AUG 27 2013

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FORM APPROVED
OMB NO. 0938-0391

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 _____ B. WING _____	C 08/15/2013

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 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews the facility failed to respond to a resident ' s request for pain medication for more than one hour for 1 (Resident #61) of 1 sampled hospice resident. The findings included: Resident #61 was originally admitted to the facility on 10/05/12 and had diagnoses that included Chronic Obstructive Pulmonary Disease (COPD), Dementia with Behavioral Disturbances, Depression, Neuropathy, Anxiety, Osteoporosis and Arthritis. The resident ' s most recent Minimum Data Set (MDS) Assessment (Quarterly) dated 5/15/13 revealed that Resident #61 had a Brief Interview for Mental Status (BIMS) score of 15 indicating that the resident was cognitively intact. The MDS revealed that the resident was independent with bed mobility and transfers and required limited assist with some activities of daily living. The Care Plan for Resident #61 dated 5/24/13 showed a problem of pain related to a history of osteoporosis. The interventions included the following: Monitor for signs and symptoms	F 309	Preparation and submission of this plan of correction is in response to the CMS Form 2567 from the 8/15/13 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 Resident #61: • Confirmed with resident #61 of her knowledge and ability to use call light for staff notification of pain. • The most recent physician order dated 07/25/2013 decreased the Morphine Sulfate to twice daily scheduled with every two hour PRN dosage. The Director of Nursing received an order from the primary physician to increase resident #61's Morphine Sulfate from twice daily to three times daily, and continue every two hour Morphine Sulfate as needed for breakthrough pain. • The Director of Nursing spoke with hospice nurse in regards to resident #61 and reported to the facility on 08/16/2013 to assess resident #61 and evaluate the need for changes to current pain medication regimen. There were no changes recommended to the plan of care. • The Director of Nursing/Designee will speak with resident #61 every two hours while awake to determine if she is receiving pain medication per her request and per physician orders for 1 week. For Resident #61 and all other residents: • All hospice care residents in the facility, care planned for pain management will be monitored weekly for four weeks by the Director of Nursing/Designee to determine if requested PRN pain medications are administered timely and are effective. • Residents identified with concerns will be monitored for one week in addition to four weeks by the Director of Nursing/ Designee, based on frequency of PRN pain medication order, I.E., every two hours while awake for PRNs ordered every two hours, every four hours while awake for PRNs ordered every four hours, etc. • 100% of in-house residents will be monitored to determine if pain needs are being met. Any resident concerns identified will have appropriate interventions implemented based on the nature of the concern to include daily/weekly monitoring as noted above. • Monitoring for the purpose of this plan of correction is defined by verbally communicating with the residents regarding pain level based on a 0-10 pain scale standardly used facility wide or by observation of signs and symptoms of pain if the resident is unable to express pain level, and if medication is received timely.	08/15/2013 08/15/2013 08/16/2013 08/23/2013 08/28/2013

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

ADMINISTRATOR 8/27/13

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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F 309	Continued From page 1 associated with pain such as increased blood pressure, increased heart rate, restlessness, inability to focus and moisture on skin. Respond immediately to complaints of pain. A review of the physician ' s orders for Resident #61 revealed an order dated 7/17/13 for a hospice consult for end of life care related to COPD. The physician ' s orders revealed that the resident also received Cymbalta 60mg once a day for depression, Buspar 15mg three times a day for anxiety, Fentanyl 25 micrograms per hour patch to be changed every 72 hours for pain and Ativan 0.5mg three times a day and every 4 hours as needed for anxiety. The record revealed that the resident was evaluated by hospice on 7/18/13 and an order written for Morphine 5 milligrams (mg) three times a day and every 2 hours as needed for pain. An entry on the resident ' s Care Plan dated 7/18/13 read: " Resident transition to hospice. DNR (Do Not Resuscitate), no hospital, no labs-hospice comfort care. " On 8/15/13 at 9:05 AM, Resident #61 was observed lying quietly in bed with nasal oxygen on and the call bell in reach. When asked how she was doing, the Resident replied that she was terrible. The Resident stated that she had asked for pain medication and the nurse was just in her room and stated that it would be 5 to 10 minutes. The Resident was not observed to have facial grimacing or restlessness and was able to answer questions without difficulty. On 8/15/13 at 9:10 AM Nurse #1 was observed to be standing at the medication cart preparing and crushing medications. A staff member standing at the nurse ' s station requested the nurse to bring a	F 309	For future residents having the potential to be affected: • For the next three months, all hospice residents admitted to the facility, or who receive new orders for PRN pain medication orders will be monitored weekly for four weeks by the Director of Nursing/Designee to determine timeliness of requested pain medication administration. Any resident concerns identified during the four week monitoring will be monitored daily by the Director of Nursing/Designee for a minimum of one week or until concern has been resolved, based on frequency of PRN pain medication order, I.E., every two hours while awake for PRNs ordered every two hours, every four hours while awake for PRNs ordered every four hours, etc. Completion date: 11/22/2013 • All other new admissions will be assessed for pain with the admission assessment form and then through MDS pain review. For Resident #61 and all other residents in the facility: • Nurse #1 was immediately in-serviced on 08/16/2013 in regards to administering PRN pain medications when requested, if within time parameters by the Director of Nursing. • All RN's, LPN's, and Medication Aides were in-serviced in regards to administering PRN pain medications when requested, if within time parameters by the Director of Nursing and Assistant Director of Nursing. • In-servicing on pain management and medication administration with Lower Cape Fear Hospice staff for all RN's, LPN's, and Medication Aides. Any RN's, LPN's or Medication Aides not in-serviced by 08/29/2013 will be in-serviced before the start of the next scheduled shift by the Director of Nursing/ Designee with material presented by Lower Cape Fear Hospice. • All RN's, LPN's, and Medication Aides have been in-serviced by the Director of Nursing/Designee on administering pain medications when unusual situations occur, such as requesting assistance from other nurses/supervising nurses when emergent situations occur as they are in the process of administering the requested pain medication. Continued Monitoring • For four weeks during daily clinical meetings (Monday - Friday), the Director of Nursing/Designee & Social Worker, as members of the QA Committee, will review the results of the pain monitoring regarding timeliness of administering requested PRN pain medications for all residents monitored and determine the need for and frequency of continued monitoring. • During the monthly QA meeting for four months, the results of the current month assessments of PRN administration will be reviewed to identify any concerns and develop action plans as needed. After the fourth QA review, the committee will determine the need for and frequency of continued monitoring.	08/15/2013 08/16/2013 08/29/2013 08/23/2013

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F 309	Continued From page 2	F 309		

pulse oximeter (a device used to check oxygen saturation). Nurse #1 was observed to put the prepared medications in a drawer of the medication cart, withdraw the device from the cart, lock the cart and walk to the nurse ' s station. On 8/15/13 at 9:16 AM Nurse #1 was observed to return to the medication cart, remove the prepared medications from the cart and administered to the resident in 409A. The Nurse returned to the cart at 9:21 AM and was observed to prepare and administer medications to the resident in 409B. Nurse #1 continued with the medication pass. On 8/15/13 at 9:57 AM, Nurse #1 was asked if Resident #61 had requested pain medication. The Nurse stated that the resident had asked for pain medication and it had slipped her mind. The Nurse stated she had been in the resident ' s room and the resident had requested pain medication. The Nurse stated that she had just walked out of Resident #61 ' s room when she observed the surveyor walk onto the hall. The Nurse stated that she had wanted to finish passing medications to 2 other residents and then planned to get Resident 61 ' s pain medication.

Resident #61 stated in an interview on 08/15/13 at 10:25 AM that she hurt all over but especially her left shoulder. The Resident stated that she signed up for hospice weeks ago and thought that they were supposed to help her with her pain and anything to make her more comfortable but that hospice that not done a thing for her. The Resident stated that it took a long time every day to get her pain medication and that it made her feel like she was not taken very good care of. The Resident stated that the nurse just gave her some morphine about 10 minutes ago (approximately 10:15 AM). Resident stated that prior to receiving the pain medication her pain

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F 309	Continued From page 3 was 9 out of 10 and now her pain was 8 out of 10 (0 is no pain and 10 is unbearable pain). On 8/15/13 at 10:57 AM, MDS Nurse #1 stated in an interview that Resident #61 had recently returned from the hospital and that a significant change MDS was in progress due to a decline in the resident ' s function and due to being on hospice. The Director of Nursing (DON) stated in an interview on 8/15/13 at 11:14 AM that she would expect the nurse to give the pain medication as soon as possible. The DON stated that if the nurse was in the middle of a medication (med) pass, she would expect the nurse to complete the med pass and then get the pain medication for the resident. The DON stated that she did not want any resident in her building to be in pain and would do some inservice training regarding the issue. The DON stated that she was surprised that Resident #61 did not ring her call bell again to ask for her pain medication. Nurse #1 stated in an interview on 8/15/13 at 3:02 PM that since the resident was placed on hospice, the resident was on scheduled pain medication and had not complained of pain as much. The Nurse stated that while passing medications she was called to bring her pulse oximeter and went to the nurse ' s station to check the oxygen saturation on a resident and called the doctor who gave an order to send the resident to the hospital. The Nurse stated that during that time she forgot that Resident #61 had requested pain medication. The Nurse stated that Resident #61 usually rang her call bell repeatedly until she got her pain medication or whatever it was that she needed.	F 309		

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	345208	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/12/2013

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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 2000 Existing Health Care section of the LSC and its referenced publications. This building is "type 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 09/12/13 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 012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.6.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliant, specific findings include; unsealed penetrations in fire rated wall by Dining room need to be seal with approved fire rated caulk to maintain rating of wall(in attic). 42 CFR 483.70(a)	K 012	• On 09/16/13, the maintenance engineer was in-serviced by Administrator/Designee on the proper procedure for applying fire rated caulk to unsealed areas of the fire rated walls during any maintenance projects involving drilling through the fire walls. The maintenance engineer will immediately apply fire rated caulk to the openings. • On 09/17/13, the maintenance engineer sealed penetrations in fire rated wall by dining room (in attic) with fire rated caulk. • The maintenance engineer will inspect all fire rated walls and apply fire rated caulking to any unsealed areas. • The maintenance engineer will inspect the fire walls monthly x 3 months and quarterly thereafter. The results of this inspection will be discussed in monthly QA meetings.	10/04/2013
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system	K 029		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 9/27/13

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K 029	Continued From page 1 option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliant, specific findings include: doors to Housekeeping storage closet and storage room by room 121 are not self closing. Also Medical records door did not close and latch for smoke tight seal.	K 029	Preparation and submission of this plan of correction is in response to the CMS form 2567 from the 09/12/13 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 document(s) also functions as the facility's credible allegation of compliance. • On 09/24/2013, the maintenance engineer installed door closures to the housekeeping storage closet and storage room by room 121. • On 09/19/2013, the maintenance engineer inspected all doors in facility for appropriate door closing mechanisms. Any doors identified during the inspection that did not meet compliance will have surface mounted door closures applied by 09/26/2013. • The maintenance engineer will inspect all facility room doors weekly x 4 weeks and quarterly thereafter. The results of this inspection will be discussed in the monthly QA meetings. • On 09/24/2013, the maintenance engineer adjusted the door on medical records to ensure latching for a smoke tight seal. • On 09/19/2013, the maintenance engineer inspected all doors in facility for appropriate latching to ensure a smoke tight seal. Any doors identified during the inspection that did not meet compliance will be adjusted to ensure that they are functioning appropriately by 09/27/2013. • The maintenance engineer will inspect all facility room doors weekly x 4 weeks and quarterly thereafter. The results of this inspection will be discussed in the monthly QA meetings.	10/04/2013 09/27/2013
K 052 SS=E	42 CFR 483.70(a) 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	K 052	• On 09/17/2013, Sentinel Security Systems completed the annual sensitivity test on all smoke detectors (see attached). • To ensure system has an approved timely maintenance and testing program complying with applicable requirements of NFPA 70 and 72, a log sheet identifying when inspections are due will be maintained by the maintenance engineer. • The log sheet will be discussed in October 2013 QA meeting and annually thereafter.	09/26/2013

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	345288	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/12/2013

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K 052	Continued From page 2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliant, specific findings include: facility could not provide proper documentation that a sensitivity test had been preformed on smoke detectors. 42 CFR 483.70(a)	K 052	Preparation and submission of this plan of correction is in response to the CMS form 2567 from the 09/12/13 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 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2 This STANDARD is not met as evidenced by: Surveyor: 27871 Based on observations and staff interview at approximately 9:30 am onward, the following items were noncompliant, specific findings include: residents rooms(101 and 110) were using multi plug outlet for TV's . 42 CFR 483.70(a)	K 147	• On 09/19/2013, all resident rooms were inspected by the maintenance engineer for the inappropriate usage of multi plug devices. • Compliant hospital grade outlet strips were added to room 101 and 110 on 09/24/2013. • All other resident rooms in need of hospital grade outlet strips were added on 09/25/2013. • Facility staff will be in-serviced by the maintenance engineer/ designee on 10/02/2013 to notify the maintenance engineer immediately of any inappropriate usage of multi plug devices noted in resident rooms. • The maintenance engineer will inspect all resident rooms weekly for non-approved usage of multi plug devices. The results of each inspection will be discussed in the monthly QA meetings.	10/04/2013