

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

PRINTED: 10/28/2013  
FORM APPROVED  
OMB NO. 0938-0391

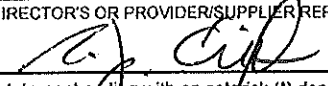
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345085	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 10/16/2013
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NAME OF PROVIDER OR SUPPLIER  EDWIN MORGAN CTR OF SCOTLAND M	STREET ADDRESS, CITY, STATE, ZIP CODE 617 PEDEN ST LAURINBURG, NC 28352
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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
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F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to record accurate vital signs in the electronic record for 1 of 3 sampled residents (Resident #1). The findings included:</p> <p>Resident #1 was admitted into the facility on 7/26/12. Diagnoses included in part Congestive Heart Failure, Atrial Fibrillation and Adult Failure to Thrive. The annual minimum data set completed on 9/16/13 indicated Resident #1 mental status was cognitively intact. A diuretic was listed as received seven times during the last seven days since admission/entry or reentry. The care plan with a target date of 10/7/13 indicated that due to congested heart failure, a diuretic therapy (Lasix 20 milligram) was ordered daily.</p> <p>A review of the electronic record dated 7/11/13 at 11:12 am revealed the following vital sign: temperature 58 recorded by NA (nursing)</p>	F 514	<p><b><u>PLAN OF CORRECTION</u></b></p> <p>Edwin Morgan Center 517 Peden Street Laurinburg, NC 28352 Provider #345085 Survey Date: 10/16/13</p> <p>F 514</p> <ol style="list-style-type: none"> <li>To address those residents that have been affected by this alleged deficient practice, the MDS Coordinator went back into the Point Click Care System on 11/3/13 and "struck out" the examples noted in the 2567 as questionable. Supporting documentation, stating the correct information, was no longer available, so the information could not be corrected in the record.</li> <li>Even though all residents had the potential to be affected, the facility would not be able to correct vital signs previously entered into Point Click Care since the original data is no longer available. The facility will go back 30 days in</li> </ol>	11/13/13
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE EXECUTIVE DIRECTOR	(X6) DATE 11/5/13
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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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NAME OF PROVIDER OR SUPPLIER  EDWIN MORGAN CTR OF SCOTLAND M			STREET ADDRESS, CITY, STATE, ZIP CODE 517 PEDEEN ST LAURINBURG, NC 28352	
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F 514	<p>Continued From page 1 assistant) #1.</p> <p>A review of the electronic record dated 9/28/13 at 7:52 am respiration's was indicated as "not applicable" by NA #2.</p> <p>A review of the electronic record dated 10/6/13 at 3:50 pm revealed the following vital signs: pulse 20, respiration's 55 and temperature 94.3 recorded by NA #3.</p> <p>A review of the electronic record dated 10/10/13 at 9:00 am revealed the following vital signs: temperature 20 and respiration's 97.4 recorded by NA #1.</p> <p>A review of the electronic record dated 2/10/13 at 2:59 pm revealed the following vital sign: temperature 76 recorded by NA #4.</p> <p>In an interview on 10/15/13 at 4:00 pm with NA #3 and Nurse #1, Nurse #1 stated that on 10/6/13 during second shift she received vital signs from NA #3 that indicated temperature 20 and respiration's 97. She added that she immediately went down to Resident #1 and rechecked the vital signs. Nurse #1 concluded that upon rechecking the vitals signs revealed the vitals that NA #3 presented to her was recorded incorrectly.</p> <p>In an interview on 10/16/13 at 11:40 am, NA #3 acknowledged that on 10/6/13 at 3:50 pm she recorded the pulse, respiration's and temperature incorrectly. She added that she forgot to go back and change the information.</p> <p>In an interview on 10/16/13 at 11:47 am, NA #1 acknowledged that on 7/11/13 at 11:12 am and 10/10/13 at 9:00 am that she "keyed the</p>	F 514	<p>each resident record to review documented vital signs. Any incorrect vital sign data will be "struck out" in the Point Click Care System and correctly reentered if supporting documentation is available. If supporting documentation is not available, the record will have to remain incomplete.</p> <p>3. To ensure that this alleged deficient practice does not reoccur, on 10/16/13 the MDS Coordinator reset the order in which the vitals are recorded on the jot sheet, the PCC Q-shift vital signs page and the PCC PRN-vital signs page. The Director of Nursing Services conducted an in-service of 10/31/13 for all licensed staff and CNAs that enter vital sign data into the PCC system explaining the survey results and the importance of accurately recording all data. This information will also be reviewed during orientation of any newly hired applicable staff.</p>	11/13/13

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F 514	Continued From page 2 temperature and respiration incorrectly."  In an interview on 10/16/13 at 11:48 am, NA #4 acknowledged that on 2/10/13 at 2:59 pm that she "recorded the temperature incorrectly, the number I recorded for the temperature should have been the for pulse."  In an interview on 10/16/13 at 11:52 am, NA #2 acknowledged that on 9/28/13 at 7:52 am it was a "possibility that she failed to document the respiration's correctly."  In an interview on 10/16/13 at 1:30 pm, the director of nursing stated that she expected the vital signs to have been recorded into the electronic record correctly. She concluded that she was not aware prior to the survey entry that there were vital signs that had been recorded incorrectly into the electronic record.	F 514	4. The Director of Nursing Service, or appropriate designee, will monitor vital sign documentation in the resident(s) electronic medical record as follows: a. 10 records per week X 1 month; then 5 records every two weeks X 2 months; then 4 records per month X 3 month; then 3 records per quarter X 2 quarters; and as needed. b. Discrepancies will be remedied at the time of discovery and outcomes of the audits will be discussed during morning administrative meeting weekly X 4 weeks, bi-monthly X2 months; monthly at the facility QM meeting; then quarterly at the facility QM meeting, and as needed. c. The QM committee will discuss the compliance with the audits and document such discussion in the facility QM meeting minutes. d. Revisions will be made and documented in the meeting minutes as needed by QM committee members. e. Appropriate employees will be re-inserviced to applicable revisions. Revisions in the plan will require monitoring to begin again at 4a and 4b.	11/13/13	

All of the above actions will be completed by November 13, 2013.