STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 345259	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 5/16/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMPSON REGIONAL MEDICAL CTR	607 BEAMAN ST BOX 258 CLINTON, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 279	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

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

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

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

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to develop a comprehensive care plan in regard to oral/dental status for one of three residents sampled (Resident #36).
Findings include:

Resident #36 was admitted on 11/28/2012 with diagnoses of pyleonephritis (kidney infection), acute renal failure, hematuria (blood in the urine), hypertension, anxiety and pressure ulcer.

The admission Minimum Data Set (MDS) dated 12/5/2012, noted that Resident #36 was cognitively intact, and needed one person to physically assist them in all activities of daily living (ADLs). The MDS further noted that Resident #36 had abnormal mouth tissue (described as ulcers, masses, or oral lesions.) This resident had no swallowing or nutritional deficiencies.

A review of nurse notes revealed that Resident #36 stated that she has dentures, but does not like to wear them. Documentation was observed in the nurse notes that there was a small ulcer on Resident #36 ' s upper gum, but the area appeared to be healing.

In an interview on 5/16/2013 at 3:30 PM, the MDS nurse looked throughout the closed record for an oral/dental status care plan for Resident #36. The MDS nurse stated that she did not know why the care plan was not written and implemented.

The above isolated deficiencies pose no actual harm to the residents

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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
	345259	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/12/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
K 000	INITIAL COMMENTS Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42 CFR 488.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type I construction, three story (skilled nursing wing)with a complete automatic sprinkler system, The deficiencies determined during the survey are as follows:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by:	K 018	Trash cans blocking the resident's room doors in room 266 and room 270 on the Skilled Nursing Unit were removed immediately on June 12, 2013 when the concern was identified by the surveyor and the Hospital Director of Facilities. Staff on duty on the Skilled Nursing Unit were re-educated to the requirement that there can be no impediment to the closing of the doors. 1) 100% of Skilled Nursing staff was educated (Attachment I) on the NFPA Life Safety Code requirements that there can be no impediment to the closing of the doors. 2) A Weekly Safety Checklist has been implemented and is completed weekly by the Skilled Nursing Unit Director. The Checklist includes direct observation/monitoring of the Physical Environment of the Skilled Nursing Unit, including.	6-12-13 6-20-13

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

Geraldine Shipp, RN, MSN — Risk Manager — 6.27.13

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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K 018	Continued From page 1 Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliant, specific findings include: trash cans blocking residents bedroom door from closing (286 and 270). 42 CFR 483.70(a)	K 018	observing for any impediments to closing of doors and other Life Safety Code discrepancies. The audit was completed June 13, 2013 (Attachment 2) and is completed weekly and submitted to the VP of Clinical Operations.	6-13-13
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliant, specific findings include: there was no audible signal on loss of power,battery and telephone at fire alarm control panel(lobby desk).	K 052	On June 17, 2013 the Fire Alarm Control contractor tested the fire alarm system and all audible signals were found to be in compliance (Attachment 3) As required by NFPF standards, fire alarm testing is performed on a quarterly basis by the Fire Alarm contractor. The results of the fire alarm testing are reviewed by the Fire & Safety Committee quarterly. Any discrepancies discovered will be reported to the Director of Facilities for immediate follow up and correction.	6-17-13
K 067 SS=E	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD	K 067		

Quality Chair, RN, MSN Risk Manager 6.27.13

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K 067	Continued From page 2 Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliant, specific findings include: all fire/smoke dampers in return vents have excess lent build up on fuse able link. 42 CFR 483.70(a)	K 067	All return vents in the Skilled Nursing Unit were cleaned by the maintenance staff the day of the inspection. In addition, 1) The Facilities Director completed a direct observation/rounding audit of the areas of deficiency on the Skilled Nursing Unit (Attachment 4) to ensure the deficiencies were corrected. 2) The maintenance staff complete a scheduled Preventative Maintenance inspection of the Skilled Nursing Unit that includes cleaning of the vents and other life safety issues. The next inspection will occur July 1, 2013. 3) The Preventative Maintenance inspections are completed monthly and the results of the Preventative Maintenance inspections are reported to the Fire and Safety Committee monthly.	6-12-13 6.27-13 7-1-13 6-24-13

Geraldine Shipp, RN, MSN Risk Manager 6-27-13