

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

PRINTED: 06/24/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ <i>JUL 19 2011</i>	(X3) DATE SURVEY COMPLETED  06/15/2011
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NAME OF PROVIDER OR SUPPLIER  PENDER MEMORIAL HOSP SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 507 FREMONT STREET BURGAW, NC 28425
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F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>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).</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview the facility failed to notify the physician</p>	F 157	<p>Corrective Action Accomplished by:</p> <p>MD notified on June 15, 2011 of Resident #7 refusing daily weights. New order received to Discontinue daily weights. New order to weigh weekly and notify MD of weight gain of 5 lbs or more in one week. (Attachment #A1)</p> <p>Resident #7 Weight obtained and documented in the Medical Record June 15th of 168 lbs. (Attachment #A2)</p> <p>Resident #7 Weight obtained and documented in the Medical Record June 22nd of 166.2 lbs. (Attachment #A2)</p> <p>Resident #7 Weight obtained and documented in the Medical Record June 29th of 165 lbs. (Attachment #A2)</p> <p>A Policy was drafted to standardize weights on June 15, 2011. This policy was revised on June 30, 2011 to address resident refusals. (Attachment #A3)</p>	<p>6-15-11</p> <p>6-15-11</p> <p>6-22-11</p> <p>6-29-11</p> <p>6-30-11</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Ruth A. Blenser* TITLE: *President* (X6) DATE: *7-15-11*

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.

*J.F. v.c.*

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NAME OF PROVIDER OR SUPPLIER  <b>PENDER MEMORIAL HOSP SNF</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>607 FREMONT STREET BURGAW, NC 28426</b>		
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F 157	Continued From page 1 of a resident ' s refusal for daily weights for 1 of 1 resident (resident # 7) with physician ' s orders for daily weights. The findings include:  Resident # 7 was admitted to the facility on 2/24/11 with diagnosis that include Renal Insufficiency, Coronary Artery Disease, Atrial Fibrillation with pacemaker, Congestive Heart Failure, Dementia, Depression, Diabetes Mellitus, Gastroesophagal Reflux Disease and Gout.  A review of Resident # 7 ' s chart revealed a Physicians Order dated 4/14/11 that reads, " Weigh daily @ (at) 0630. Notify MD (medical doctor) of 3 lbs (pounds) or more weight gain in 2 days or 5 lbs. or more weight gain in one week. "  A review of Resident # 7 ' s MAR (medical administration record) dated 4/01/01 reads as, " Weigh daily at 0630 notify MD of 3 lbs or more weight gain in 2 days or 5 lbs. or more weight gain in one week. A review of the May 2011 MAR, from 4/15/11 thru 4/30/11 Revealed staff initialed and wrote R for refused weights on the MAR. A review of the June 2011 MAR from 5/01/11 thru 5/31/11 revealed staff had initialed and wrote R for refused weights.  In an interview on 6/15/11 at 11:45 AM Nurse # 1 revealed that she was aware of the MAR charting with " R " daily (refusal) but had not called the MD( medical doctor) to report that the weights were not being done and to inquire if he wanted to keep the order or discontinue it.	F 157	Measures/Systemic Changes to ensure deficient practice does not recur: All SNF staff members will be educated/in-serviced on the Weight Policy and Procedure by July 13, 2011 and then annually. All new SNF staff members will be educated/in-serviced on the Weight Policy and Procedure during New Hire Orientation and annually per the Unit Specific Orientation/Annual Competency Validation Checklist. (Attachment A4, A5, and A6)  Plans to Monitor Performance:  All weights will be monitored through Random Spot checks using the Weight Documentation Spot Check Tool. (Attachment #A7) All weight concerns will be monitored weekly for 3 months then monthly for 6 months through the Quality Assessment/Assurance Committee Minutes (Attachment #A8) using the Weekly Weight Quality Assurance Tool (Attachment #A9)	7-13-11	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS  The facility must conduct initially and periodically	F 272		7-13-11	

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F 272	Continued From page 2 a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.  A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.  This REQUIREMENT is not met as evidenced	F 272	Corrective Action Accomplished for affected residents as well as residents having the potential to be affected by:  Resident #10 MDS assessment and CAAS were placed on the chart 6-15-11.  MDS Coordinator audited 100% of charts to ensure timely completion/placement of required MDS Assessments [ie, comprehensive, quarterly, etc] in each patient medical record [as applicable] (Attachment #B1)  A "MDS Chain of Command Policy" was put into place to establish guidelines for communication of MDS issues to the CFO and/or President without punitive action. (Attachment #B2)	6-15-11  7-1-11  7-1-11	

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F 272	<p>Continued From page 3</p> <p>by:</p> <p>Based on record review and staff interview, the facility failed to complete an initial comprehensive Minimum Data Set (MDS) assessment within fourteen days of admission for one (Resident # 10) of ten (10) sampled residents. Findings included:</p> <p>Resident #10 was admitted to the facility 05/16/2011 with cumulative diagnoses: Total Knee replacement, Diabetes Mellitus, Osteoarthritis, Hypothyroidism and Hypertension. Resident #10 was discharged from the facility 06/04/2011.</p> <p>Medical record review revealed no Minimum Data Set (MDS) assessment on the chart.</p> <p>The MDS Coordinator was interviewed about assessments that might have been completed but not yet available on the residents' medical records. On 06/15/2011 at 11:50 AM., the MDS Coordinator stated she did not have any completed MDS assessments in the computer.</p> <p>On 06/15/2011 at 12:00 PM., the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been completed as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 06/15/2011 at 12:00 PM., the Director of Nursing (DON) stated she was the staff member</p>	F 272	<p>All current MDS personnel will be educated on DHSR Regulations F272, F275, F276, F286, F287, F490 and "MDS Chain of Command Policy" by 7-13-11 and then annually. All new MDS personnel will be educated/in-serviced during New Hire Orientation and annually per the Unit Specific Orientation/Annual Competency Validation checklist. (Attachment #B3)</p> <p>Measures/Systemic Changes to ensure deficient practice does not recur:</p> <ul style="list-style-type: none"> <li>* MDS Coordinator position increased from 32 hours per week to 40 hours per week</li> <li>* MDS Computer upgrade</li> <li>* MDS Software upgrade</li> <li>* Hired 2nd MDS Coordinator</li> <li>* Mobile laptop for real time MDS data entry</li> </ul>	<p>7-13-11</p> <p>10/10</p> <p>11/10</p> <p>12/10</p> <p>1/11</p> <p>2/11</p>	

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F 272	Continued From page 4 who was supposed to assist the Minimum Data Set (MDS) Coordinator if the MDS Coordinator began falling behind in completing assessments. On October 1, 2010, there was a change in management and the skilled nursing unit experienced an increase in census. The DON stated she became interim DON in October 2010 and remained clinical coordinator over the skilled nursing unit and was unable to assist the MDS Coordinator in performing/ completing assessments.  On 06/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. A decision had been made to increase the census on the skilled nursing unit and residents were admitted to the skilled nursing unit quicker than the staff had the capability of completing MDS's. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. She stated she verbalized her concerns to the previous DON and asked for assistance. The MDS Coordinator stated she did not receive assistance until February 2011 when the facility hired another MDS Coordinator on an as needed (PRN) basis. She stated she had given the MDS schedule for May 2011 to the prn MDS Coordinator for her to complete the assessments. The MDS Coordinator stated she checked the charts approximately one and one half (1 ½) weeks ago and realized all the assessments for May had not been completed as scheduled. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.	F 272	* iPad with software application for faster, more efficient real time MDS data entry * President-Administrator attended DHSR MDS Training [Raleigh] * MDS coordinator and Nurse Manager attended "Update in MDS 3.0 Implementation" presented by Cindy DePorter * RN with MDS 3.0 experience has been hired to fill previously vacant clinical coordinator position to serve as back up/additional MDS Personnel Plans to Monitor Performance:  MDS assessments will be monitored for completion/placement in resident medical record through Random Spot Checks. (Attachment #B4) All relevant MDS due dates/completion dates will be discussed weekly for 3 months then monthly for 6 months in the Quality Assessment/Assurance Committee Meeting using the MDS Calendar Tool. (Attachment #B5) 6-15-11	5/11  6/11 6/11  7/11   7-13-11	
F 275	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT	F 275			

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F 275 SS=E	Continued From page 5 LEAST EVERY 12 MONTHS  A facility must conduct a comprehensive assessment of a resident not less than once every 12 months.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete an annual comprehensive Minimum Data Set (MDS) assessment within 366 days of the latest comprehensive assessment for four (4) of ten (10) sampled residents (Resident #2, #3, #8, #9). Findings included:  1. Resident #2 was admitted to the facility 01/14/2008.  Medical record review revealed a quarterly Minimum Data Set (MDS) assessment dated 09/07/2010. The next assessment was an annual MDS dated 03/03/2011.  The MDS Coordinator was interviewed about assessments that might have been completed but not yet available on the residents' medical records. On 06/15/2011 at 11:50 AM., the MDS Coordinator stated she did not have any completed MDS assessments in the computer.  On 06/15/2011 at 12:00 PM., the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been	F 275	Corrective Action Accomplished for affected residents as well as potential residents by:  Annual Assessments were performed and placed on the medical record for Resident # 2, 3, 8, and 9.  MDS Coordinator audited 100% of charts to ensure timely completion/placement of required MDS Assessments [ie, comprehensive, quarterly, etc] in each patient medical record [as applicable] (Attachment #B1)  A "MDS Chain of Command Policy" was put into place to establish guidelines for communication of MDS issues to the CFO and/or President without punitive action. (Attachment #B2)  All current MDS personnel will be educated on DHSR Regulations F272, F275, F276, F286, F287, F490 and "MDS Chain of Command Policy" by 7-13-11 and then annually. All new MDS personnel will be educated/in-serviced during New Hire Orientation and annually per the Unit Specific Orientation/Annual Competency Validation checklist. (Attachment #B3)	6-15-11  7-1-11  7-1-11  7-13-11	

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F 275	Continued From page 6 completed as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.  On 06/15/2011 at 12:00 PM., the Director of Nursing (DON) stated she was the staff member who was supposed to assist the Minimum Data Set (MDS) Coordinator if the MDS Coordinator began falling behind in completing assessments. On October 1, 2010, there was a change in management and the skilled nursing unit experienced an increase in census. The DON stated she became interim DON in October 2010 and remained clinical coordinator over the skilled nursing unit and was unable to assist the MDS Coordinator in performing/ completing assessments.  On 06/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. A decision had been made to increase the census on the skilled nursing unit and residents were admitted to the skilled nursing unit quicker than the staff had the capability of completing MDS's. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. She stated she verbalized her concerns to the previous DON and asked for assistance. The MDS Coordinator stated she did not receive assistance until February 2011 when the facility hired another MDS Coordinator on an as needed (PRN) basis. She stated she had given the MDS schedule for May 2011 to the prn MDS Coordinator for her to complete the assessments. The MDS Coordinator stated she checked the charts approximately one and one half (1 ½) weeks ago and realized all the	F 275	Measures/Systemic changes to ensure deficient practice does not recur: * MDS Coordinator position increased from 32 hours per week to 40 hours per week * MDS Computer upgrade * MDS Software upgrade * Hired 2nd MDS Coordinator * Mobile laptop for real time MDS data entry * iPad with software application for faster, more efficient real time MDS data entry * President-Administrator attended DHR MDS Training [Raleigh] * MDS coordinator and Nurse Manager attended "Update in MDS 3.0 Implementation" presented by Cindy DePorter * RN with MDS 3.0 experience has been hired to fill previously vacant Clinical Coordinator position to serve as back up/additional MDS personnel  Plans to Monitor Performance: MDS assessments will be monitored for completion/placement in resident medical record through Random Spot Checks. (Attachment #B4) All relevant MDS due dates/completion dates will be discussed weekly for 3 months then monthly for 6 months in the Quality Assessment/Assurance Committee Meeting using the MDS Calendar Tool. (Attachment #B5)	10/10 11/10 12/10 1/11 2/11 5/11 5/11 5/11 7/11 7-13-11	

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F 275	<p>Continued From page 7</p> <p>assessments for May had not been completed as scheduled. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.</p> <p>2. Resident #3 was admitted to the facility 03/23/2010.</p> <p>Medical record review revealed a quarterly MDS dated 1/26/2011 and an annual MDS assessment dated 04/23/2011.</p> <p>The MDS Coordinator was interviewed about assessments that might have been completed but not yet available on the residents' medical records. On 06/15/2011 at 11:50 AM., the MDS Coordinator stated she did not have any completed MDS assessments in the computer.</p> <p>On 06/15/2011 at 12:00 PM., the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been completed as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 06/15/2011 at 12:00 PM., the Director of Nursing (DON) stated she was the staff member who was supposed to assist the Minimum Data Set (MDS) Coordinator if the MDS Coordinator began falling behind in completing assessments. On October 1, 2010, there was a change in</p>	F 275			



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F 275	<p>Continued From page 8</p> <p>management and the skilled nursing unit experienced an increase in census. The DON stated she became interim DON in October 2010 and remained clinical coordinator over the skilled nursing unit and was unable to assist the MDS Coordinator in performing/ completing assessments.</p> <p>On 06/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. A decision had been made to increase the census on the skilled nursing unit and residents were admitted to the skilled nursing unit quicker than the staff had the capability of completing MDS's. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. She stated she verbalized her concerns to the previous DON and asked for assistance. The MDS Coordinator stated she did not receive assistance until February 2011 when the facility hired another MDS Coordinator on an as needed (PRN) basis. She stated she had given the MDS schedule for May 2011 to the prn MDS Coordinator for her to complete the assessments. The MDS Coordinator stated she checked the charts approximately one and one half (1 ½) weeks ago and realized all the assessments for May had not been completed as scheduled. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.</p> <p>3. Resident #9 was admitted to the facility 01/29/2010.</p> <p>Medical record review revealed an annual</p>	F 275			

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F 275	<p>Continued From page 9</p> <p>Minimum Data Set (MDS) dated 03/20/2011. Resident #9's third quarterly assessment was dated 10/28/2010.</p> <p>The MDS Coordinator was interviewed about assessments that might have been completed but not yet available on the residents' medical records. On 06/15/2011 at 11:50 AM., the MDS Coordinator stated she did not have any completed MDS assessments in the computer.</p> <p>On 06/15/2011 at 12:00 PM., the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been completed as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 06/15/2011 at 12:00 PM., the Director of Nursing (DON) stated she was the staff member who was supposed to assist the Minimum Data Set (MDS) Coordinator if the MDS Coordinator began falling behind in completing assessments. On October 1, 2010, there was a change in management and the skilled nursing unit experienced an increase in census. The DON stated she became interim DON in October 2010 and remained clinical coordinator over the skilled nursing unit and was unable to assist the MDS Coordinator in performing/ completing assessments.</p> <p>On 06/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October</p>	F 275			

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NAME OF PROVIDER OR SUPPLIER  PENDER MEMORIAL HOSP SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 607 FREMONT STREET BURGAW, NC 28425		
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F 275	<p>Continued From page 10</p> <p>2010. A decision had been made to increase the census on the skilled nursing unit and residents were admitted to the skilled nursing unit quicker than the staff had the capability of completing MDS's. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. She stated she verbalized her concerns to the previous DON and asked for assistance. The MDS Coordinator stated she did not receive assistance until February 2011 when the facility hired another MDS Coordinator on an as needed (PRN) basis. She stated she had given the MDS schedule for May 2011 to the prn MDS Coordinator for her to complete the assessments. The MDS Coordinator stated she checked the charts approximately one and one half (1 ½) weeks ago and realized all the assessments for May had not been completed as scheduled. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.</p> <p>4. Resident # 8 was admitted to the facility on 2/10/2009.</p> <p>Medical record review revealed an annual Minimum Data Set (MDS) assessment dated 1/31/2010. Quarterly MDS assessments were in the record and dated 4/22/2010, 7/16/2010, 10/10/2010 and 3/22/2011. The most recent annual MDS assessment was dated 5/31/2011.</p> <p>The MDS Coordinator was interviewed about assessments that might have been completed but not yet available on the residents' medical records. On 6/15/2011 at 11:50 AM, the MDS</p>	F 275			

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F 275	<p>Continued From page 11</p> <p>Coordinator stated she did not have any completed MDS assessments in the computer.</p> <p>On 6/15/2011 at 12:00 PM, the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been completed as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 6/15/2011 at 12:00 PM, the Director of Nursing (DON) stated she was the staff member who was supposed to assist the Minimum Data Set (MDS) Coordinator if the MDS Coordinator began falling behind in completing assessments. On October 1, 2010, there was a change in management and the skill nursing unit experienced an increase in census. The DON stated she became interim DON in October 2010 and remained clinical coordinator over the skilled nursing unit and was unable to assist the MDS Coordinator in performing/ completing assessments.</p> <p>On 6/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. A decision had been made to increase the census on the skilled nursing unit and residents were admitted to the skilled nursing unit quicker than the staff had the capability of completing MDS 's. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. She stated she verbalized her concerns to the previous DON and asked for</p>	F 275			

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F 275	Continued From page 12 assistance. The MDS Coordinator stated she did not receive assistance until February 2011 when the facility hired another MDS coordinator on an as needed (PRN) basis. She stated she had given the MDS schedule for May 2011 to the prn MDS Coordinator for her to complete the assessments. The MDS Coordinator stated she checked the charts approximately one and one half (1 ½) weeks ago and realized all the assessments for May had not been completed as scheduled. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.	F 275			
F 276 SS=E	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS  A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.  This REQUIREMENT is not met as evidenced by: 4. Resident # 4 was admitted to the facility on 11/15/2010.  Medical record review revealed an admission MDS dated 11/27/2010. The next quarterly MDS was dated 3/27/2011.  The MDS Coordinator was interviewed about assessments that might have been completed but not yet available on the residents' medical records. On 6/15/2011 at 11:50 AM, the MDS Coordinator stated she did not have any	F 276	Corrective Action Accomplished for affected residents as well as residents with the potential to be affected by:  Quarterly Assessments were performed and placed on the Medical Record for Resident # 4, 5, and 7.	6-15-11	

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F 276	<p>Continued From page 13 completed MDS assessments in the computer.</p> <p>On 6/15/2011 at 12:00 PM, the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been completed as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 6/15/2011 at 12:00 PM, the Director of Nursing (DON) stated she was the staff member who was supposed to assist the Minimum Data Set (MDS) Coordinator if the MDS Coordinator began falling behind in completing assessments. On October 1, 2010, there was a change in management and the skill nursing unit experienced an increase in census. The DON stated she became interim DON in October 2010 and remained clinical coordinator over the skilled nursing unit and was unable to assist the MDS Coordinator in performing/ completing assessments.</p> <p>On 6/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. A decision had been made to increase the census on the skilled nursing unit and residents were admitted to the skilled nursing unit quicker than the staff had the capability of completing MDS ' s. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. She stated she verbalized her concerns to the previous DON and asked for assistance. The MDS Coordinator stated she did</p>	F 276	<p>MDS Coordinator audited 100% of charts to ensure timely completion/placement of required MDS Assessments [ie, comprehensive, quarterly, etc] in each patient medical record [as applicable] (Attachment #B1)</p> <p>A "MDS Chain of Command Policy" was put into place to establish guidelines for communication of MDS issues to the CFO and/or President without punitive action. (Attachment #B2)</p> <p>All current MDS personnel will be educated on DHR Regulations F272, F275, F276, F286, F287, F490 and "MDS Chain of Command Policy" by 7-13-11 and then annually. All new MDS personnel will be educated/in-serviced during New Hire Orientation and annually per the Unit Specific Orientation/Annual Competency Validation checklist. (Attachment #B3)</p>	<p>7-1-11</p> <p>7-1-11</p> <p>7-13-11</p>	

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F 276	<p>Continued From page 14</p> <p>not receive assistance until February 2011 when the facility hired another MDS coordinator on an as needed (PRN) basis. She stated she had given the MDS schedule for May 2011 to the prn MDS Coordinator for her to complete the assessments. The MDS Coordinator stated she checked the charts approximately one and one half (1 ½) weeks ago and realized all the assessments for May had not been completed as scheduled. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.</p> <p>5. Resident #5 was admitted to the facility on 1/07/2007.</p> <p>Medical record review revealed an annual MDS dated 10/28/2010 the next quarterly MDS was dated 02/15/2011.</p> <p>The MDS Coordinator was interviewed about assessments that might have been completed but not yet available on the residents' medical records. On 6/15/2011 at 11:50 AM, the MDS Coordinator stated she did not have any completed MDS assessments in the computer.</p> <p>On 6/15/2011 at 12:00 PM, the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been completed as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the</p>	F 276	<p>Measures/Systemic Changes to ensure deficient practice does not recur:</p> <ul style="list-style-type: none"> <li>* MDS Coordinator position increased from 32 hours per week to 40 hours per week</li> <li>* MDS Computer upgrade</li> <li>* MDS Software upgrade</li> <li>* Hired 2nd MDS Coordinator</li> <li>* Mobile laptop for real time MDS data entry</li> <li>* iPad with software application for faster, more efficient real time MDS data entry</li> <li>* President-Administrator attended DHSR MDS Training [Raleigh]</li> <li>* MDS coordinator and Nurse Manager attended "Update in MDS 3.0 Implementation" presented by Cindy DePorter</li> <li>* RN with MDS 3.0 experience has been hired to fill previously vacant Clinical Coordinator position to serve as back up/additional MDS personnel</li> </ul> <p>Plans to Monitor Performance:</p> <p>MDS assessments will be monitored for completion/placement in resident medical record through Random Spot Checks. (Attachment #B4) All relevant MDS due dates/completion dates will be discussed weekly for 3 months then monthly for 6 months in the Quality Assessment/Assurance Committee Meeting using the MDS Calendar Tool. (Attachment #B5)</p>	<p>10/10</p> <p>11/10</p> <p>12/10</p> <p>1/11</p> <p>2/11</p> <p>5/11</p> <p>6/11</p> <p>6/11</p> <p>7/11</p> <p>7-13-11</p>	

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F 276	<p>Continued From page 15 problem, she stated no.</p> <p>On 6/15/2011 at 12:00 PM, the Director of Nursing (DON) stated she was the staff member who was supposed to assist the Minimum Data Set (MDS) Coordinator if the MDS Coordinator began falling behind in completing assessments. On October 1, 2010, there was a change in management and the skill nursing unit experienced an increase in census. The DON stated she became interim DON in October 2010 and remained clinical coordinator over the skilled nursing unit and was unable to assist the MDS Coordinator in performing/ completing assessments.</p> <p>On 6/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. A decision had been made to increase the census on the skilled nursing unit and residents were admitted to the skilled nursing unit quicker than the staff had the capability of completing MDS 's. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. She stated she verbalized her concerns to the previous DON and asked for assistance. The MDS Coordinator stated she did not receive assistance until February 2011 when the facility hired another MDS coordinator on an as needed (PRN) basis. She stated she had given the MDS schedule for May 2011 to the prn MDS Coordinator for her to complete the assessments. The MDS Coordinator stated she checked the charts approximately one and one half (1 ½) weeks ago and realized all the assessments for May had not been completed as scheduled. When asked regarding a time frame that assessments were not completed and</p>	F 276			



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F 276	<p>Continued From page 16</p> <p>transmitted, she stated assessments were not completed timely from October 2010 through May 2011.</p> <p>6. Resident # 7 was admitted to the facility 02/24/2011.</p> <p>Medical record review revealed an admission assessment dated 03/07/2011. There were no further assessments in the chart.</p> <p>On 6/15/11 at 4:00 PM, the MDS Coordinator stated Resident # 7 is due an MDS assessment, we should be working on it but with the state in the building we have not started yet.</p> <p>The MDS Coordinator was interviewed about assessments that might have been completed but not yet available on the residents' medical records. On 6/15/2011 at 11:50 AM, the MDS Coordinator stated she did not have any completed MDS assessments in the computer.</p> <p>On 6/15/2011 at 12:00 PM, the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been completed as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 6/15/2011 at 12:00 PM, the Director of Nursing (DON) stated she was the staff member who was supposed to assist the Minimum Data Set (MDS) Coordinator if the MDS Coordinator</p>	F 276			

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F 276	<p>Continued From page 17</p> <p>began falling behind in completing assessments. On October 1, 2010, there was a change in management and the skill nursing unit experienced an increase in census. The DON stated she became interim DON in October 2010 and remained clinical coordinator over the skilled nursing unit and was unable to assist the MDS Coordinator in performing/ completing assessments.</p> <p>On 6/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. A decision had been made to increase the census on the skilled nursing unit and residents were admitted to the skilled nursing unit quicker than the staff had the capability of completing MDS' s. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. She stated she verbalized her concerns to the previous DON and asked for assistance. The MDS Coordinator stated she did not receive assistance until February 2011 when the facility hired another MDS coordinator on an as needed (PRN) basis. She stated she had given the MDS schedule for May 2011 to the prn MDS Coordinator for her to complete the assessments. The MDS Coordinator stated she checked the charts approximately one and one half (1 ½) weeks ago and realized all the assessments for May had not been completed as scheduled. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.</p> <p>Based on record review and staff interview, the facility failed to complete a quarterly Minimum</p>	F 276			

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F 276	<p>Continued From page 18</p> <p>Data Set (MDS) for six (6) of ten (10) sampled residents (Resident # 1, #3, #4, #5, #6, #7). Findings included:</p> <p>1. Resident #1 was admitted to the facility 09/27/2010.</p> <p>Medical record review revealed Resident #1's admission Minimum Data Set (MDS) was dated 10/06/2010. The next quarterly Minimum Data Set (MDS) assessment was dated 03/22/2011.</p> <p>The MDS Coordinator was interviewed about assessments that might have been completed but not yet available on the residents' medical records. On 06/15/2011 at 11:50 AM., the MDS Coordinator stated she did not have any completed MDS assessments in the computer.</p> <p>On 06/15/2011 at 12:00 PM., the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been completed as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 06/15/2011 at 12:00 PM., the Director of Nursing (DON) stated she was the staff member who was supposed to assist the Minimum Data Set (MDS) Coordinator if the MDS Coordinator began falling behind in completing assessments. On October 1, 2010, there was a change in management and the skilled nursing unit experienced an increase in census. The DON</p>	F 276			

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F 276	<p>Continued From page 19</p> <p>stated she became interim DON in October 2010 and remained clinical coordinator over the skilled nursing unit and was unable to assist the MDS Coordinator in performing/ completing assessments.</p> <p>On 06/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. A decision had been made to increase the census on the skilled nursing unit and residents were admitted to the skilled nursing unit quicker than the staff had the capability of completing MDS's. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. She stated she verbalized her concerns to the previous DON and asked for assistance. The MDS Coordinator stated she did not receive assistance until February 2011 when the facility hired another MDS Coordinator on an as needed (PRN) basis. She stated she had given the MDS schedule for May 2011 to the prn MDS Coordinator for her to complete the assessments. The MDS Coordinator stated she checked the charts approximately one and one half (1 ½) weeks ago and realized all the assessments for May had not been completed as scheduled. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.</p> <p>2. Resident #3 was admitted to the facility 03/23/2010.</p> <p>Medical record review revealed Resident #3 had a quarterly MDS assessment dated 09/19/2010. The next MDS quarterly assessment was dated</p>	F 276			

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F 276	<p>Continued From page 20 01/26/2011.</p> <p>The MDS Coordinator was interviewed about assessments that might have been completed but not yet available on the residents' medical records. On 06/15/2011 at 11:50 AM., the MDS Coordinator stated she did not have any completed MDS assessments in the computer.</p> <p>On 06/15/2011 at 12:00 PM., the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been completed as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 06/15/2011 at 12:00 PM., the Director of Nursing (DON) stated she was the staff member who was supposed to assist the Minimum Data Set (MDS) Coordinator if the MDS Coordinator began falling behind in completing assessments. On October 1, 2010, there was a change in management and the skilled nursing unit experienced an increase in census. The DON stated she became interim DON in October 2010 and remained clinical coordinator over the skilled nursing unit and was unable to assist the MDS Coordinator in performing/ completing assessments.</p> <p>On 06/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. A decision had been made to increase the census on the skilled nursing unit and residents</p>	F 276			

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NAME OF PROVIDER OR SUPPLIER  PENDER MEMORIAL HOSP SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 507 FREMONT STREET BURGAW, NC 28425		
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F 276	<p>Continued From page 21</p> <p>were admitted to the skilled nursing unit quicker than the staff had the capability of completing MDS's. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. She stated she verbalized her concerns to the previous DON and asked for assistance. The MDS Coordinator stated she did not receive assistance until February 2011 when the facility hired another MDS Coordinator on an as needed (PRN) basis. She stated she had given the MDS schedule for May 2011 to the prn MDS Coordinator for her to complete the assessments. The MDS Coordinator stated she checked the charts approximately one and one half (1 ½) weeks ago and realized all the assessments for May had not been completed as scheduled. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.</p> <p>3. Resident #6 was admitted to the facility 12/10/2010.</p> <p>Medical record review revealed an admission MDS dated 12/22/2010. The next quarterly assessment was dated 04/13/2011.</p> <p>The MDS Coordinator was interviewed about assessments that might have been completed but not yet available on the residents' medical records. On 06/15/2011 at 11:50 AM., the MDS Coordinator stated she did not have any completed MDS assessments in the computer.</p> <p>On 06/15/2011 at 12:00 PM., the Administrator stated there had been a change in the Chief</p>	F 276			

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F 276	<p>Continued From page 22</p> <p>Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been completed as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 06/15/2011 at 12:00 PM., the Director of Nursing (DON) stated she was the staff member who was supposed to assist the Minimum Data Set (MDS) Coordinator if the MDS Coordinator began falling behind in completing assessments. On October 1, 2010, there was a change in management and the skilled nursing unit experienced an increase in census. The DON stated she became interim DON in October 2010 and remained clinical coordinator over the skilled nursing unit and was unable to assist the MDS Coordinator in performing/ completing assessments.</p> <p>On 06/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. A decision had been made to increase the census on the skilled nursing unit and residents were admitted to the skilled nursing unit quicker than the staff had the capability of completing MDS's. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. She stated she verbalized her concerns to the previous DON and asked for assistance. The MDS Coordinator stated she did not receive assistance until February 2011 when the facility hired another MDS Coordinator on an as needed (PRN) basis. She stated she had given the MDS schedule for May 2011 to the prn</p>	F 276		

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F 276	Continued From page 23 MDS Coordinator for her to complete the assessments. The MDS Coordinator stated she checked the charts approximately one and one half (1 ½) weeks ago and realized all the assessments for May had not been completed as scheduled. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.	F 276			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to ensure that 1 of 10 residents (resident # 5) receiving tube feedings were given the amount of water flush as ordered by the physician. The findings include:  1. Resident # 5 was admitted to the facility on 1/01/07 with diagnosis that include Peg Tube placement on 1/08/07, Aphasia, Vascular Dementia, Hypertension, Hypokalemia, Osteoarthritis, Transient Ischemic Accident and Gastroesophagal Reflux Disorder.  A review of the Physician 's Order recap sheet dated 6/01/11 revealed an order for Fibersource HN @ 30ML/HR (milliliter/ hour) (4 A-10PM) = Total Vol 540 (volume) Flush 100 ML/ H2O (water) every 4 hours.	F 281	Corrective Action accomplished for those residents found to be affected by:  MD notified of transcription error on 6-15-11. New order received. (Attachment #E1) New Tube Feeding Administration Record was initiated. (Attachment #E2)	6-15-11	



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F 281	<p>Continued From page 24</p> <p>A review of the monthly Tube Feeding Administration Records from August 5, 2009 thru June 14, 2011 revealed staff initiated the Tube Feeding Administration Record indicating the 200 ML of water was given every six hours.</p> <p>A review of the Tube Feeding Administration Record for the month of June 2011 reads as, " Flush Tube with 200 ML water every SIX hours. " The Tube Feeding Administration Record for the month of June 2011, revealed staff initials indicating 200 ML flushes were given every 6 hours from June 1st thru the 14th and on June 15th at 12AM and 6 AM.</p> <p>A review of Resident ' s # 5 chart revealed a Physician ' s order dated 8/05/09 which reads, " 200cc (cubic centimeters) NS (normal saline) via GT (gastroenteral tube) ever 4 hrs. (hours) START NOW. "</p> <p>In an interview with Nurse # 1 on 6/15/11 at 10:20 AM she stated, " This flush change dates back to August 5, 2009 a change from 200 cc every 6 hours verses 100 cc every 4 hours. As to why the orders were not changed on the Physician ' s recap orders I do not know. The pharmacy can not say why we did not catch it for 2 years. "</p> <p>In an interview on 6/15/11 at 11:10 AM, Nurse # 1 revealed she spoke with Resident # 5 ' s Physician and he said to change the Tube Feeding flush to 100 cc ' s of water every 4 hours.</p> <p>In an interview on 6/15/11 at 11:30 AM the Director of Nursing stated, " I would expect staff at the end of the month when transferring orders to double check for any changes in the orders.</p>	F 281	<p>Corrective Action Accomplished for those residents having potential to be affected by:</p> <p>All resident tube feeding flush orders were reviewed for accuracy on June 28, 2011.</p> <p>All current Tube Feeding Flush orders re-verified with MD for accuracy on 7-1-11. (Attachment #E3, E4, E5, and E6)</p> <p>Measures/Systemic Changes to ensure deficient practice does not recur:</p> <p>Nurse responsible for End of Month Physican Order Review will verify current flush order for accuracy and transcribe flush orders onto Tube Feeding Administration Record. (Attachment #E7 and #E8)</p> <p>Plans to Monitor Performance:</p> <p>A Second Nurse will sign off on Tube Feeding Administration Record for order/transcription accuracy. (Attachment #E7 and E8)</p>	<p>6-28-11</p> <p>7-1-11</p> <p>6-30-11</p> <p>7-1-11</p>	

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F 281	Continued From page 25	F 281			
F 286 SS=E	<p>Now the nurses record the Tube Feeding orders onto the computer and the ward secretary is the one who transfers the information from the computer to the resident ' record. "</p> <p>483.20(d) MAINTAIN 15 MONTHS OF RESIDENT ASSESSMENTS</p> <p>A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to maintain fifteen (15) months of resident Minimum Data Set (MDS) assessments in the active medical record for ten (10) of ten sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, # 9, #10). Findings included:</p> <p>1. Resident #1 was admitted to the facility on 09/27/2010.</p> <p>Medical record review revealed the following Minimum Data Set (MDS) assessments on the chart: an admission MDS dated 10/06/2010 and a quarterly MDS dated 03/22/2011.</p> <p>The MDS Coordinator was interviewed about assessments that might have been completed but not yet available on the residents' medical records. On 06/15/2011 at 11:50 AM., the MDS Coordinator stated she did not have any completed MDS assessments in the computer.</p> <p>On 06/15/2011 at 12:00 PM., the Administrator</p>	F 286	<p>Corrective Action Accomplished for affected residents as well as residents with the potential to be affected by: MDS Coordinator audited 100% of charts to ensure timely completion/placement of required MDS Assessments [ie, comprehensive, quarterly, etc] in each patient medical record [as applicable] (Attachment #B1)</p> <p>A "MDS Chain of Command Policy" was put into place to establish guidelines for communication of MDS issues to the CFO and/or President without punitive action. (Attachment #B2)</p> <p>All current MDS personnel will be educated on DHSR Regulations F272, F275, F276, F286, F287, F490 and "MDS Chain of Command Policy" by 7-13-11 and then annually. All new MDS personnel will be educated/in-serviced during New Hire Orientation and annually per the Unit Specific Orientation/Annual Competency Validation Checklist. (Attachment #B3)</p>	<p>7-1-11</p> <p>7-1-11</p> <p>7-13-11</p>	

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F 286	<p>Continued From page 26</p> <p>stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been completed as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 06/15/2011 at 12:00 PM., the Director of Nursing (DON) stated she was the staff member who was supposed to assist the Minimum Data Set (MDS) Coordinator if the MDS Coordinator began falling behind in completing assessments. On October 1, 2010, there was a change in management and the skilled nursing unit experienced an increase in census. The DON stated she became interim DON in October 2010 and remained clinical coordinator over the skilled nursing unit and was unable to assist the MDS Coordinator in performing/ completing assessments.</p> <p>On 06/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. A decision had been made to increase the census on the skilled nursing unit and residents were admitted to the skilled nursing unit quicker than the staff had the capability of completing MDS's. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. She stated she verbalized her concerns to the previous DON and asked for assistance. The MDS Coordinator stated she did not receive assistance until February 2011 when the facility hired another MDS Coordinator on an as needed (PRN) basis. She stated she had</p>	F 286	<p>Measures/Systemic Changes to ensure deficient practice does not recur:</p> <ul style="list-style-type: none"> <li>* MDS Coordinator position increased from 32 hours per week to 40 hours per week</li> <li>* MDS Computer upgrade</li> <li>* MDS Software upgrade</li> <li>* Hired 2nd MDS Coordinator</li> <li>* Mobile laptop for real time MDS data entry</li> <li>* iPad with software application for faster, more efficient real time MDS data entry</li> <li>* President-Administrator attended DHSR MDS Training [Raleigh]</li> <li>* MDS coordinator and Nurse Manager attended "Update in MDS 3.0 Implementation" presented by Cindy DePorter</li> <li>* RN with MDS 3.0 experience has been hired to fill previously vacant Clinical Coordinator position to serve as back up/additional MDS personnel.</li> </ul> <p>Plans to Monitor Performance:</p> <p>MDS assessments will be monitored for completion/placement in resident medical record through Random Spot Checks. (Attachment #B4) All relevant MDS due dates/completion dates will be discussed weekly for 3 months then monthly for 6 months in the Quality Assessment/Assurance Committee Meeting using the MDS Calendar Tool. (Attachment #B5)</p>	<p>10/10</p> <p>11/10</p> <p>12/10</p> <p>1/11</p> <p>2/11</p> <p>5/11</p> <p>6/11</p> <p>6/11</p> <p>7/11</p> <p>7-13-11</p>	

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F 286	<p>Continued From page 27</p> <p>given the MDS schedule for May 2011 to the prn MDS Coordinator for her to complete the assessments. The MDS Coordinator stated she checked the charts approximately one and one half (1 ½) weeks ago and realized all the assessments for May had not been completed as scheduled. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.</p> <p>2. Resident #2 was admitted to the facility on 01/14/2008.</p> <p>Medical record review revealed the following MDS assessments on the chart: a quarterly MDS assessment dated 09/07/2010 and an annual MDS assessment dated 03/03/2011.</p> <p>The MDS Coordinator was interviewed about assessments that might have been completed but not yet available on the residents' medical records. On 06/15/2011 at 11:50 AM., the MDS Coordinator stated she did not have any completed MDS assessments in the computer.</p> <p>On 06/15/2011 at 12:00 PM., the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been completed as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p>	F 286			

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F 286	<p>Continued From page 28</p> <p>On 06/15/2011 at 12:00 PM., the Director of Nursing (DON) stated she was the staff member who was supposed to assist the Minimum Data Set (MDS) Coordinator if the MDS Coordinator began falling behind in completing assessments. On October 1, 2010, there was a change in management and the skilled nursing unit experienced an increase in census. The DON stated she became interim DON in October 2010 and remained clinical coordinator over the skilled nursing unit and was unable to assist the MDS Coordinator in performing/ completing assessments.</p> <p>On 06/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. A decision had been made to increase the census on the skilled nursing unit and residents were admitted to the skilled nursing unit quicker than the staff had the capability of completing MDS's. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. She stated she verbalized her concerns to the previous DON and asked for assistance. The MDS Coordinator stated she did not receive assistance until February 2011 when the facility hired another MDS Coordinator on an as needed (PRN) basis. She stated she had given the MDS schedule for May 2011 to the prn MDS Coordinator for her to complete the assessments. The MDS Coordinator stated she checked the charts approximately one and one half (1 ½) weeks ago and realized all the assessments for May had not been completed as scheduled. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May</p>	F 286			

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F 286	<p>Continued From page 29 2011.</p> <p>3. Resident #3 was admitted to the facility 03/23/2010.</p> <p>Medical record review revealed the following MDS assessments on the chart: a quarterly MDS assessment dated 09/19/2010, a quarterly MDS assessment dated 01/26/2011 and an annual MDS assessment dated 04/23/2011.</p> <p>The MDS Coordinator was interviewed about assessments that might have been completed but not yet available on the residents' medical records. On 06/15/2011 at 11:50 AM., the MDS Coordinator stated she did not have any completed MDS assessments in the computer.</p> <p>On 06/15/2011 at 12:00 PM., the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been completed as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 06/15/2011 at 12:00 PM., the Director of Nursing (DON) stated she was the staff member who was supposed to assist the Minimum Data Set (MDS) Coordinator if the MDS Coordinator began falling behind in completing assessments. On October 1, 2010, there was a change in management and the skilled nursing unit experienced an increase in census. The DON stated she became interim DON in October 2010</p>	F 286			

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F 286	<p>Continued From page 30</p> <p>and remained clinical coordinator over the skilled nursing unit and was unable to assist the MDS Coordinator in performing/ completing assessments.</p> <p>On 06/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. A decision had been made to increase the census on the skilled nursing unit and residents were admitted to the skilled nursing unit quicker than the staff had the capability of completing MDS's. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. She stated she verbalized her concerns to the previous DON and asked for assistance. The MDS Coordinator stated she did not receive assistance until February 2011 when the facility hired another MDS Coordinator on an as needed (PRN) basis. She stated she had given the MDS schedule for May 2011 to the prn MDS Coordinator for her to complete the assessments. The MDS Coordinator stated she checked the charts approximately one and one half (1 ½) weeks ago and realized all the assessments for May had not been completed as scheduled. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.</p> <p>4. Resident #6 was admitted to the facility 12/10/2010.</p> <p>Medical record review revealed the following MDS assessments on the chart: an entry assessment dated 12/10/2010, an admission MDS assessment dated 12/22/2010 and a</p>	F 286			

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  06/15/2011
NAME OF PROVIDER OR SUPPLIER  PENDER MEMORIAL HOSP SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 507 FREMONT STREET 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 286	<p>Continued From page 31</p> <p>quarterly MDS assessment dated 04/13/2011.</p> <p>The MDS Coordinator was interviewed about assessments that might have been completed but not yet available on the residents' medical records. On 06/15/2011 at 11:50 AM., the MDS Coordinator stated she did not have any completed MDS assessments in the computer.</p> <p>On 06/15/2011 at 12:00 PM., the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been completed as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 06/15/2011 at 12:00 PM., the Director of Nursing (DON) stated she was the staff member who was supposed to assist the Minimum Data Set (MDS) Coordinator if the MDS Coordinator began falling behind in completing assessments. On October 1, 2010, there was a change in management and the skilled nursing unit experienced an increase in census. The DON stated she became interim DON in October 2010 and remained clinical coordinator over the skilled nursing unit and was unable to assist the MDS Coordinator in performing/ completing assessments.</p> <p>On 06/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. A decision had been made to increase the census on the skilled nursing unit and residents</p>	F 286			



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F 286	<p>Continued From page 32</p> <p>were admitted to the skilled nursing unit quicker than the staff had the capability of completing MDS's. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. She stated she verbalized her concerns to the previous DON and asked for assistance. The MDS Coordinator stated she did not receive assistance until February 2011 when the facility hired another MDS Coordinator on an as needed (PRN) basis. She stated she had given the MDS schedule for May 2011 to the prn MDS Coordinator for her to complete the assessments. The MDS Coordinator stated she checked the charts approximately one and one half (1 ½) weeks ago and realized all the assessments for May had not been completed as scheduled. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.</p> <p>5. Resident #9 was admitted to the facility 01/29/2010.</p> <p>Medical record review revealed the following MDS assessments on the chart: a quarterly MDS assessment dated 10/28/2010 and an annual MDS assessment dated 03/20/2011.</p> <p>The MDS Coordinator was interviewed about assessments that might have been completed but not yet available on the residents' medical records. On 06/15/2011 at 11:50 AM., the MDS Coordinator stated she did not have any completed MDS assessments in the computer.</p> <p>On 06/15/2011 at 12:00 PM., the Administrator</p>	F 286			

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F 286	<p>Continued From page 33</p> <p>stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been completed as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 06/15/2011 at 12:00 PM., the Director of Nursing (DON) stated she was the staff member who was supposed to assist the Minimum Data Set (MDS) Coordinator if the MDS Coordinator began falling behind in completing assessments. On October 1, 2010, there was a change in management and the skilled nursing unit experienced an increase in census. The DON stated she became interim DON in October 2010 and remained clinical coordinator over the skilled nursing unit and was unable to assist the MDS Coordinator in performing/ completing assessments.</p> <p>On 06/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. A decision had been made to increase the census on the skilled nursing unit and residents were admitted to the skilled nursing unit quicker than the staff had the capability of completing MDS's. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. She stated she verbalized her concerns to the previous DON and asked for assistance. The MDS Coordinator stated she did not receive assistance until February 2011 when the facility hired another MDS Coordinator on an as needed (PRN) basis. She stated she had</p>	F 286			

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F 286	<p>Continued From page 34</p> <p>given the MDS schedule for May 2011 to the prn MDS Coordinator for her to complete the assessments. The MDS Coordinator stated she checked the charts approximately one and one half (1 ½) weeks ago and realized all the assessments for May had not been completed as scheduled. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.</p> <p>6. Resident #10 was admitted to the facility 05/16/2011. Resident #10 was discharged from the facility 06/04/2011.</p> <p>Medical record review revealed there was not an admission Minimum Data Set (MDS) assessment on the chart.</p> <p>The MDS Coordinator was interviewed about assessments that might have been completed but not yet available on the residents' medical records. On 06/15/2011 at 11:50 AM., the MDS Coordinator stated she did not have any completed MDS assessments in the computer.</p> <p>On 06/15/2011 at 12:00 PM., the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been completed as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p>	F 286			

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F 286	<p>Continued From page 35</p> <p>On 06/15/2011 at 12:00 PM., the Director of Nursing (DON) stated she was the staff member who was supposed to assist the Minimum Data Set (MDS) Coordinator if the MDS Coordinator began falling behind in completing assessments. On October 1, 2010, there was a change in management and the skilled nursing unit experienced an increase in census. The DON stated she became interim DON in October 2010 and remained clinical coordinator over the skilled nursing unit and was unable to assist the MDS Coordinator in performing/ completing assessments.</p> <p>On 06/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. A decision had been made to increase the census on the skilled nursing unit and residents were admitted to the skilled nursing unit quicker than the staff had the capability of completing MDS's. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. She stated she verbalized her concerns to the previous DON and asked for assistance. The MDS Coordinator stated she did not receive assistance until February 2011 when the facility hired another MDS Coordinator on an as needed (PRN) basis. She stated she had given the MDS schedule for May 2011 to the prn MDS Coordinator for her to complete the assessments. The MDS Coordinator stated she checked the charts approximately one and one half (1 ½) weeks ago and realized all the assessments for May had not been completed as scheduled. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May</p>	F 286			

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F 286	<p>Continued From page 36 2011.</p> <p>7. Resident # 4 was admitted to the facility on 11/15/2010.</p> <p>Medical record review revealed the following MDS assessments on the chart: an entry MDS assessment dated 11/15/2010, an admission MDS assessment dated 11/27/2010 and a quarterly MDS assessment dated 3/27/2011.</p> <p>The MDS Coordinator was interviewed about assessments that might have been completed but not yet available on the residents' medical records. On 6/15/2011 at 11:50 AM, the MDS Coordinator stated she did not have any completed MDS assessments in the computer.</p> <p>On 6/15/2011 at 12:00 PM, the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been completed as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 6/15/2011 at 12:00 PM, the Director of Nursing (DON) stated she was the staff member who was supposed to assist the Minimum Data Set (MDS) Coordinator if the MDS Coordinator began falling behind in completing assessments. On October 1, 2010, there was a change in management and the skill nursing unit experienced an increase in census. The DON stated she became interim DON in October 2010</p>	F 286			

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F 286	<p>Continued From page 37</p> <p>and remained clinical coordinator over the skilled nursing unit and was unable to assist the MDS Coordinator in performing/ completing assessments.</p> <p>On 6/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. A decision had been made to increase the census on the skilled nursing unit and residents were admitted to the skilled nursing unit quicker than the staff had the capability of completing MDS 's. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. She stated she verbalized her concerns to the previous DON and asked for assistance. The MDS Coordinator stated she did not receive assistance until February 2011 when the facility hired another MDS coordinator on an as needed (PRN) basis. She stated she had given the MDS schedule for May 2011 to the prn MDS Coordinator for her to complete the assessments. The MDS Coordinator stated she checked the charts approximately one and one half (1 ½) weeks ago and realized all the assessments for May had not been completed as scheduled. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.</p> <p>8. Resident # 5 was admitted to the facility on 1/07/2007.</p> <p>Medical record review revealed the following MDS assessments on the chart: an annual MDS assessment dated 10/28/2010, a Quarterly MDS assessment dated 02/15/2011 and a Quarterly</p>	F 286			

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F 286	<p>Continued From page 38 MDS assessment dated 05/16/2011.</p> <p>On 6/15/2011 at 9:50 AM, the MDS Coordinator stated during the time change to MDS 3.0 they went through two different computer programs. The current Point-Click-Care programmers said they could import all our MDS information over into their program, which they didn't. All that information was dropped, if I had realized the information was dropped I would have done an annual MDS assessment.</p> <p>The MDS Coordinator was interviewed about assessments that might have been completed but not yet available on the residents' medical records. On 6/15/2011 at 11:50 AM, the MDS Coordinator stated she did not have any completed MDS assessments in the computer.</p> <p>On 6/15/2011 at 12:00 PM, the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been completed as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 6/15/2011 at 12:00 PM, the Director of Nursing (DON) stated she was the staff member who was supposed to assist the Minimum Data Set (MDS) Coordinator if the MDS Coordinator began falling behind in completing assessments. On October 1, 2010, there was a change in management and the skill nursing unit experienced an increase in census. The DON</p>	F 286		

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F 286	<p>Continued From page 39</p> <p>stated she became interim DON in October 2010 and remained clinical coordinator over the skilled nursing unit and was unable to assist the MDS Coordinator in performing/ completing assessments.</p> <p>On 6/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. A decision had been made to increase the census on the skilled nursing unit and residents were admitted to the skilled nursing unit quicker than the staff had the capability of completing MDS 's. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. She stated she verbalized her concerns to the previous DON and asked for assistance. The MDS Coordinator stated she did not receive assistance until February 2011 when the facility hired another MDS coordinator on an as needed (PRN) basis. She stated she had given the MDS schedule for May 2011 to the prn MDS Coordinator for her to complete the assessments. The MDS Coordinator stated she checked the charts approximately one and one half (1 ½) weeks ago and realized all the assessments for May had not been completed as scheduled. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.</p> <p>9. Resident # 8 was admitted to the facility on 2/10/2009.</p> <p>Medical record review revealed the following MDS assessments on the chart: an annual MDS assessment dated 1/31/2010, Quarterly MDS</p>	F 286			



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F 286	<p>Continued From page 40 assessment dated 4/22/2010, 7/16/2010, 10/10/2010 and 3/22/2011 and an annual MDS assessment dated 5/31/2011.</p> <p>The MDS Coordinator was interviewed about assessments that might have been completed but not yet available on the residents' medical records. On 6/15/2011 at 11:50 AM, the MDS Coordinator stated she did not have any completed MDS assessments in the computer.</p> <p>On 6/15/2011 at 12:00 PM, the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been completed as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 6/15/2011 at 12:00 PM, the Director of Nursing (DON) stated she was the staff member who was supposed to assist the Minimum Data Set (MDS) Coordinator if the MDS Coordinator began falling behind in completing assessments. On October 1, 2010, there was a change in management and the skill nursing unit experienced an increase in census. The DON stated she became interim DON in October 2010 and remained clinical coordinator over the skilled nursing unit and was unable to assist the MDS Coordinator in performing/ completing assessments.</p> <p>On 6/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October</p>	F 286		

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F 286	Continued From page 41 2010. A decision had been made to increase the census on the skilled nursing unit and residents were admitted to the skilled nursing unit quicker than the staff had the capability of completing MDS ' s. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. She stated she verbalized her concerns to the previous DON and asked for assistance. The MDS Coordinator stated she did not receive assistance until February 2011 when the facility hired another MDS coordinator on an as needed (PRN) basis. She stated she had given the MDS schedule for May 2011 to the prn MDS Coordinator for her to complete the assessments. The MDS Coordinator stated she checked the charts approximately one and one half (1 ½) weeks ago and realized all the assessments for May had not been completed as scheduled. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.	F 286		
F 287 SS=E	483.20(f) ENCODING/TRANSMITTING RESIDENT ASSESSMENT  (1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment.	F 287	Corrective Action Accomplished for affected residents as well as residents with the potential to be affected by:  MDS Coordinator audited 100% of charts to ensure timely completion/placement of required MDS Assessments [ie, comprehensive, quarterly, etc] in each patient medical record [as applicable] (Attachment #B1)	7-1-11

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F 287	Continued From page 42  (2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.  (3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on a resident that does not have an admission assessment.  (4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS.  This REQUIREMENT is not met as evidenced by: Based on medical record review and staff	F 287	A "MDS Chain of Command Policy" was put into place to establish guidelines for communication of MDS issues to the CFO and/or President without punitive action. (Attachment #B2)  All current MDS personnel will be educated on DHSR Regulations F272, F275, F276, F286, F287, F490 and "MDS Chain of Command Policy" by 7-13-11 and then annually. All new MDS personnel will be educated/in-serviced during New Hire Orientation and annually per the Unit Specific Orientation/Annual Competency Validation Checklist. (Attachment #B3)	7-1-11  7-13-11

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345245	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/15/2011
NAME OF PROVIDER OR SUPPLIER  PENDER MEMORIAL HOSP SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 607 FREMONT STREET 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 287	<p>Continued From page 43</p> <p>interview, the facility failed to electronically transmit admission, annual and quarterly Minimum Data Set (MDS) assessments for ten (10) of ten residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10). Findings included:</p> <p>1. Resident #1 was admitted to the facility on 09/27/2010.</p> <p>Medical record review revealed the following Minimum Data Set (MDS) assessments on the chart: an admission MDS dated 10/06/2010 and a quarterly MDS dated 03/22/2011.</p> <p>A query of the State Database on 06/15/2011 at 2:36 PM. did not have any transmissions for the period between October 2010 and March 2011 for Resident #1.</p> <p>On 06/15/2011 at 12:00 PM., the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been transmitted as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 06/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May</p>	F 287	<p>Measures/Systemic Changes to ensure deficient practice does not recur:</p> <ul style="list-style-type: none"> <li>* MDS Coordinator position increased from 32 hours per week to 40 hours per week</li> <li>* MDS Computer upgrade</li> <li>* MDS Software upgrade</li> <li>* Hired 2nd MDS Coordinator</li> <li>* Mobile laptop for real time MDS data entry</li> <li>* iPad with software application for faster, more efficient real time MDS data entry</li> <li>* President-Administrator attended DHSR MDS Training [Raleigh]</li> <li>* MDS coordinator and Nurse Manager attended "Update in MDS 3.0 Implementation" presented by Cindy DePorter</li> <li>* RN with MDS 3.0 experience has been hired to fill previously vacant Clinical Coordinator position to serve as back up/additional MDS personnel.</li> </ul> <p>Plans to Monitor Performance:</p> <p>MDS assessments will be monitored for completion/placement in resident medical record through Random Spot Checks. (Attachment #B4) All relevant MDS due dates/completion dates will be discussed weekly for 3 months then monthly for 6 months in the Quality Assessment/Assurance Committee Meeting using the MDS Calendar Tool. (Attachment #B5)</p>	<p>10/10</p> <p>11/11</p> <p>12/10</p> <p>1/11</p> <p>2/11</p> <p>5/11</p> <p>6/11</p> <p>6/11</p> <p>7/11</p> <p>7-13-11</p>

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F 287	<p>Continued From page 44 2011.</p> <p>2. Resident #2 was admitted to the facility on 01/14/2008.</p> <p>Medical record review revealed the following MDS assessments on the chart: a quarterly MDS assessment dated 09/07/2010 and an annual MDS assessment dated 03/03/2011.</p> <p>A query of the State Database on 06/15/2011 at 2:36 PM. did not have any transmissions for the period between October 2010 and March 2011 for Resident #2.</p> <p>On 06/15/2011 at 12:00 PM., the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been transmitted as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 06/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.</p> <p>3. Resident #3 was admitted to the facility 03/23/2010.</p>	F 287			

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F 287	<p>Continued From page 45</p> <p>Medical record review revealed the following MDS assessments on the chart: a quarterly MDS assessment dated 09/19/2010, a quarterly MDS assessment dated 01/26/2011 and an annual MDS assessment dated 04/23/2011.</p> <p>A query of the State Database on 06/15/2011 at 2:36 PM. did not have any transmissions for the period between October 2010 and March 2011 for Resident #3.</p> <p>On 06/15/2011 at 12:00 PM., the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been transmitted as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 06/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.</p> <p>4. Resident # 4 was admitted to the facility 11/15/2010.</p> <p>Medical record review revealed the following MDS assessments on the chart: an entry MDS</p>	F 287		

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F 287	<p>Continued From page 46</p> <p>assessment dated 11/15/2010, an admission MDS assessment dated 11/27/2010 and a quarterly MDS assessment dated 03/27/2011.</p> <p>A query of the State Database on 06/15/2011 at 2:36 PM. did not have any transmissions for the period between October 2010 and March 2011 for Resident #4.</p> <p>On 06/15/2011 at 12:00 PM., the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been transmitted as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 06/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.</p> <p>5. Resident #5 was admitted to the facility 01/07/2007.</p> <p>Medical record review revealed the following MDS assessments on the chart: an annual MDs assessment dated 10/28/2010, a quarterly MDS assessment dated 02/15/2011 and a quarterly MDS assessment dated 05/16/2011.</p>	F 287			

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F 287	<p>Continued From page 47</p> <p>A query of the State Database on 06/15/2011 at 2:36 PM. did not have any transmissions for the period between October 2010 and March 2011 for Resident #5.</p> <p>On 06/15/2011 at 12:00 PM., the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been transmitted as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 06/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.</p> <p>6. Resident #6 was admitted to the facility 12/10/2010.</p> <p>Medical record review revealed the following MDS assessments on the chart: an entry assessment dated 12/10/2010, an admission MDS assessment dated 12/22/2010 and a quarterly MDS assessment dated 04/13/2011.</p> <p>A query of the State Database on 06/15/2011 at 2:36 PM. did not have any transmissions for the</p>	F 287			



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F 287	<p>Continued From page 48 period between October 2010 and March 2011 for Resident #6.</p> <p>On 06/15/2011 at 12:00 PM., the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been transmitted as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 06/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.</p> <p>7. Resident # 7 was admitted to the facility 02/24/2011.</p> <p>Medical record review revealed the following MDS assessments on the chart: a MDS entry record dated 02/24/2011 and an admission MDS assessment dated 03/07/2011. A query of the State Database on 06/15/2011 at 2:36 PM. did not have any transmissions for the period between October 2010 and March 2011 for Resident #7.</p> <p>On 06/15/2011 at 12:00 PM., the Administrator stated there had been a change in the Chief</p>	F 287			

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F 287	<p>Continued From page 49</p> <p>Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been transmitted as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 06/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.</p> <p>8. Resident #8 was admitted to the facility 02/10/2009.</p> <p>Medical record review revealed the following MDS assessments on the chart: an annual MDS assessment dated 01/31/2010, Quarterly MDS assessments dated 4/22/2010, 07/16/2010, 10/10/2010 and 03/22/2011 and an annual MDS assessment dated 05/31/2011.</p> <p>A query of the State Database on 06/15/2011 at 2:36 PM. did not have any transmissions for the period between October 2010 and March 2011 for Resident #8.</p> <p>On 06/15/2011 at 12:00 PM., the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better</p>	F 287		

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F 287	<p>Continued From page 50</p> <p>organization. She stated she had not been aware that the Minimum Data Sets had not been transmitted as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 06/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.</p> <p>9. Resident #9 was admitted to the facility 01/29/2010.</p> <p>Medical record review revealed the following MDS assessments on the chart: a quarterly MDS assessment dated 10/28/2010 and an annual MDS assessment dated 03/20/2011.</p> <p>A query of the State Database on 06/15/2011 at 2:36 PM. did not have any transmissions for the period between October 2010 and March 2011 for Resident #9.</p> <p>On 06/15/2011 at 12:00 PM., the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been transmitted as required by regulation until recently. When asked if there had been a</p>	F 287		

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F 287	<p>Continued From page 51</p> <p>corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 06/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.</p> <p>10. Resident #10 was admitted to the facility 05/16/2011. Resident #10 was discharged from the facility 06/04/2011.</p> <p>Medical record review revealed there was not an admission Minimum Data Set (MDS) assessment on the chart.</p> <p>A query of the State Database on 06/15/2011 at 2:36 PM. did not have any transmissions for the period between October 2010 and March 2011 for Resident #10.</p> <p>On 06/15/2011 at 12:00 PM., the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been transmitted as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she became aware of the problem, she stated no.</p> <p>On 06/15/2011 at 12:00 noon, the MDS</p>	F 287			

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F 287	Continued From page 52 Coordinator stated problems began in October 2010. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.	F 287		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE  Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.  This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interview, the facility failed to obtain and verify weights for two (2) of ten (10) sampled residents (Resident #1, #2). Findings included:  1. Resident #1 was admitted to the facility on 09/27/2010. Cumulative diagnoses included: Dementia with behavioral problems, Depression, Anxiety, Glaucoma, Diabetes Mellitus and low albumin (02/22/2011).  A quarterly Minimum Data Set (MDS) dated	F 325	Corrective Action Accomplished By:  Resident #1 weight obtained and documented in the Medical Record for June is 126.8 lbs (Attachment #H1) Resident #2 weight obtained and documented in the Medical Record for June is 173.8 lbs (Attachment #H2)	6-30-11  6-28-11

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F 325	<p>Continued From page 53</p> <p>03/22/2011 indicated Resident #1 had short and long term memory impairment and was moderately impaired in decision-making. She required total assistance with eating. Resident #1 was on a mechanically altered/ therapeutic diet. Weight loss was noted on the MDS.</p> <p>A review of the weight record in Resident #1's chart revealed no weights recorded since resident's admission in September 2010.</p> <p>A review of the facility's weight record log book from January 2011 through June 2011 revealed a weight of 139.2 pounds for March 1, 2011 and 127.6 pounds for April 2011. Weights for January, February, May and June 2011 were blank.</p> <p>On 6/15/2011 at 11:30 AM., the unit clerk stated she looked at the weight record log book periodically (approximately every two weeks) and recorded the weights in the resident's medical record. She stated she did not notify anyone if there was not a weight recorded in the weight record log book. The unit clerk reviewed the weight record log book and stated she had failed to record the weights for March 2011 and April 2011 for Resident #1.</p> <p>On 06/15/2011 at 11:35 AM., Nurse #1 stated the nursing assistants obtained the resident's weights gave the information to the licensed nursing staff on the unit. The licensed staff documented the weights in the weight record log. The unit clerk transcribed the weights from the weight log book to the resident's medical record. Nurse #1 stated there was no one assigned to make sure all of the weights had been obtained and recorded in</p>	F 325	<p>A Policy was drafted to standardize weights on June 15, 2011. This policy was revised on June 30, 2011 to address resident refusals. (Attachment #A3)</p> <p>Measures/Systemic Changes to ensure deficient practice does not recur:</p> <p>All SNF staff members will be educated/in-serviced on the Weight Policy and Procedure by July 13, 2011 and then annually. All new SNF staff members will be educated/in-serviced on the Weight Policy and Procedure during New Hire Orientation and annually per the Unit Specific Orientation/Annual Competency Validation Checklist. (Attachment #A4, A5, and A6)</p> <p>Plans to Monitor Performance: All weights will be monitored through Random Spot Checks using the Weight Documentation Spot Check Tool. (Attachment #A7) All weight concerns will be monitored weekly for 3 months then monthly for 6 months through the Quality Assessment/Assurance Committee (Attachment #A8) using the Weekly Weight Quality Assurance Tool. (Attachment #A9)</p>	<p>6-30-11</p> <p>7-13-11</p> <p>7-13-11</p>

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F 325	<p>Continued From page 54</p> <p>the weight record book. Nurse #1 indicated she expected the weights to be recorded in the weight log book and on the resident's medical record.</p> <p>On 06/15/2011 at 112:30 PM., the Director of Nursing (DON) stated she expected weights to be obtained for all residents at lest monthly unless otherwise specified by physician's order. The DON said the weights were obtained by the nursing assistants. Weights were documented in the weight record log book by the licensed nursing staff and transcribed in the resident's medical record by the unit clerk. The DON stated Nurse #1 checked the weight record log book to ensure all weights have been obtained. She stated she expected the weights to be obtained at least monthly and documented on the resident's medical record.</p> <p>2. Resident #2 was admitted to the facility on 01/14/2008. Cumulative diagnoses included: Cerebrovascular accident (CVA), Quadriplegia, Aphasia, Diabetes Mellitus and Gastrostomy tube.</p> <p>A quarterly Minimum Data Set (MDS) indicated Resident #2 was alert and oriented and independent in decision-making. Resident #2 required total assistance with eating and received continuous gastrostomy tube feedings. No weight loss was noted on the MDS.</p> <p>A review of the weight record in Resident #2's chart revealed no weights recorded from January 2011 through June 2011.</p> <p>A review of the facility's weight record log book from January 2011 through June 2011 revealed a</p>	F 325			

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

PRINTED: 06/24/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345245</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/15/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>PENDER MEMORIAL HOSP SNF</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>507 FREMONT STREET BURGAW, NC 28425</b>		
(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 325	<p>Continued From page 55</p> <p>weight of 178.4 pounds for March, 2011 and 175.6 pounds for May 10, 2011. Weights for January, February, April and June 2011 were blank.</p> <p>On 6/15/2011 at 11:30 AM., the unit clerk stated she looked at the weight record log book periodically (approximately every two weeks) and recorded the weights in the resident's medical record. She stated she did not notify anyone if there was not a weight recorded in the weight record log book. The unit clerk reviewed the weight record log book and stated she had failed to record the weights for March 2011 and April 2011 for Resident #2.</p> <p>On 06/15/2011 at 11:35 AM., Nurse #1 stated the nursing assistants obtained the resident's weights gave the information to the licensed nursing staff on the unit. The licensed staff documented the weights in the weight record log. The unit clerk transcribed the weights from the weight log book to the resident's medical record. Nurse #1 stated there was no one assigned to make sure all of the weights had been obtained and recorded in the weight record book. Nurse #1 indicated she expected the weights to be recorded in the weight log book and on the resident's medical record.</p> <p>On 06/15/2011 at 11:30 PM., the Director of Nursing (DON) stated she expected weights to be obtained for all residents at least monthly unless otherwise specified by physician's order. The DON said the weights were obtained by the nursing assistants. Weights were documented in the weight record log book by the licensed nursing staff and transcribed in the resident's medical record by the unit clerk. The DON stated</p>	F 325			



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NAME OF PROVIDER OR SUPPLIER  PENDER MEMORIAL HOSP SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 507 FREMONT STREET 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 325	Continued From page 56 Nurse #1 checked the weight record log book to ensure all weights have been obtained. She stated she expected the weights to be obtained at least monthly and documented on the resident's medical record.	F 325		
F 490 SS=E	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING  A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.  This REQUIREMENT is not met as evidenced by: Resident # 7 was admitted to the facility 02/24/2011.  Medical record review revealed the following MDS assessments on the chart: a MDS entry record dated 02/24/2011 and an admission MDS assessment dated 03/07/2011. A query of the State Database on 06/15/2011 at 2:36 PM. did not have any transmissions for the period between October 2010 and March 2011 for Resident #7.  On 06/15/2011 at 12:00 PM., the Administrator stated there had been a change in the Chief Nurse Executive position and the facility was just beginning to get things in place for better organization. She stated she had not been aware that the Minimum Data Sets had not been transmitted as required by regulation until recently. When asked if there had been a corrective plan of action initiated when she	F 490	Corrective Action Accomplished for affected residents as well as residents with the potential to be affected by:  MDS Coordinator audited 100% of charts to ensure timely completion/placement of required MDS Assessments [ie, comprehensive, quarterly, etc] in each patient medical record [as applicable] (Attachment #B1)  A "MDS Chain of Command Policy" was put into place to establish guidelines for communication of MDS issues to the CFO and/or President without punitive action. (Attachment #B2)  All current MDS personnel will be educated on DHSR Regulations F272, F275, F276, F286, F287, F490 and "MDS Chain of Command Policy" by 7-13-11 and then annually. All new MDS personnel will be educated/in-serviced during New Hire Orientation and annually per the Unit Specific Orientation/Annual Competency Validation checklist. (Attachment #B3)	7-1-11  7-1-11  7-13-11

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NAME OF PROVIDER OR SUPPLIER  PENDER MEMORIAL HOSP SNF			STREET ADDRESS, CITY, STATE, ZIP CODE 607 FREMONT STREET BURGAW, NC 28425		
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F 490	Continued From page 57 became aware of the problem, she stated no.  On 06/15/2011 at 12:00 noon, the MDS Coordinator stated problems began in October 2010. The MDS Coordinator stated she struggled to keep the assessments up to date but was unable to do so. When asked regarding a time frame that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011.	F 490	Measures/Systemic Changes to ensure deficient practice does not recur: * MDS Coordinator position increased from 32 hours per week to 40 hours per week * MDS Computer upgrade * MDS Software upgrade * Hired 2nd MDS Coordinator * Mobile laptop for real time MDS data entry * iPad with software application for faster, more efficient real time MDS data entry * President-Administrator attended DHR MDS Training [Raleigh] * MDS coordinator and Nurse Manager attended "Update in MDS 3.0 Implementation" presented by Cindy DePorter * RN with MDS 3.0 experience has been hired to fill previously vacant Clinical Coordinator position to serve as backup/additional MDS personnel.  Plans to Monitor Performance: MDS assessments will be monitored for completion/placement in resident medical record through Random Spot Checks. (Attachment #B4) All relevant MDS due dates/completion dates will be discussed weekly for 3 months then monthly for 6 months. in the Quality Assessment/Assurance Committee Meeting using the MDS Calendar Tool. (Attachment #B5)	10/10 11/11 12/10 1/11 2/11 5/11 6/11 6/11 7/11  7-13-11	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345245	(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01 B WING _____	(X3) DATE SURVEY COMPLETED  07/08/2011
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NAME OF PROVIDER OR SUPPLIER  PENDER MEMORIAL HOSP SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 507 FREMONT STREET BURGAW, NC 28425
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K 038 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: A. Based on observation on 07/08/2011 the facility had N.C. Special Locking on an Exit door in the path of egress from the stair well. This lock operation does not meet the code for N.C Special Locking accepted by CMS. 42 CFR 483.70 (a)</p>	K 038	<p>K 038</p> <p>Corrective Action Accomplished by:</p> <p>The special locking on that exit door has been removed and the connection to the computer has been removed. A standard panic bar has been installed on the door.</p> <p>All exits throughout the building were checked to assure this special locking does not occur elsewhere.</p>	7-18-11
K 061 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems have valves supervised so that at least a local alarm will sound when the valves are closed. NFPA 72, 9.7.2.1</p> <p>This STANDARD is not met as evidenced by: A Based on observation on 07/08/2011 the facility had installed a new back-flow preventer (located in a hot-box outside) and the valves (2) were not supervised. B The old back -flow is in a pit about (20) twenty feet from the new one, this has a main control valve which is still in use that is not supervised C. The PIV does have a tamper alarm installed but it does not work, no signal was sent ( visual or audible)</p>	K 061	<p>Measures/Systemic Changes to ensure deficit practice does not recur:</p> <p>Education was provided to all Plant Operations employees concerning this code standard.</p> <p>Plans to Monitor:</p> <p>Any changes to any exit doors cannot be accomplished without Plant Ops Manager's approval. Exit doors will be an agenda item on the next 3 Environment of Care committees and then reviewed annually at Environment of Care Committee</p>	7-18-11          7-18-11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Kath A. Shaver* TITLE *President* (X6) DATE *7-22-11*

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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STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  345245	(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01 B WING _____	(X3) DATE SURVEY COMPLETED  07/08/2011
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NAME OF PROVIDER OR SUPPLIER  PENDER MEMORIAL HOSP SNF	STREET ADDRESS, CITY, STATE, ZIP CODE 507 FREMONT STREET BURGAW, NC 28425
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K 061	Continued From page 1 42 CFR 483.70 (a)	K 061	<p>K 061 Corrective Action Accomplished by:</p> <p>3 tamper switches for the back flow valves will be installed. The PIV's tamper alarm will be repaired.</p> <p>After completion of the tamper switches and the repair of the PIV tamper alarm, an inspection will take place by the Town of Burgaw – Fire Chief and Inspection Department. All shut off valves for the Sprinkler System will be inspected.</p> <p>Measures/Systemic Changes to ensure deficit practice does not recur:</p> <p>Tamper switches will remain in place at all times. Education was provided to Plant Operations employees of the code regulations concerning these tamper alarms.</p> <p>Plans to Monitor:</p> <p>Results of the inspections will be reported through the next Environment of Care Committee. An annual testing will be completed on these tamper switches and reported through the Environment of Care committee</p>	<p>7-29-11</p> <p>7-29-11</p> <p>7-29-11</p>