that she had a blister on right lower lateral aspect of her leg. She reported there were other blisters as well in this area of her leg. She specified she reported this to the LN #6 who was caring for Resident #99 that day. She stated when the resident came back for physical therapy the next day she did not have a dressing on her leg. She stated she told nursing about the wounds again. She reported she told her supervisor on 4/26/12 that the wounds were getting worse. An observation was made on 6/1/12 at 12:40 PM LN #4 performing a dressing change to Resident #99's right lower extremity wound. The wound measured 9 X 1.5 X 0.4 cm. with 2.5 cm of tendon showing. The wound was cleaned with normal saline, a clear dressing was applied to the area around the wound and ointment was applied to the wound bed. The showing tendon was covered with white foam dressing and black granufoam was inserted into the wound bed, covered with a clear dressing and the wound vac was attached. During the dressing change on 6/1/12 at 12:40 PM LN #4 explained she is usually notified if a blister is found on a resident. She further reported that a clear blister is automatically a stage II	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 21 pressure ulcer and a bloody blister is automatically a stage III pressure ulcer. An interview was conducted on 6/1/12 at 1:17 PM with the Unit Manager she stated she did not assess the wound blisters when she learned of them. She stated the wound nurse should have been notified. She further stated she could have missed the wounds on Resident #99's leg when she filled out the discharge summary. She further reported she wrote Resident #99's care plan. She stated the care plan should have involved specific care regarding the leg immobilizer. An interview was conducted on 6/1/12 at 1:26 PM with the Assistant Director of Nursing. She stated that when a wound was discovered it should be reported to the wound nurse. An interview was conducted on 6/1/12 at 2:57 PM with the Director of Nursing (DON). The DON stated her expectation was that skin assessments were done. When a wound was found she expected there would be communication between staff that needed to know. She stated she was never informed when the wounds were originally found on 4/19/12. She stated her expectation was for the Nurse Manager to report the wound during the morning stand up meeting. She stated she thought that when Resident #99 returned from the hospital that it was a new wound. She stated the process broke down when the wound was not reported originally in morning stand up. She would have expected for skin checks to have been done daily. She stated a dressing should have been applied per wound care protocol.	F 314		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(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 328	Continued From page 22 The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, staff and physician interviews and record review, the facility failed to monitor oxygen saturation levels for one (1) of three (3) sampled residents who received oxygen therapy (Resident #244). The findings are: Resident #244 was admitted to the facility with diagnoses which included Congestive Heart Failure and Chronic Obstructive Pulmonary Disease. Admission physician's orders dated 4/16/12 included continuous oxygen administration at 2 Liters per minute. Review of Resident #244's admission Minimum Data Set (MDS) dated 4/23/12 assessed Resident #244 as cognitively intact. The admission MDS listed Resident #244 required oxygen therapy and was short of breath when sitting or at rest. The care plan dated 4/30/12 did not include oxygen therapy.	F 328	Prefix Tag:328 It is the intent of this facility to ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. 1) Corrective action to be accomplished for those residents to have been affected by the alleged deficient practice. The residents care plan was updated to address respiratory needs and oxygen therapy. The resident's O2 stats are being checked daily per MD clarification orders. 2) Corrective action to be accomplished for those residents having potential to be affected by the same alleged deficient practice: Chart checks were implemented beginning 6/1/2012 to identify possible physician orders that have not been noted. Therapy staff were educated on 5/31/2012 to not remove charts from specified areas until all new orders have been noted.	6/22/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345161	A. BUILDING _____ B. WING _____	C 06/01/2012

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F 328	Continued From page 23 Review of physician's orders dated 5/16/12 revealed direction to titrate Resident #244's oxygen to keep the oxygen saturation level at 88% or above. Review of the May 2012 Medication Administration Record (MAR) revealed a handwritten FYI (for your information) with instructions for oxygen titration to keep oxygen saturation level at 88% or above. There was no documentation of Resident #244's oxygen saturation levels on the MAR. Review of Resident #244's May 2012 respiratory form revealed there were no documented oxygen saturation levels. Review of nursing notes revealed the following documentation of oxygen saturation levels: · 5/16/12: Night shift documented an oxygen saturation level of 82% to 83% and no complaint of respiratory difficulty. · 5/16/12: Day shift documented an 88% O2 saturation level and evening shift documented 90% O2 saturation level with adjustment of oxygen at 2 to 3 L/min. · 5/17/12: Night shift documented 90%, day shift documented 92% and evening shift documented 94%. · 5/22/12: 90% and 93% on day shift and 92% on evening shift. During an interview on 5/30/12 at 4:31 PM, Resident #244 explained she was received oxygen continuously. During this interview, Resident #244 appeared short of breath. Resident #244 reported she frequently felt out of	F 328	In-service education was completed for licensed nurses on 6/22/2012 regarding Respiratory Policies and Procedures, How to titrate O2, and How to chart O2 stats. 3) Measures to be put into place or systemic changes made to ensure that the alleged deficient practice will not occur. The 24 hour report has had an addition to require physician notification for O2 stats less than 88% unless the resident already has a different order. The CQI checklist for Charge Nurses was updated to address monitoring for O2 saturation levels. 4) Facility's plan to monitor its performance so solutions are sustained and integrated into the facility's quality assurance system. These measures will be monitored by the ADoN from the 24 hour report with oversight by the Administrator through the Quality Assurance process. The ADoN will report on the measures implemented to the Quality Assurance Committee which will monitor for effectiveness for a minimum of 6 months. The Committee will make further recommendations to adjust the	6/22/12

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F 328	Continued From page 24 breath. Interview with Resident #244 on 5/31/12 at 9:52 AM revealed the facility staff did not check her oxygen saturation level regularly but would if she requested or became more short of breath. At this time, Resident #244 requested Licensed Nurse (LN) #1 to check her oxygen saturation level which was 89%. Interview with LN #1 on 5/31/12 at 11:03 AM revealed she did not measure Resident #244's oxygen saturation level because there was no physician's order to check it regularly. LN #1 explained she would measure the oxygen saturation level if Resident #244 showed symptoms of respiratory distress. Interview with LN #2, the unit manager, on 5/31/12 at 11:15 AM revealed oxygen saturation levels should be checked every shift when parameters are ordered. LN #2 explained oxygen saturation levels would be checked in the event of respiratory difficulty. LN #2 reported routine oxygen saturation levels were not obtained for Resident #244. Interview with the Director of Nursing (DON) on 5/31/12 at 11:19 AM revealed she expected Resident #244's oxygen saturation levels to be checked every shift. The DON explained the oxygen saturation levels should be documented on the respiratory form. Interview with the physician on 5/31/12 at 11:31 AM revealed she expected Resident #244's oxygen saturation level to be checked every shift.	F 328	measures as needed. The Administrator is responsible to see that recommendations are acted upon in a timely manner.	6/22/2012