Email received 3/16/12 accepted in aspen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345472	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWOOD NURSING AND RETIREME	180 SOUTHWOOD DRIVE BOX 708 CLINTON, NC 28328

(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 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure that a resident's drug regimen was free from an unnecessary drug for 1 of 10 residents (Resident #117). Findings included: Record review indicated Resident #117 was	F 329	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 329 **Corrective Action for Resident Affected** The Zocor for Resident #117 was discontinued according to physician order on 1/5/2012. **Corrective Action for Resident Potentially Affected** All residents have the potential to be affected by this practice. On March 15, 2012 the director of nursing and support nurse audited all resident charts for pharmacy consultant reports that have not been implemented. This was completed by first reviewing the summary consultant reports for the last three months and then checking the medical record to ensure that the consult was addressed by the attending physician and that any order changes had been implemented by the staff nurses. Consult reports were also checked to ensure that the medication changes were for the correct resident. Additionally, the pharmacy consultant reviewed all consultant reports written in the last 3 months to ensure that consults have been addressed by the attending physician and	January 5, 2012 March 15, 2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joseph P Kalmar — TITLE: Administrator — (X6) DATE: 3/15/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PB

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F 329	Continued From page 1 admitted to the facility on 11/15/2011. Review of the resident's Accumulative Diagnosis Sheet indicated the following diagnoses: Chronic Kidney Disease, Hypertension, Cardiac Dysrhythmias, Osteoarthritis, Dementia, Allergic Rhinitus, Congestive Heart Failure, Bradycardia, Chronic Kidney Disease, and Osteoarthritis. Review of the resident's admission orders dated 11/15/2011 revealed the following medications: 1. Norvasc 10 milligrams (mg) every day (qd) 2. Hydralazine HCL 25 mg three times a day (tid) 3. Metoprolol Tartrate 100 mg two times a day (bid) 4. Cetirizine HCL 10 mg at bedtime (hs) 5. Lisinopril 2.5 mg every morning. 6. Aricept 5 mg qd 7. Tylenol 650 mg every 4 hrs as needed (prn) 8. Tramadol 50 mg q 4 hrs prn 9. Coumadin 6 mg every Tuesday, Thursday and Saturday 10. Coumadin 5 mg every Monday, Wednesday, Friday and Sunday Review of a physician's order dated 11/21/2011 at 1:00 PM indicated an order that read "Decrease Zocor to 10 mg." The order was signed by Licensed Practical Nurse (LPN) #2. Review of the resident's November 2011 medication administration record (MAR) revealed Zocor 10 mg was started on 11/21/2011 with the first dose given on 11/22/2011. Record review of Pharmacy Progress notes dated 12/08/2011 revealed "Consult on chart to reduce	F 329	~~implemented by the staff nurses.~~ Consult reports were also checked to ensure that the medication changes were for the correct resident. Any consults that have not been addressed will be called to the physician by the Director of Nursing or Support Nurse and any orders received will be implemented as appropriate. Systemic Changes An in-service was conducted on Thursday, March 15, 2012 by Staff Development Coordinator Nurse. All nurses attended: RNs and LPNs, FT, PT and PRN. Any in-house nurse who did not receive in-service training by Monday, March 19th, 2012 will not be allowed to work until training has been completed. The in-service topics included the following: 1. The difference between a routine pharmacy consult report and a non-routine pharmacy consultant report. A non-routine consult report would include any item that is a medication error, allergic reaction or other item that might harm to the resident if medication administration continued. 2. The proper procedure for handling a non-routine pharmacy consultant report will include calling the physician and if there is no response by the end of the shift then the DON or other nurse manager should be contacted for instructions. They will then advise staff on what steps should be implemented to protect the resident. This might include whether to hold the medication or contact the medical director.	March 19, 2012

Recieved 3/26/12

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F 329	Continued From page 2 Zocor to 10 mg, however, this was to be sent on another resident. This occurred while the resident was at (other facility). The order had been voided there". The note was signed by the facility Pharmacy Consultant. Review of a fax dated 12/08/2011 indicated under Presenting Concern and What Lead To Concern "Resident #117 is taking Zocor 10 mg from a consult that was on the wrong patient. This was initiated here on 11/2/2011. Can we discontinue this order, no diagnosis of hyperlipidemia." The fax was signed by LPN #1 and time stamped 12/08/2011. The fax was addressed to Physician #1. Review of a physician progress note dated 12/21/2011 and signed by Physician #2, the resident's attending physician, revealed "She also has hypercholesterolemia, I reviewed medications and will make no changes at this time". Review of a fax dated 12/08/2011 indicated under Presenting Concern and What Lead To Concern "Resident #117 is taking Zocor 10 mg from a consult that was on the wrong patient. This was initiated here on 11/2/2011. Can we discontinue this order, no diagnosis of hyperlipidemia." The fax was signed by Licensed Practical Nurse #1 (LPN #1) and time stamped 12/29/2011. The fax was addressed to Physician #2. Physician #2 wrote and order to discontinue Zocor on 12/30/2011. Physician # 1 wrote and order to discontinue Zocor on 01/04/2012. Review of physician orders indicated Zocor was discontinued on 01/05/2012.	F 329	~~This information has been integrated into the~~ standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. Quality Assurance The Director of Nursing will monitor this issue using the "Survey QA Tool for Pharmacy Consultant Reports". The monitoring will include checking all pharmacy consults for non-routine events and following up on nursing response to the issues. See attached monitoring tool. This will be done weekly or whenever the pharmacy consultant review medications for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Pharmacy Consultant will monitor this issue using the "Survey QA Tool for Pharmacy Consultant Reports". The monitoring will include checking all pharmacy consults for non-routine events and following up on nursing response to the issues. See attached monitoring tool. This will be done weekly or whenever the pharmacy consultant review medications for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.	ongoing ~~June~~ June 15, 2012

M.P. Kapur

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F 329	Continued From page 3 Review of the resident's MAR indicated Zocor 10 mg was scheduled daily 11/22/2011 until 01/05/2012. Twelve doses throughout this period were signed as not given, medication unavailable. In an interview with LPN #1 on 02/28/2012 at 11:00 AM, she reported on 12/08/2011, she was approached by the facility Pharmacist Consultant who reported Resident #117 was on Zocor in error. Upon direction from the consultant, she faxed the report to the Physician #1 on 12/08/2011 which indicated Resident #117 was taking Zocor from a consult meant for another patient and asking if the Zocor could be discontinued on that basis along with information which showed the resident did not have a diagnosis which supported the use of Zocor. The nurse reported she faxed this information with the facility Pharmacist Consultant at her side. She also reported she refaxed the information to Physician #2 on 12/29/2011 because no action had been taken on the original fax sent on 12/08/2011. LPN #1 further indicated she knew the resident continued receiving Zocor after the Pharmacy Consultant told her the resident should not be taking it. The facility Pharmacist Consultant was interviewed on 02/29/2012 at 9:30 AM and indicated the original consult for Zocor was done while resident #117 was in a different facility and further reported the consult had the resident's name on it but was meant for another resident. She indicated she caught the error immediately at the other facility, and the order was voided out by her. She further indicated Resident #117 never received Zocor while in the other facility. She also indicated when she did the drug regimen review	F 329		

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F 329	Continued From page 4 for resident #117 on 12/08/2011, she saw the resident had been put on Zocor on 11/21/2012. She indicated she went to LPN #1 and reported the error to her and asked her to contact the physician. She revealed LPN #1 reported it would be better to fax the information to the physician. The Pharmacist indicated she stayed with LPN #1 while she faxed the information because it needed to be handled immediately. The Pharmacist also indicated there was usually good turnaround in response time to pharmacy recommendations and was not sure why this one took so long. The Pharmacist further reported from a pharmaceutical standpoint, the side effect concerns for a resident on Zocor was myopathies and liver function. The Pharmacist also reported Resident #117 had no diagnoses that supported the use of Zocor. LPN #2 was interviewed on 02/29/2012 at 10:34 AM and indicated on 11/21/2011, she took the order for Zocor from a consult sheet. She indicated this consult could not be located. In an interview with the facility Director of Nursing (DON) on 02/29/2012 at 10:54 AM, she reported "We have held medications in the past per nursing judgement. The nurses should have held the Zocor if they knew it was ordered in error and continued to call the physician. In this case, my expectations were the nurse should have called the doctor instead of faxing, as this resident was receiving Zocor in error." The DON also reported they could not locate a consult sheet for Resident #117 with an order for Zocor on 11/21/2011. In an interview with Physician #1 on 03/01/2012 at 10:10 AM, he indicated Physician #2 was one	F 329		

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F 329	Continued From page 5 of his partners and the attending physician of Resident #117. He reported it was not unusual for consults to be sent to him on one of his partner's patients. He indicated sometimes he contacted the facility and let them know it was not his patient, but he also indicated that at times, he addressed the issue himself. He indicated in this case, he addressed the Zocor issue when he got it, based on the information from the pharmacist. He further indicated, due to him having 2 offices in 2 towns, consult papers got backed up, so he very well may not have seen the consult until a month later. The resident's attending physician, Physician #2, was unavailable for interview.	F 329	**F 371** **Corrective Action for Resident Affected** No residents were identified in the 2567 to be affected. On February 29, 2012 the dietary worker observed not wearing a hair net put a hair net on for the remainder of his shift and been compliant with the dress code policy since. **Corrective Action for Resident Potentially Affected** All residents have the potential to be affected by this practice. On February 29, 2012 the dietary manager reviewed the dress code policy and monitored all staff comply with the dress code policy. No hairs or other pathogens were found in resident food.	Feb. 29, 2012 Feb. 29, 2012
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facililty failed to ensure that staff wore hairnets during the tray line. Findings included:	F 371	**Systemic Changes** An in-service was conducted on March 15, 2012- by the Dietary Manager for all dietary personnel. Any in-house staff member who did not receive in-service training by March 19, 2012 will not be allowed to work until training has been completed. The in-service topics include: potential hazards to food safety and the dress code policy. It is our responsibility to ensure foods prepared and served are safe to consume. **Quality Assurance** The Dietary Manager or designee will monitor this issue using the "Dietary Dress Code Policy QA Tool". The monitoring will include checking all staff that work are wearing a hair net and following the dress code as indicated. See attached monitoring tool. This will be done daily for three months or until resolved by QA committee. Reports will be given to the weekly Quality of Life - QA committee and corrective action initiated as appropriate.	March 19, 2012

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F 371	Continued From page 6 Continuous tray line observation done on 02/29/2012 revealed the following: The lunch tray line began at 12:02 PM. Dietary Staff #1 was positioned at the end of the line. His hair was observed to be a short to medium tight curly style. Dietary Staff #1 was also observed with a short beard. During the tray line, he was positioned over filled beverage glasses which had no lids. As each tray came to the end of the line, he bent over the filled beverage glasses, picked up each tray and placed a lid over the plate on the tray. He then placed filled beverage glasses, over which he stood, on each tray. He then placed each completed tray on the meal cart. He repeated this process until all trays were done. The tray line ended at 12:40 PM. On 02/29/2012 at 12:41 PM, Dietary Staff #1 was interviewed and asked if he was supposed to wear a hair net during the tray line. He responded "I don't have to wear a hair net because my hair is short." Review of the Dietary Services Program: Number DS-100 indicated under "Dress Code" Hair nets covering all hair will be worn by all dietary employees at all times. Caps or nets shall be worn by male employees according to the length of their hair. The facility Dietary Manager Ashley was interviewed on 02/29/2012 at 12:50 PM and indicated Dietary Staff #1's hair was usually short, and a hair net was not usually needed. She further indicated it had grown out, and he should have worn a net during the tray line.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		

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F 428	Continued From page 7 The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to act on a pharmacist recommendation for 1 of 10 residents (Resident #117). Findings included: Record review indicated Resident #117 was admitted to the facility on 11/15/2011. Review of the resident's Accumulative Diagnosis Sheet indicated the following diagnoses: Chronic Kidney Disease, Hypertension, Cardiac Dysrhythmias, Osteoarthritis, Dementia, Allergic Rhinitus, Congestive Heart Failure, Bradycardia, Chronic Kidney Disease, and Osteoarthritis. Review of the resident's admission orders dated 11/15/2011 revealed the following medications: 1. Norvasc 10 milligrams (mg) every day (qd) 2. Hydralazine HCL 25 mg three times a day (tid) 3. Metoprolol Tartrate 100 mg two times a day	F 428	F 428 **Corrective Action for Resident Affected** The Zocor for Resident #117 was discontinued according to physician order on 1/5/2012. **Corrective Action for Resident Potentially Affected** All residents have the potential to be affected by this practice. On March 15, 2012 the director of nursing and support nurse audited all resident charts for pharmacy consultant reports that have not been implemented. This was completed by first reviewing the summary consultant reports for the last three months and then checking the medical record to ensure that the consult was addressed by the attending physician and that any order changes had been implemented by the staff nurses. Consult reports were also checked to ensure that the medication changes were for the correct resident. Additionally, the pharmacy consultant reviewed all consultant reports written in the last 3 months to ensure that consults have been addressed by the attending physician and implemented by the staff nurses. Consult reports were also checked to ensure that the medication changes were for the correct resident. Any consults that have not been addressed will be called to the physician by the Director of Nursing or Support Nurse and any orders received will be implemented as appropriate.	January 5, 2012 March 15th, 2012

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F 428	Continued From page 8 (bid) 4. Cetirizine HCL 10 mg at bedtime (hs) 5. Lisinopril 2.5 mg every morning. 6. Aricept 5 mg qd 7. Tylenol 650 mg every 4 hrs as needed (prn) 8. Tramadol 50 mg q 4 hrs prn 9. Coumadin 6 mg every Tuesday, Thursday and Saturday 10. Coumadin 5 mg every Monday, Wednesday, Friday and Sunday Review of a physician's order dated 11/21/2011 at 1:00 PM indicated an order that read "Decrease Zocor to 10 mg." The order was signed by Licensed Practical Nurse (LPN) #2. Review of the resident's November 2011 medication administration record (MAR) revealed Zocor 10 mg was started on 11/21/2011 with the first dose given on 11/22/2011. Record review of Pharmacy Progress notes dated 12/08/2011 revealed "Consult on chart to reduce Zocor to 10 mg, however, this was to be sent on another resident. This occurred while the resident was at (other facility). The order had been voided there". The note was signed by the facility Pharmacy Consultant. Review of a fax dated 12/08/2011 indicated under Presenting Concern and What Lead To Concern "Resident #117 is taking Zocor 10 mg from a consult that was on the wrong patient. This was initiated here on 11/2/2011. Can we discontinue this order, no diagnosis of hyperlipidemia." The fax was signed by LPN #1 and time stamped 12/08/2011. The fax was addressed to Physician #1.	F 428	**Systemic Changes** An in-service was conducted on Thursday, March 15, 2012 by Staff Development Coordinator Nurse. All nurses attended: RNs and LPNs, FT, PT and PRN. Any in-house nurse who did not receive in-service training by Monday, March 19th, 2012 will not be allowed to work until training has been completed. The in-service topics included the following: 1. The difference between a routine pharmacy consult report and a non-routine pharmacy consultant report. A non-routine consult report would include any item that is a medication error, allergic reaction or other item that might harm to the resident if medication administration continued. 2. The proper procedure for handling a non-routine pharmacy consultant report will include calling the physician and if there is no response by the end of the shift then the DON or other nurse manager should be contacted for instructions. They will then advise staff on what steps should be implemented to protect the resident. This might include whether to hold the medication or contact the medical director. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.	March 19, 2012

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F 428	Continued From page 9 Review of a physician progress note dated 12/21/2011 and signed by Physician #2, the resident's attending physician, revealed "She also has hypercholesterolemia, I reviewed medications and will make no changes at this time". Review of a fax dated 12/08/2011 indicated under Presenting Concern and What Lead To Concern "Resident #117 is taking Zocor 10 mg from a consult that was on the wrong patient. This was initiated here on 11/2/2011. Can we discontinue this order, no diagnosis of hyperlipidemia." The fax was signed by Licensed Practical Nurse #1 (LPN #1) and time stamped 12/29/2011. The fax was addressed to Physician #2. Physician #2 wrote and order to discontinue Zocor on 12/30/2011. Physician # 1 wrote and order to discontinue Zocor on 01/04/2012. Review of physician orders indicated Zocor was discontinued on 01/05/2012. Review of the resident's MAR indicated Zocor 10 mg was scheduled daily 11/22/2011 until 01/05/2012. Twelve doses throughout this period were signed as not given, medication unavailable. In an interview with LPN #1 on 02/28/2012 at 11:00 AM, she reported on 12/08/2011, she was approached by the facility Pharmacist Consultant who reported Resident #117 was on Zocor in error. Upon direction from the consultant, she faxed the report to the Physician #1 on 12/08/2011 which indicated Resident #117 was taking Zocor from a consult meant for another patient and asking if the Zocor could be discontinued on that basis along with information	F 428	**Quality Assurance** The Director of Nursing will monitor this issue using the "Survey QA Tool for Pharmacy Consultant Reports". The monitoring will include checking all pharmacy consults for non-routine events and following up on nursing response to the issues. See attached monitoring tool. This will be done weekly or whenever the pharmacy consultant review medications for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate. The Pharmacy Consultant will monitor this issue using the "Survey QA Tool for Pharmacy Consultant Reports". The monitoring will include checking all pharmacy consults for non-routine events and following up on nursing response to the issues. See attached monitoring tool. This will be done weekly or whenever the pharmacy consultant review medications for three months or until resolved by QOL/QA committee. Reports will be given to the weekly Quality of Life- QA committee and corrective action initiated as appropriate.	ongoing June 15, 2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345472	A. BUILDING _____ B. WING _____	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWOOD NURSING AND RETIREME	180 SOUTHWOOD DRIVE BOX 708 CLINTON, NC 28328

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F 431	Continued From page 12 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to ensure that there were no expired medications in the medication storage room. The findings include:	F 431	F 431 **Corrective Action for Resident Affected** No residents were identified in the 2567 to be affected. The expired medications were removed from the medication room by DON on March 1, 2012. **Corrective Action for Resident Potentially Affected** All residents have the potential to be affected by this practice. On March 1, 2012 the director of nursing reviewed all medications in the medication room for expiration dates. On March 14, 2012 the pharmacy consultant reviewed the medication room for expired medications. No expired medications were found. **Systemic Changes** An in-service was conducted on March 15, 2012- by the Staff Development. Those who attended all RNs, and LPNs, FT, PT, and PRN. Any in-house staff member who did not receive in-service training by March 19, 2012 will not be allowed to work until training has been completed. The in-service topics included ensuring that any medication that they utilize from the medication room has not expired.	March 1, 2012 March 14 2012 March 19, 2012

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F 431	Continued From page 13 During an observation of the emergency medication box located in the medication storage room on 03/01/12 at 11:15 AM, four Erythromycin 250 mg. (milligram) tablets with an expiration date of 01/20/12 were found in the lower drawer of the emergency box. There was a hand written label on the top of the box that had the date 12/31/11 written on it. During an interview with the Director of Nursing on 03/01/12 at 11:25 AM it was revealed "the box is checked by pharmacy once a month. The date on the box is the last time it was checked. They are here all the time, I don't know why there are expired drugs in the box." At 11:35 AM the Director of Nursing was interviewed again. At this time she stated "I have just spoken to the pharmacy, I was wrong. They keep a list of the expiration dates of all the medications in the emergency box and they come out when a drug is about to expire. They said it was just an oversight on there part. This will be fixed today."	F 431	Currently pharmacy conducts an on-sight review to identify any expired medications and replaces them with current medications. In addition to this review the central supply coordinator will review the medication room on a weekly basis to ensure that expired medications are returned to pharmacy in a timely manner. The central supply coordinator was educated on this new process on March 13, 2012 by the DON. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. **Quality Assurance** The Director of Nursing will monitor this issue using the "Survey QA Tool Medication Room Review". The monitoring will include checking the medication room to ensure that no expired medications are in the room. See attached monitoring tool. This will be done weekly for three months or until resolved by QA committee. Reports will be given to the weekly Quality of Life - QA committee and corrective action initiated as appropriate.	ongoing June 15, 2012

Survey QA Tool for Pharmacy Consultant Reports

Instructions:
After the facility consult pharmacist has reviewed all charts and made recommendations all recommendations and summary report are provided to the DON. The DON will check for non-routine pharmacy consults and follow up on nursing response to pharmacy recommendations.

All pharmacy recommendations will be monitored until all recommendations have been completed from monthly pharmacist visit. A weekly review by the QA team of compliance with pharmacy recommendations will be completed for 3 months and placed in the monthly QOL record.

Date of Report _____

Person completing QA tool _____

Date Pharmacist recommendations received by DON	
(Y/N) Any non-routine pharmacy consults received?	
Non-routine pharmacy consults completed in a timely manner?	
(Y/N) All MD consults completed from pharmacy recommendations?	
(Y/N) All Staff recommendations completed from pharmacy recommendations?	

Pharmacy Consultant Reviewed QA Tool

Initials: _____

Date: _____

Problems indicated:

SOUTHWOOD NURSING & RETIREMENT CENTER

DIETARY Dress Code Policy QA AUDIT

WEEK OF_____

DATE							
All Staff in Proper Uniform							
All Staff wearing hair nets covering all hair							
Comments							

Survey QA Tool Medication Room Review

Instructions:
The medication room will be reviewed by the Supply Clerk or designee on a weekly basis. Any medications or therapeutic items found to be expired will be removed from the medication room and reported to the DON.

This will be completed weekly for 3 months and placed in the monthly QOL record.

Date of Review				
(Y/N) Medication room reviewed for expired medications.				
(Y/N) Any medications found to be expired?				
Initials of person inspecting room for				

Pharmacy Consultant Reviewed QA Tool

Initials: _____

Date: _____

Problems indicated:

PRINTED: 03/23/2012
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K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the Existing Health Care section of the LSC and its referenced publications. This building is Type III(211) construction, one story, with a complete automatic sprinkler system. The deficiencies determined during the survey are as follows:	K 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation on between 12:30 PM and 4:30 PM the following was noted: 1) The door to the boiler room located next to the staff exit is not self-closing. 2) The clean utility room is not self-closing. 3) The dry storage room in the kitchen is not self closing . 42 CFR 483.70(a)	K 029	K029 Corrective Action for Deficient Practice On 3/28/2012 the three doors identified: boiler room, clean utility room and dry storage room in the dietary department had self closing mechanisms installed. Identify other issues having potential to affect residents by the same practice All facility doors attached to rooms with stored hazardous materials have been inspected for a self closing mechanism on the door and in working order. Systemic Changes The administrator and maintenance director will ensure doors attached to rooms with stored hazardous materials have self closing mechanisms. Quality Assurance The administrator and maintenance director will monitor door closing mechanism during weekly environmental rounds. K038 Corrective Action for Deficient Practice On March 28, 2012 the Smitha Hare Memorial Garden gate received a caster on the bottom of the gate to allow for easy opening. On April 4, 2012 concrete was layed from the main Smitha Hare Memorial Garden walk way to the gate for exit purposes.	March 28, 2012 April 4, 2012

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

Jennifer P Sumner — Administrator — 4/6/2012

PRINTED: 03/23/2012
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K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation on between 12:30 PM and 4:30 PM the following was noted: 1) In the Smitha Hare Memorial Garden there is not a hard service path to the public way. 2) The gate in the Smitha Hare Memorial Garden required more than 15 lbs of force to open. Gate is dragging on the ground and will not allow for gate to be opened. 42 CFR 483.70(a)	K 038	Identify other issues having potential to affect residents by the same practice All exits were assessed and found to be accessible. Systemic Changes The administrator and maintenance director will ensure exits are easily accessible and in accordance to life safety codes. Quality Assurance The administrator and maintenance director will monitor exit doors and gates on weekly environmental rounds. K045 Corrective Action for Deficient Practice On April 3, 2012 a double light fixture was secured above the door of the Smitha Hare Memorial Garden connected to the emergency power. Identify other issues having potential to affect residents by the same practice All other emergency lights outside exit doors were inspected for compliance. Systemic Changes The administrator and maintenance director will ensure emergency lights are affixed and working properly during weekly environmental rounds. Quality Assurance The administrator and maintenance director will monitor emergency lights on weekly environmental rounds.	April 3, 2012
K 045 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation on between 12:30 PM and 4:30 PM the following was noted: 1) Additional illumination connected to emergency power is need in the Smitha Hare Memorial Garden.	K 045	K056 Corrective Action for Deficient Practice By April 26, 2012 the sprinkler heads under the carport will be replaced by the sprinkler system contractor. By April 11, 2012 a power source connected to the facility emergency power system will be ran to the sprinkler riser room and supplemental heat source connected. By April 26, 2012 the sprinkler system	April 26, 2012

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K 045	Continued From page 2 42 CFR 483.70(a)	K 045	contractor will supply a minimum of three 200 degree sprinkler heads and a minimum of three 155 degree sprinkler heads along with a wrench for replacement purposes. **Identify other issues having potential to affect residents by the same practice** All facility sprinkler heads were checked by the maintenance director and administrator. The supply of supplemental heat, sprinkler heads and wrench will remain in the sprinkler riser room. **Systemic Changes** The administrator and maintenance director will ensure the supply of sprinkler heads, wrench and supplemental heating supply are maintained in the sprinkler riser room. On weekly environmental rounds the maintenance director will inspect sprinkler heads for repairs or replacement. **Quality Assurance** The administrator and maintenance director will monitor sprinkler riser room supplies and sprinkler head maintenance.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation on between 12:30 PM and 4:30 PM the following was noted: 1) The sprinkler heads under the carport have paint on the glass bulbs and are not maintained in good condition. 2) Facility did not have spare sprinkler heads and wrench in the sprinkler riser room. 3) Supplemental heat connected to emergency power was not provided for in the sprinkler riser room.	K 056	<u>K069</u> **Corrective Action for Deficient Practice** On March 28, 2012 the kitchen exhaust fan was serviced by an outside contractor. The exhaust fan motor was replaced fixing the negative air pressure. **Identify other issues having potential to affect residents by the same practice** Other areas of the facility were assessed for negative air pressure and none were observed.	March 28, 2012
K 069 SS=D	42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96	K 069		

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K 069	Continued From page 3 This STANDARD is not met as evidenced by: Based on observation on between 12:30 PM and 4:30 PM the following was noted: 1) Based upon observation at the time of the survey the kitchen was experiencing a sever negative pressure. NFPA 96 (Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations 1998 Edition) Section 5-3* Replacement Air. - " Replacement air quantity shall be adequate to prevent negative pressures in the commercial cooking area(s) from exceeding 0.02 in. water column (4.98 kPa). " 42 CFR 483.70(a)	K 069	Systemic Changes The administrator and maintenance director will ensure negative air pressure is not experienced in other locations of the facility. Quality Assurance The administrator and maintenance director will monitor the air pressure on weekly environmental rounds.	
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. This STANDARD is not met as evidenced by: Based on observation on between 12:30 PM and 4:30 PM the following was noted: 1) The smoke dampers located in the smoke wall on T-Hall in the attic smoke wall did not close upon activation of the fire alarm system. 42 CFR 483.70(a)	K 104	K104 Corrective Action for Deficient Practice On April 2, 2012 the smoke damper located in the fire wall in the attic was repaired to close upon activation of the fire alarm system. Identify other issues having potential to affect residents by the same practice All facility smoke dampers within fire walls of the attic were inspected and repaired if necessary. Systemic Changes The maintenance director will ensure all facility smoke dampers located in the attic are inspected on a monthly basis. Quality Assurance The maintenance director will inspect the smoke dampers located within the fire wall of the attic on a monthly basis.	April 2, 2012