OCT 12 2012 OCT 12 2012

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

PRINTED: 08/24/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345298	A. BUILDING _____ B. WING _____	C 08/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTINGTON HEALTH CARE	311 S CAMPBELL ST BURGAW, NC 28425

(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 164 SS=G	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview the facility failed to provide full visual privacy when providing direct care for 1 of 3 residents (Resident #47) observed receiving personal care.	F 164	Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 9/20/12 survey. It does not constitute an agreement or admission by Huntington Health Care of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiency. The facility reserves all rights to contest the deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction (and the attached documents) also functions as the facility's credible allegation of compliance. F164 For Resident #47: • The CNA who failed to provide care to resident #47 in compliance with facility and regulatory standards was suspended on 9/15/12 followed by termination of employment on 9/21/12. • The social services director spoke with resident #47 to assure his needs were meet timely and to resident #47's satisfaction. • A body audit was done on resident #47 to assess for excoriation and/or skin breakdown and also assessed was the resident's catheter. This was completed on 9/19/12. F164 For resident #47 and all other in-house residents and new admissions: • In-servicing for all RN's, LPN's, and CNA's began on 9/17/12 that included providing privacy and maintaining dignity during administration of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 10/12/12

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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	345288	A. BUILDING _____ B. WING _____	C 09/20/2012

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HUNTINGTON HEALTH CARE	311 S CAMPBELL ST BURGAW, NC 28425

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F 184	Continued From page 1 Findings include: A review of the facility policy for Quality of life - " Perineal Care " dated September 15, 2011 read in part, " 5. Fold the sheet down to the lower part of the body. Cover the upper torso with a sheet. 6. Raise the gown or lower the pajamas. Avoid unnecessary exposure of the resident ' s body. " Resident #47 was admitted to the facility on 10/28/11 with diagnoses of hypertension, anemia, benign prostatic hyperplasia (BPH), prostate cancer, congestive heart failure, and hypothyroidism. Record review of the resident's most recent quarterly Minimum Data Set (MDS) assessment dated 7/1/12 and annual MDS dated 4/2/12 revealed on his brief interview for mental status (BIMS) he scored a 12 meaning he was alert and oriented and was interviewable. Resident #47 required extensive assistance for toilet use and had a catheter for urine elimination due to obstructive uropathy. Review of Resident # 47's Care Area Assessment (CAA) summary dated 4/18/12 revealed he required extensive assistance with activities of daily living (ADL). Resident #47 was involved in his personal care and was incontinent of bowel and had a urinary catheter in place for obstructive uropathy. He could alert staff of toileting needs, however when staff went into assist him, he would have already had an incontinent episode. A review of the resident care plan dated 4/23/12	F 184	Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 9/20/12 survey. It does not constitute an agreement or admission by Huntington Health Care of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiency. The facility reserves all rights to contest the deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction (and the attached documents) also functions as the facility's credible allegation of compliance. personal care, provision of care in a timely manner to assure that resident's needs are met, foley catheter maintenance, provision of care in a timely manner, appropriate and timely reporting of abnormal findings, and correct procedures for handling dirty linen. • Based on most recent MDS assessments a listing of ADL dependent residents, and residents with catheters will be compiled. MDS coordinator will supply list to the DON. This list will be divided into interviewable and non-interviewable residents for inclusion on an appropriate audit form. The nurse in charge on each unit will complete this portion. • Daily audits will be performed through resident interviews and observations to assure that care is provided in a manner to comply with facility and regulatory standards related to privacy during personal, timeliness of incontinence care, catheter care, and proper handling	

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F 164	Continued From page 2 revealed he required extensive assistance with ADL care. An intervention was to check Resident #47 every 2 hours to ensure he was comfortable and well positioned and to provide assistance for all toileting needs. On 9/19/12 at 4:08 pm Resident #47 was observed in his room with a strong urine odor. Resident #47 was asked if he was dry and he stated he was. The resident ' s nursing assistant (NA#1) was observed entering the resident ' s room. Resident #47 was observed lying on his back and NA#1 was observed pulling up the resident ' s gown to his chest and pulling the covers down exposing his genital area down to his legs. NA#1 was observed cleaning the resident's front including his genital area with a wash cloth and then rinsing and drying the resident with a towel. Nursing Assistant #2 was observed knocking on the door and immediately entering the resident's room at 4:19 pm. When he opened the door NA #1 did not cover the resident exposing his genital area down to his legs. Other facility staff were observed walking down the hall while the door was opened. NA #2 was observed helping NA#1 roll the resident on his right side to clean his bottom. NA#1 washed his bottom and rinsed him. NA #1 stated she did not have enough wash cloths and was observed walking out of the resident ' s room. The door was opened and facility staff were observed walking down the hall. The resident remained uncovered while the door was opened. NA#1 was observed re-entering the resident's room with the resident remaining uncovered. During an interview on 9/19/12 at 4:50 pm NA#1 stated she did leave Mr. Lawrence uncovered	F 164	Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 9/20/12 survey. It does not constitute an agreement or admission by Huntington Health Care of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiency. The facility reserves all rights to contest the deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction (and the attached documents) also functions as the facility's credible allegation of compliance. of dirty linens. Audits will be divided among all shifts to assure 100% of identified residents are assessed weekly until the QA committee determines substantial compliance. • Orientation for new hires within the nursing dept. will continue to include discussions of resident's rights and facility policies related to providing privacy during personal care, maintaining dignity, timeliness of care, care of foley catheters to include reporting problems, and safe handling of dirty linens. • All ADL dependent residents and catheter residents will be audited to monitor compliance. Audits will be performed by the nurse in charge, medication nurses, and treatment nurses. The social services director will perform a % of inter-viewable resident audits on his/her scheduled work days. This will be in addition to the nursing audits. These audits will be a part of the QA process for the facility. The audits will be conducted weekly, then monthly, and then quarterly thereafter until the QA committee feels our goals have been meet.	

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F 164	Continued From page 3 when she left the room and when NA #2 entered the room. During an interview on 9/20/12 at 9:05 am, Resident #47 stated, " It was quite embarrassing to be exposed to so many people. " During an interview on 9/20/12 9:36am, the Director of Nursing (DON) stated she expected staff to maintain patient privacy. Whenever staff are providing care, a resident should be covered to avoid unnecessary exposure of the resident ' s body. During an interview on 9/21/12 at 9:30 am, NA#2 stated he knew to provide privacy when entering a room, but there were so many staff coming in and out he did not have time to cover the resident.	F 164	Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 9/20/12 survey. It does not constitute an agreement or admission by Huntington Health Care of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiency. The facility reserves all rights to contest the deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction (and the attached documents) also functions as the facility's credible allegation of compliance. • Daily during M-F morning meetings the nurse in charge will discuss results of audits. Areas of concern will be identified and appropriate interventions taken, e.g., 1 on 1 in-servicing, employee counselling etc. • Once the QA committee under the direction of the Administrator determines that substantial compliance has been obtained on-going monitoring will be determined by the committee to include frequency and % of residents to be audited	
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 record review, observation and interviews the facility failed to provide personal hygiene care for 1 of 2 residents (Resident #47) observed receiving care. Findings include:	F 312		10/12/12

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	345296	A. BUILDING _____ B. WING _____	C 09/20/2012

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F 312	Continued From page 4 Resident #47 was admitted to the facility on 10/29/11 with diagnoses of hypertension, anemia, benign prostatic hyperplasia (BPH), prostate cancer, congestive heart failure, and hypothyroidism. Record review of the Resident's most recent quarterly Minimum Data Set (MDS) assessment dated 7/1/12 and annual MDS dated 4/2/12 revealed on his brief interview for mental status he scored a 12 meaning he was alert and oriented and was interviewable. Resident #47 required extensive assistance for toilet use and had a catheter for urine elimination due to obstructive uropathy. Review of Resident # 47's Care Area Assessment (CAA) summary dated 4/16/12 revealed he required extensive assistance with activities of daily living (ADL). Resident #47 was involved in his personal care and was incontinent of bowel and had a urinary catheter in place for obstructive uropathy. He could alert staff of toileting needs, however when staff went into assist him, he would have already had an incontinent episode. A review of the resident care plan dated 4/23/12 revealed he required extensive assistance with ADL care. An intervention was to check Resident #47 every 2 hours to ensure he was comfortable and well positioned and to provide assistance for all toileting needs. On 9/18/12 at 4:08 pm Resident #47 was observed in his room with a strong urine odor. The resident's nursing assistant (NA#1) was observed entering the resident's room. Resident	F 312	F312 For Resident #47: • The CNA who failed to provide care to resident #47 in compliance with facility and regulatory standards was suspended on 9/15/12 followed by termination of employment on 9/21/12. • The social services director spoke with resident #47 to assure his needs were meet timely and to resident #47's satisfaction. • A body audit was done on resident #47 to assess for excoriation and/or skin breakdown and also assessed was the resident's catheter. This was completed on 9/19/12. F312 For resident #47 and all other in-house residents and new admissions: • In-servicing for all RN's, LPN's, and CNA's began on 9/17/12 that included providing privacy and maintaining dignity during administration of personal care, provision of care in a timely manner to assure that resident's needs are met, foley catheter	

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F 312	Continued From page 6 #47 was observed lying on his back and NA#1 removed a yellow stained towel from the resident's groin area and placed the soiled towel on the floor. NA#1 was observed cleaning the resident's front including his genital area with a wash cloth and then rinsing and drying the resident with a towel. Nursing Assistant #2 was observed entering the resident's room at 4:19 pm. NA #2 was observed helping NA#1 roll the resident on his right side to clean his bottom. Resident #47 was observed being turned on his left side and a soiled pad under the resident's shoulders to midway his thighs was observed with a large dark yellow brown ring that included the entire pad, with a strong urine odor. The soiled pad was placed in a plastic bag on the floor. The soiled linen was bagged and taken to the soiled linen room. During an observation on 9/19/12 at 4:25 pm, Nurse #1 entered the soiled linen room. During an interview on 9/19/12 at 4:25 pm, Nurse #1, after observing the soiled linen pad from Resident #47's bottom, stated the pad was saturated with urine and there was a dark yellow brown circle from the top of the pad to the bottom of the pad. She stated there was a strong urine odor. During an interview on 9/19/12 at 4:50 pm NA#1 stated she did smell a strong urine odor when entering Resident #47's room. She stated she thought staff had spilled some urine on the floor when emptying the resident ' s catheter. NA#1 stated she had been in Resident #47 's room several times during her shift and this was the first time she had found him to be wet with urine. She stated he did have a catheter and she did not know it was leaking.	F 312	Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 9/20/12 survey. It does not constitute an agreement or admission by Huntington Health Care of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiency. The facility reserves all rights to contest the deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction (and the attached documents) also functions as the facility's credible allegation of compliance. • maintenance, provision of care in a timely manner, appropriate and timely reporting of abnormal findings, and correct procedures for handling dirty linen. • Based on most recent MDS assessments a listing of ADL dependent residents, and residents with catheters will be compiled. MDS coordinator will supply list to the DON. This list will be divided into inter-viewable and non-interviewable residents for inclusion on an appropriate audit form. The nurse in charge on each unit will complete this portion. • Daily audits will be performed through resident interviews and observations to assure that care is provided in a manner to comply with facility and regulatory standards related to privacy during personal, timeliness of incontinence care, catheter care, and proper handling of dirty linens. Audits will be divided among all shifts to assure 100% of identified residents are assessed weekly until the QA committee determines substantial compliance.	

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F 312	Continued From page 6 During an interview on 9/20/12 8:35am, the Director of Nursing (DON) stated her expectations for the Resident #47 having a urine soaked pad would be that that should not have ever happened. The DON stated NA#1 told her the resident was alert and oriented and he did not use his call bell to let her know he was wet. The DON further stated NA#1 knew that incontinent rounds were done every two hours. Resident #47 had a catheter and he should have been checked every two hours. NA#1 should have checked the pad to make sure it was dry.	F 312	Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 9/20/12 survey. It does not constitute an agreement or admission by Huntington Health Care of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiency. The facility reserves all rights to contest the deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction (and the attached documents) also functions as the facility's credible allegation of compliance.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441	• Orientation for new hires within the nursing dept. will continue to include discussions of resident's rights and facility policies related to providing privacy during personal care, maintaining dignity, timeliness of care, care of foley catheters to include reporting problems, and safe handling of dirty linens. • All ADL dependent residents and catheter residents will be audited to monitor compliance. Audits will be performed by the nurse in charge, medication nurses, and treatment nurses. The social services director will perform a % of inter-viewable resident audits on his/her scheduled work days. This will be in addition to the nursing audits. These audits will be a part of the QA process for the facility. The audits will be conducted weekly, then monthly, and then quarterly thereafter until the QA committee feels our goals have been meet.	

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F 441	Continued From page 7 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, facility policy review and staff interviews, the facility failed to ensure the sanitary removal of soiled linens after providing incontinence care by staff leaving urine soiled linens on the floor for 1 of 3 sampled residents (Resident #47) whose personal care was observed. Findings include: Review of the facility's policy entitled, "Infection Control Guidelines for all Nursing Procedures" dated January 24, 2011 read in part, "17. Discard soiled towels, wash cloth, etc., in the plastic bag to be taken to soiled linen room." On 9/19/12 at 4:08 pm, Nursing Assistant (NA#1) was observed entering Resident #47 ' s room to provide incontinence care. NA#1 was observed removing a yellow stained towel from the resident's groin area and placing the soiled towel	F 441	Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 9/20/12 survey. It does not constitute an agreement or admission by Huntington Health Care of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiency. The facility reserves all rights to contest the deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction (and the attached documents) also functions as the facility's credible allegation ofcompliance. • Daily during M-F morning meetings the nurse in charge will discuss results of audits. Areas of concern will be identified and appropriate interventions taken, e.g., 1 on 1 in-servicing, employee counseling etc. • Once the QA committee under the direction of the Administrator determines that substantial compliance has been obtained on-going monitoring will be determined by the committee to include frequency and % of residents to be audited	10/12/12

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F 441	Continued From page 8 on the left side of the resident ' s bed onto the floor. After NA#1 cleaned the resident, she took the towel and washcloth and dropped them on the right side of the resident ' s bed onto the floor. NA#2 was observed entering the resident ' s room and assisting NA#1. NA#1 rolled the resident on his right side to clean his bottom. She washed his bottom and rinsed him. She took the towel she had placed on the floor and wiped the resident ' s bottom. She then placed the towel and wash cloth on the floor. Nursing Assistant #2 was observed with a plastic bag taking the soiled linen from the floor and placing the soiled towels and wash cloths into the plastic bag. During an interview on 9/19/12 at 4:50 pm, NA#1 stated she did place the towels and washcloths on the floor and wiped the resident with a towel she had placed on the floor. She stated the reason was because she was nervous and was not thinking. During an interview on 9/20/12 9:35 am, the Director of Nursing (DON) stated her expectations for NA#1 was for her to have never placed the soiled linen on the floor. The DON stated NA#1 should never had taken the towel from the floor and dried the resident. During an interview on 9/21/12 at 9:30 am, NA#2 stated he was not aware that soiled linens could not be placed on the floor. He stated he always kept plastic bags with him and saw the soiled linen on the floor and placed them in the plastic bag. During an interview on 9/21/12 at 1:20 pm, the	F 441	Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 9/20/12 survey. It does not constitute an agreement or admission by Huntington Health Care of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiency. The facility reserves all rights to contest the deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction (and the attached documents) also functions as the facility's credible allegation of compliance. F441 For Resident #47: • The CNA who failed to provide care to resident #47 in compliance with facility and regulatory standards was suspended on 9/15/12 followed by termination of employment on 9/21/12. • The social services director spoke with resident #47 to assure his needs were meet timely and to resident #47's satisfaction. • A body audit was done on resident #47 to assess for excoriation and/or skin breakdown and also assessed was the resident's catheter. This was completed on 9/19/12. F441 For resident #47 and all other in-house residents and new admissions: • In-servicing for all RN's, LPN's, and CNA's began on 9/17/12 that included providing privacy and maintaining dignity during administration of personal care, provision of care in a timely manner to assure that resident's needs are met, foley catheter	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345288	A. BUILDING _____ B. WING _____	C 09/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTINGTON HEALTH CARE	311 S CAMPBELL ST BURGAW, NC 28425

(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 441	Continued From page 9 DON stated staff were trained during orientation to always have a plastic bag on them to place soiled linens in. They are instructed to transport the soiled linen to the soiled linen room and discard into the dirty linen container.	F 441	Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 9/20/12 survey. It does not constitute an agreement or admission by Huntington Health Care of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiency. The facility reserves all rights to contest the deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction (and the attached documents) also functions as the facility's credible allegation of compliance. • maintenance, provision of care in a timely manner, appropriate and timely reporting of abnormal findings, and correct procedures for handling dirty linen. • Based on most recent MDS assessments a listing of ADL dependent residents, and residents with catheters will be compiled. MDS coordinator will supply list to the DON. This list will be divided into inter-viewable and non-interviewable residents for inclusion on an appropriate audit form. The nurse in charge on each unit will complete this portion. • Daily audits will be performed through resident interviews and observations to assure that care is provided in a manner to comply with facility and regulatory standards related to privacy during personal, timeliness of incontinence care, catheter care, and proper handling of dirty linens. Audits will be divided	

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- among all shifts to assure 100% of identified residents are assessed weekly until the QA committee determines substantial compliance.
- Orientation for new hires within the nursing dept. will continue to include discussions of resident's rights and facility policies related to providing privacy during personal care, maintaining dignity, timeliness of care, care of foley catheters to include reporting problems, and safe handling of dirty linens.
- All ADL dependent residents and catheter residents will be audited to monitor compliance. Audits will be performed by the nurse in charge, medication nurses, and treatment nurses. The social services director will perform a % of inter-viewable resident audits on his/her scheduled work days. This will be in addition to the nursing audits.

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These audits will be a part of the QA process for the facility. The audits will be conducted weekly, then monthly, and then quarterly thereafter until the QA committee feels our goals have been meet.

- Daily during M-F morning meetings the nurse in charge will discuss results of audits. Areas of concern will be identified and appropriate interventions taken, e.g., 1 on 1 in-servicing, employee counseling etc.
- Once the QA committee under the direction of the Administrator determines that substantial compliance has been obtained on-going monitoring will be determined by the committee to include frequency and % of residents to be audited

10/12/12

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	345298	A. BUILDING 01 - MAIN BUILDING 01 B. WING NOV 26 2012	11/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTINGTON HEALTH CARE	311 S CAMPBELL ST BURGAW, NC 28425

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K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type V construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 11/01/12 survey. It does not constitute an agreement or admission by Huntington Health Care of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiency. The facility reserves all rights to contest the deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction (and the attached documents) also functions as the facility's credible allegation of compliance.	
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 3:30 pm onward, the following items were noncompliant, specific findings include: cross corridor doors on going into 400 hall were not positive latching. 42 CFR 483.70(a)	K 027	For 400 Hall Fire Doors *The maintenance engineer will re-install the ADA approved positive latching mechanism to cross corridor doors going into 400 hall. *Monthly checks of all fire doors will be included in the maintenance engineers Maintenance Quality Assurance Round Sheet. *Tag K027 shall be discussed in the next QA meeting and quarterly thereafter. *Facility maintenance department will be in-serviced by the Administrator/Designee by 11/08/12. COMPELETION DATE: NOVEMBER 14, 2012	11/14/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ADMINISTRATOR — (X6) DATE: 11-20-2012

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.

GW

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345298	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTINGTON HEALTH CARE	311 S CAMPBELL ST BURGAW, NC 28425

(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
K 082 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 3:30 pm onward, the following items were noncompliant, specific findings include: 1. sprinkler heads in laundry room and nourishment room(100 hall) have excess lent on orifice. 2. facility could not provide proper documentation that sprinkler system has had: a. 3 year full flow trip test, b. 5 year obstruction investigation.	K 082	Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 11/01/2012 survey. It does not constitute an agreement or admission by Huntington Health Care of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiency. The facility reserves all rights to contest the deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction (and the attached documents) also functions as the facility's credible allegation of compliance. For Laundry Room and Nourishment Room (100 hall) * Removed lent from sprinkler heads. * Facility maintenance department will be in-serviced by the Administrator/Designee by 11/08/12. * Weekly checks of sprinkler heads in Laundry room and Monthly checks of all sprinkler heads and will be included in the maintenance engineer's Maintenance Quality Assurance Round Sheet. *Tag K082 shall be discussed in the next QA meeting and quarterly thereafter. COMPLETED 11/1/12 For Sprinkler System a) doesn't apply, building doesn't have dry system b) The administrator has contracted with our sprinkler company "Sunland" to perform a five year obstruction and flow test. This test will be conducted on Monday, November 26, 2012. This date is the earliest date that this procedure can be scheduled. During this procedure the system will be drained, inspected and refilled. COMPLETION DATE: NOVEMBER 26,2012.	11/26/12
K 084 SS=F	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at	K 084	All facility Fire Extinguishers are current for their annual outside inspection. Our next outside annual inspection is routinely scheduled for December 2012. *The maintenance engineer will check each fire extinguisher monthly to assure that each shows proper charge in the indication gauge window. A card currently reading and dated on each extinguisher will continue to be initialed by the maintenance engineer at the time of inspection. The administrator will periodically check extinguishers and cards to assure compliance. *Monthly checks of fire extinguishers will be included in the maintenance engineer's Quality Assurance Round Sheet. *Facility maintenance department will be in-serviced by the Administrator/Designee by 11/8/12 *Tag K084 will be discussed in the next QA meeting and quarterly thereafter. COMPLETION DATE: NOVEMBER 8, 2012	11/08/12

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	345298	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTINGTON HEALTH CARE	311 S CAMPBELL ST BURGAW, NC 28425

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K 084	Continued From page 2 approximately 3:30 pm onward, the following items were noncompliant, specific findings include: all portable fire extinguisher in facility were not up to current date. 42 CFR 483.70(a)	K 084	Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 11/01/12 survey. It does not constitute an agreement or admission by Huntington Health Care of the truth of the facts alleged or of the correctness of the conclusions stated on the statement of deficiency. The facility reserves all rights to contest the deficiencies, findings, conclusions and actions of the Agency. This Plan of Correction (and the attached documents) also functions as the facility's credible allegation of compliance.	
K 144 88=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 3:30 pm onward, the following items were noncompliant, specific findings include: generator did not crank and transfer in 10 seconds when tested. 42 CFR 483.70(a)	K 144	For Generator Testing *Maintenance engineer will check the generator operation and load switch times to assure that the transfer is less than 10 seconds 2 times weekly and then weekly. *Upon consultation with generator service provider "Gregory Poole"; the maintenance engineer was able to identify the switch necessary to control transfer time. The switch now sits at its' maximum transfer time "5 seconds". The generator has been tested twice and transfer times were under 10 seconds both times. *Facility maintenance department will be in-serviced by the Administrator/Designee by 11/09/12. *Generator checks of twice weekly and then weekly will be included with the maintenance engineer's Maintenance Quality Assurance Round Sheet. *Tag K 144 will be discussed in the next QA meeting and quarterly thereafter. COMLETION DATE: NOVEMBER 8,2012.	11/8/12