STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345001	A. BUILDING _____ B. WING _____	05/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CONVALESCENT CENTER	1417 W PETTIGREW STREET DURHAM, NC 27705

(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 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to provide proper oral (mouth) care for 1 of 1 sampled resident (Resident #19). Findings included: A review of the facility's policy/procedure entitled "Oral hygiene procedure" (undated) read in part, "Oral care is an essential part of morning and evening care. Supplies needed for routine mouth care: toothpaste or powder, towel, emesis basin, glass of water, toothpaste (repeat)." According to the National Nurse Aide Assessment Program candidate handbook dated 2011, page 37 - a guide for minimal competency evaluation for nurse aide certification in North Carolina: mouth (oral) care include toothpaste applied to a toothbrush, and the mouth is cleaned - including the tongue, and surfaces of the teeth. Resident #19 was admitted into the facility on 6/3/05 and readmitted on 9/2/11. Cumulative diagnosis included Joint Contracture of Hand, Forearm, Ankle, and Paralysis. The quarterly Minimum Data Set (MDS) completed on 2/22/12	F 312	This plan of correction constitutes Hillcrest Convalescent Center's ("Hillcrest") written allegation of compliance for the deficiency cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. [F 312] It is the policy of Hillcrest to provide necessary services to residents who are unable to carry out activities of daily living, including, but not limited to, good nutrition, grooming, and personal and oral hygiene. It can be noted that throughout the many years Resident #19 has called Hillcrest his home, that he has always required extensive assistance with activities of daily living, and that services described above have been performed and allowed him to maintain good health. He is well dressed every day, has no skin breakdown, is clean shaven, and has no cavities or ulcers in his mouth.	May 30, 2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kevin Wade Smith, Administrator	Administrator	5/25/12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345001	A. BUILDING _____ B. WING _____	05/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CONVALESCENT CENTER	1417 W PETTIGREW STREET DURHAM, NC 27705

(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 312	Continued From page 1 indicated Resident #19's short and long term memory was intact. Resident #19 had the ability to recall location of own room, staff names/faces, and that he resided in a nursing home. The MDS indicated Resident #19 had difficulty (modified independence) in new situations only. The MDS revealed extensive assistance of two people was required for bed mobility, transfers, and ambulation did not occur. Extensive assistance of one person was required with personal hygiene. Total assistance of one person assist was required for dressing and bathing. Balance was impaired in that Resident #19 was only able to stabilize with staff assistance during surface to surface transfer. Range of motion was impaired on both sides of the upper/lower extremities (shoulder, elbow, wrist, hand, hip, knee, ankle, and foot). A review of the care plan initiated on 2/23/12 (problem onset date) for communication, indicated Resident #19 communicated with gestures, sometimes with a communication board, and responded better with concrete yes/no questions. Approach/intervention strategies included encouraging Resident #19 to increase voice volume - to assist with effective communication, due to a tendency to whisper. A review of the care plan initiated on 2/23/12 (problem onset date) for hand contracture's stated Resident #19 was dependent on the staff for most of daily care. Stated goal indicated the staff would provide oral hygiene with resident assisting, if able. Approach/intervention strategy included provision of dental care. In a family interview on 5/1/12 at 11:47 am, with	F 312	Therefore, Hillcrest attests and the lack of any of other documentation in this Summary Statement makes clear that any other criteria within this regulation are not under question. Resident #19 and resident's wife's stated preferred oral care has been noted and his Care Plan has been updated to reflect this. Other residents who fit the qualifications of this regulation were identified by the Director of Nurses. Assessments of oral care were done and no problems identified. The Director of Staff Training and/ or the Director of Nurses and/or their designee will retrain by in-service re-education all nursing staff on providing oral care for residents unable to carry out oral care. Going forward, assigned nurses will monitor four (4) dependent residents daily for two weeks and then weekly for three months to ensure that oral care needs continue to be met by their aides.	May 30, 2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345001	A. BUILDING _____ B. WING _____	05/02/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 312	Continued From page 2 Resident #19 present revealed concerns that Resident #19's teeth was not being brushed on a daily basis. Clarification with Resident #19 during the interview, he indicated the staff did not provide oral care which included brushing his teeth on a daily basis, through a head gesture "No". On 5/2/12 at 8:35 am, Resident #19's teeth were observed with whitish-brownish matter between several of the upper/lower teeth, when asked to open mouth. Resident #19 confirmed that his teeth/mouth care had not been provided through a slow head gesture "No". This was confirmed a second time, and Resident #19 was consistent with a gesture "No". Located on the window seal in Resident #19's room were green peppermint mouthwash, toothpaste, emesis basin, and a toothbrush. On 5/2/12 at 9:47 am, Resident #19 was observed in his room eating breakfast. In an interview on 5/2/12 at 9:52 am, Resident #19 indicated through a slow head gesture "No" that he had not received oral care prior to eating breakfast. On 5/2/12 at 12:36 pm, Resident #19 was observed eating lunch. In an interview on 5/2/12 at 2:20 pm, NA (Nurse aide) #1 primary care giver for the day, indicated she noticed around 7:30 am, during morning care that Resident #19 had matter on the inside of his mouth, and dried drool (saliva) on the outside of his mouth from the previous night. NA #1 stated she wiped the inside and outside of Resident	F 312	And finally, this allegation and the quality initiative described above will be addressed at the next scheduled Quality Assurance meeting as well as the monitoring of results of this quality initiative. The committee will review the study results and revise the action plan as necessary to ensure continued compliance.	May 30, 2012

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	345001	A. BUILDING _____ B. WING _____	05/02/2012

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F 312	Continued From page 3 #19's mouth with a wash cloth. NA #1 added, she did not brush Resident #19's teeth, tongue, or use the oral rinse (peppermint mouthwash) that was located in his room all day. NA #1 concluded Resident #19 was not capable of providing mouth care independently, nor did he refuse oral care to be completed. In an interview on 5/2/12 at 2:27 pm, with NA #1 present Resident #19 indicated via head gesture "Yes" that he wanted his teeth brushed with toothpaste, and mouth rinsed with the oral peppermint mouthwash daily. In an interview on at 5/2/12 2:30 pm, the Director of Nursing (DON) stated mouth care was individualized per resident/family member. The DON indicated she expected mouth care to be performed during morning care, prior to eating breakfast. In an interview on 5/2/12 at 5:38 pm, the DON indicated she expected during mouth care items that could have been utilized for oral care included: lemon swabs, toothpaste, toothbrush and pink swaps. In an interview on 5/2/12 at 6:20 pm (prior to conclusion of the annual survey departure) the DON explained she had talked with the restorative aide (RA) approximated 5 minutes ago, and the RA informed her she wetted a pink swap with water, and swapped Resident #19's mouth during the morning hours. She added, the RA stated she did not brush Resident #19's teeth/tongue, use toothpaste, or mouthwash.	F 312		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345001	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	05/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLCREST CONVALESCENT CENTER	1417 W PETTIGREW STREET DURHAM, NC 27705

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K 000	INITIAL COMMENTS There were no Life Safety Code Deficiencies noted at time of survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE Administrator

(X6) DATE 6/7/201

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	345001	A. BUILDING 02 - BUILDING 02 B. WING	05/30/2012

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K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 5/30/12 at approximately noon the following fire alarm components were non-compliant, specific findings include: A. The magnetic door hold open devices, tied into the facility Fire Alarm Control Panel (FACP), would re-engage while the FACP was still in the alarm but silenced mode. This was for three of the fieldstone crossing doors only. B. The FACP showed a telephone trouble condition upon arrival. Digital Alarm Communicator, DACT #2 was indicating the trouble condition.	K 052	This plan of correction constitutes Hillcrest Convalescent Center, Inc.'s (Hillcrest's) written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. [K 052] After onsite review and work by the Fire Alarm Control Panel (FACP) contractor, the magnetic door hold open devices do not re-engage while the FACP is in the alarm but silenced mode, and no trouble condition exists on the FACP including no telephone trouble. All other standards appear to be met. The maintenance director inspected the facility and observed no other similar concerns. The maintenance director or his designee will observe the FACP periodically to ensure the standards continue to be met. This plan of correction will be reviewed in the next regularly scheduled Quality Assurance meeting and evaluated for its effectiveness.	June 15, 2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Thurlow Smith	Administrator	6/15/1

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