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

PRINTED: 02/04/2015 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER HARNETT WOODS NURSING AND REHABILITATION CENTER DOUNN, NC 28334 SUMMARY STATEMENT OF DEFICIENCES SUMMARY STATEMENT OF DEFICIENCE BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) FREETY TAG F 312 483.25(a)(3) ADL CARE PROVIDED FOR SS=D DEFIDING INFORMATION) F 312 483.25(a)(3) ADL CARE PROVIDED FOR DEFICIENCES and PRESIDENTS 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, staff interviews and record review, the facility failed to properly complete incontinent for 1 of 2 residents observed receiving incontinent care (Resident # 2). Findings included: Resident # 2 was admitted on 11/21/14 with diagnoses that included urinary tract infection (UTI). Review of the 11/28/14 Admission Minimum Data Set (MDS) indicated Resident # 2 was cognitively intact. The MDS also indicated the resident required extensive assistance with personal hygiene and toleiting. The care plan for Resident # 2, last reviewed on 12/41/4, identified the resident as being at risk for an UTI based on a history of recurrent UTI's interventions to prevent or minimize the development of a UTI included appropriate perineal care. On 01/06/15 at 9:35 AM, an observation was made of Resident # 2 receiving her morning care.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
STREET ADDRESS_CITY_STATE_ZIP CODE	345478		B. WING					
FREERY TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 312 483.25(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, staff interviews and record review, the facility failed to properly complete incontinent for 1 of 2 residents observed receiving incontinent care (Resident # 2). Findings included: Resident # 2 was admitted on 11/21/14 with diagnoses that included urinary tract infection (UTI). Review of the 11/28/14 Admission Minimum Data Set (MDS) indicated Resident # 2 was cognitively intact. The MDS also indicated the resident required extensive assistance with personal hygiene and toileting. The care plan for Resident # 2, last reviewed on 12/4/14, identified the resident gerined extensive assistance with personal hygiene and toileting. The care plan for Resident # 2, last reviewed on 12/4/14, identified the resident as being at risk for an UTI based on a history of recurrent UTI's. Interventions to prevent or minimize the development of a UTI included appropriate perineal care On 01/06/15 at 9.35 AM, an observation was made of Resident # 2 receiving her morning care.	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 604 LUCAS ROAD				
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made of Resident # 2 receiving her morning care. observed on January 8, 2015 by the		by: Based on observations, staff interviews and record review, the facility failed to properly complete incontinent for 1 of 2 residents observed receiving incontinent care (Resident # 2). Findings included: Resident # 2 was admitted on 11/21/14 with diagnoses that included urinary tract infection (UTI). Review of the 11/28/14 Admission Minimum Data Set (MDS) indicated Resident # 2 was cognitively intact. The MDS also indicated the resident required extensive assistance with personal hygiene and toileting. The care plan for Resident # 2, last reviewed on 12/4/14, identified the resident as being at risk for an UTI based on a history of recurrent UTI's. Interventions to prevent or minimize the development of a UTI included appropriate hygiene techniques, and providing appropriate perineal care			Harnett Woods Nursing and Rehabilitation acknowledges receipt of the Statement of Deficiencies and propose this plan of correction to the extend that the summary of findings is factual correct and in order to maintain compliance with applicable rules and provisions of quality care of the residents. The plan of correction is submitted as a written allegation of compliance. Harnett Woods Nursing and Rehabilitation response to the State of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute admission that any deficiencies is accurate. Further Harnett Woods reserves the right to submit any documentation to refute any of the stated deficiencies on this Statement of Deficiencies through the informal dispute resolution formal appeal procedure and/or any other administrative legal proceeding.			
ADODATODY DIDECTOR'S OD DDOVIDED/SLIDDLIED DEDDESENTATIVE'S SICNIATLIDE TITLE (Y6) DATE		made of Resident #	2 receiving her morning care.		observed on January 8, 2015 b			

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed

(X6) D.

01/16/2015

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 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345478	B. WING _		•	06/2015	
NAME OF I	PROVIDER OR SUPPLIEF	₹		STREET ADDRESS, CITY, STATE, ZIP	CODE		
HADNET	T WOODS NIIDSING	AND REHABILITATION CENTER		604 LUCAS ROAD			
HANNET	I WOODS NORSING	S AND REHABILITATION CENTER		DUNN, NC 28334			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI	PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE DSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE		
F 312			F 3′				
		oper body was washed.		Assistant Director of Nursing for the			
		(NA) # 1 then washed the		proper delivery of incontine	ence care with		
		um. After completing the		no issues identified.			
		NA washed the resident 's		T. D			
		nd then repeated washing the		The Director of Nursing in-			
		out changing the water or the		Nursing Assistant #1 on Ja			
		esident was turned on her left		on the correct technique for			
		washed her back and rectal		care and proper bathing pr			
	area without chan	ging the water or the washcloth.		Assistant Director observe Assistant #1 with a return of			
	An interview was l	neld with NA#1 on 1/6/15 at		of a bath which included in			
		ted she had been taught in		on January 8, 2015 with re			
		nge the bath water if the		provided for any identified	•		
		wel movement. She stated she		provided for any identified	100000.		
		cation on perineal care from the		The Staff Facilitator began	in-services on		
		ntation, but did not remember		the correct technique for in			
		ight. The NA acknowledged		and proper bath procedure			
		the resident 's perineal area,		2015. The Staff Facilitator			
		domen and back to the perineal		in-services with 100% Nurs			
	area without chan	ging the bath water or the		and Nurses by January 16			
	washcloth. She a	dded that using the same cloth		hired Nursing Assistants a	nd Nurses will		
	and water and use	ed for the rest of the body could		be trained on correct incon	tinent care with		
	increase the risk of	of an infection.		return demonstration by the	e Staff		
				Facilitator during orientatio			
		icilitator was interviewed on		of Nursing, Assistant Direc			
		. The staff facilitator stated		Staff Facilitator, MDS Nurs			
		o leave the perineal area for		Nurse and RN Supervisor			
		g care. She added when the		observed 100% of the Nurs			
		perineal area, then went to other		Nursing Assistants with ret			
		ack to the perineal area, it		demonstration of proper ar			
		nt # 2 ' s risk of an urinary		incontinent care by Januar			
	infection.			Nursing Assistants and Nu			
	The Director of N.	uroing (DON) was intentioused		work until they receive thes			
	The Director of Nursing (DON) was interviewed on 1/6/14 at 4:00 PM. She stated she expected			and perform return demon	อแสแบบ.		
		to change the water prior to		The Staff Facilitator, MDS	Nurses		
		eal area. The DON stated		Treatment Nurse, and RN			
		rineal area to the abdomen and		began audits of facility nurs			
		al area could increase the risk		utilizing the Resident Care			

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		345478	B. WING _			C 00/2045	
NAME OF PROVIDER OR SUPPLIER HARNETT WOODS NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 604 LUCAS ROAD DUNN, NC 28334		06/2015	
(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 particular of an infection.	ge 2	F 31	regarding proper bathing prowhich includes incontinent cate January 7, 2015. The Reside Audit Tool will be completed weeks and then monthly x 3 nursing staff members. The I Nursing and/or the Assistant Nursing will review the results Resident Care audit tools we weeks and monthly x 3 mont proper techniques are being include resident #2. The Dire Nursing/Assistant Director of follow up immediately on any identified. The results of the audit tool we monthly with the Executive Quantitional action will occur if necessary and to determine and/or frequency for continue monitoring.	are starting ent Care weekly x 4 months on 15 Director of Director of s of the ekly x 4 hs to ensure followed to ctor of Nursing will concerns will be shared uality onths. deemed the need of		