### Laboratory Director's or Provider/Supplier Representative's Signature

**Signature:**

**Date:** 4/13/11

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**Summary Statement of Deficiencies**

**Tag:** F 323

<table>
<thead>
<tr>
<th>Prefix</th>
<th>ID</th>
<th>Summary Statement of Deficiencies</th>
<th>F 323</th>
</tr>
</thead>
<tbody>
<tr>
<td>SS=1D</td>
<td></td>
<td><strong>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</strong></td>
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</tbody>
</table>

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:

- Based on record review, staff interviews and observations, the facility failed to put interventions in place to prevent falls for 1 of 3 sampled residents. (Resident # 40)

Findings include:

- Resident # 40 was admitted to the facility on 7/8/2009 with diagnoses of Difficulty in Walking, Muscles Weakness, Altered mental status, Cellulites of left, Depression, Osteoarthritis, Parkinson’s and Pacemaker.

- Resident # 40’s annual Minimum Data Set (MDS) dated 7/5/2010 indicated the resident had a fall in the past 31-180 days. The Resident Assessment Protocol (RAP) dated 7/5/2010 documented "Resident has a long history of occasional falls."

- Resident # 40’s care plan last updated 3/16/2011, indicated the resident’s problem as being at risk for falls due to "history of falls." The approaches for the falls included "Report any change in condition, bed in lowest position and bed pad alarm when in bed."

- Review of the facility’s Resident Incident Report

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**Corrective Action for Resident Affected:**

**4/13/11**

For Resident #40 the following fall interventions were put in place: dysentery placed in wheelchair 3/18/11 by Support Nurse, urines checked for UTI 3/21/11 by Support Nurse, wing mattress put on bed 3/21/11 by Maintenance and Staff Development Coordinator, auto-lock breaks on wheelchair by Maintenance 3/22/11, high-low bed ordered 3/25/11 by Administrator and care plan reviewed and updated by Care Plan Coordinator and Staff Development Coordinator on 3/23/11.
**F 323** Corrective Action for Resident Potentially Affected:

All resident's who have fallen are at risk for the alleged deficient practice. A falls review meeting was held by the Quality of Life Team on 3/17/11 and all residents who have fallen in the past 6 months were reviewed for appropriate interventions and the need for any additional interventions. Any additional interventions recommended will be put in place by Staff Development Coordinator and Falls Nurse by 4/3/11.

**Systemic Changes:**

A falls intervention box containing various fall prevention items such as bed alarms, chair alarms, dyscasc, gripper socks, floor strips, TABS, and wander guard was placed at the nurses station by the Staff Development Coordinator for staff to have access to and initiate when a resident falls if indicated. An in-service was conducted on 3/25/11, 3/28/11, 3/29/11 and 3/31/11 by the Staff Development Coordinator. Those who attended were all RN's and LPN's, PT, and PRN. In-service done with Staff Development Coordinator and Falls Nurse, 3/18/11 on falls interventions by Nurse Consultant. Any in-house staff member who did not receive in-service training will not be allowed to work until training has been completed. The in-service topics included: location and content of the falls intervention box and when to initiate items from the falls box to assist in preventing future falls and the proper procedure to follow. This information has been integrated into the standard orientation training and in the required in-service refresher courses.
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<tr>
<td>F 323</td>
<td></td>
<td>Continued From page 2</td>
<td>F 323</td>
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<td>for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained.</td>
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<td>During the interview on 3/16/2011 at 11:00 AM, Nurse #1 reported the resident was confused and had several falls in the past last month. Nurse #1 further reported the intervention put in place was the best the facility could do to prevent the resident from falling from the bed. Nurse #1 was asked why the intervention was not changed but only mainly indicated staff was to respond more quickly to sounding alarms. Nurse #1 answered that it was difficult for the staff to reach the resident on time when the alarm sounded.</td>
<td></td>
<td></td>
<td>Quality Assurance</td>
<td></td>
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<td>During the interview on 3/16/2011 at 2:00 PM, the Director of Nursing (DON) reported she will make sure in the future the facility uses a different intervention any time the resident had a fall and document the intervention in the Resident's Incident Report.</td>
<td></td>
<td></td>
<td>The Staff Development Coordinator will monitor this issue using the &quot;QA Monitor Falls Review&quot; for making sure appropriate and timely interventions are put in place for residents who fall. This will be completed weekly x 4 weeks then monthly x 2 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. Monitoring began on 3/23/11 and will continue through 6/11 and longer, if necessary.</td>
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</table>
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
Shoreland Healthcare Center

**STREET ADDRESS, CITY, STATE, ZIP CODE**
200 Flower/Pridgen Dr
Whiteville, NC 28472

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<tr>
<td>K012</td>
<td>SS=ID</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD</td>
<td>Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.5.4, 19.3.5.1</td>
</tr>
</tbody>
</table>

This STANDARD is not met as evidenced by:
Surveyor: 25594
Based on observation on Thursday 4/14/11 between approximately 10:15 AM and 2:00 PM the following was noted:
1) The area around the sprinkler heads and eschuson plate were not properly sealed in order to maintain the required rating of the ceiling.
42 CFR 483.70(a)

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| K012 | | | Correction Action:
All areas around sprinkler heads are sealed in order to maintain the required rating of the ceiling.

Potential Affect:
All residents have the potential to be affected by this alleged deficient practice.

Systemic Changes:
All sprinkler heads were checked and those not properly sealed were sealed with the required sealant.

Monitoring:
Maintenance Director will monitor sprinkler heads when he performs the monthly building inspection and report to QOL committee.

Date of Completion:
4/20/11

Correction Action:
The holes/penetrations in the smoke wall in the attic area on 100 half were sealed using the required sealant to maintain the fire resistive rating of the smoke barrier.

Potential Affect:
All residents have the potential to be affected by this alleged deficient practice.

Systemic Changes:
Sealant was placed around the penetrations to ensure a tight seal was in place and that the deficient practice does not occur again.

Monitoring:
Maintenance Director will monitor smoke barrier penetration when he performs the monthly building inspection and report to QOL committee.

Date of Completion:
4/15/11

Director's or Provider/Supplier Representative's Signature

Title

Date
K 025  Continued From page 1
1) The smoke wall in the attic area on 100 Hall had holes and/ or penetrations that were not sealed in order to maintain the required rating of the wall. 42 CFR 483.70(a).
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:
Surveyor: 28594
Based on observation on Thursday 4/14/11 between approximately 10:15 AM and 2:00 PM the following was noted:
1) The dry storage room in the kitchen did not close, latch and seal when checked.
2) The one laundry room corridor door was found wedged open and the other laundry room corridor door did not close, latch and seal when checked. 42 CFR 483.70(a)

K 028
Correction Action:
Dry storage room door in kitchen repaired.
Wedge removed from laundry room door.
Laundry room corridor door repaired.

Potential Affect:
All residents have the potential to be affected by this alleged deficient practice.

Systemic Changes:
Dry storage room door and laundry room corridor door were repaired and closed, latched and sealed.
Laundry room staff in-serviced on "Self Closing Doors" on 4/27/11 and 4/29/11.

Monitoring:
Maintenance Director will monitor self closing doors and doors closing, latching and sealing monthly on Monthly Building Inspection.

Date of Completion:
5/6/11

K 038
Correction Action:
Staff in-serviced on the use and function of the two master override switches for the mag lock doors.

Potential Affect:
All residents have the potential to be affected by this alleged deficient practice.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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| K 038         | Continued From page 2                                                                                           | K 038         | Systematic Changes:
An in-service was held on 4/21/11, 4/26/11, 4/27/11, and 4/28/11 on use and function of the two master override switches for the mag lock doors to the facility.

Monitoring:
Staff Development Coordinator will monitor staff by asking 10 staff weekly for one month, the function and use of the mag locks and then monthly for 2 months.

Date of Completion: 5/29/11 |
| K 052         | NFPA 101 LIFE SAFETY CODE STANDARD                                                                               | K 052         | Correction Action:
Smoke head sensitivity inspection will be completed yearly.

Potential Affect:
All residents have the potential to be affected by this alleged deficient practice.

Systematic Changes:
Sunland Fire Protection, Inc. will perform a smoke head sensitivity test yearly in accordance with NFPA 70 National Electrical Code and NFPA 72.

Monitoring:
Maintenance Director will monitor this yearly for testing to be completed.

Date of Completion: 5/29/11 |
**Summary Statement of Deficiencies**

(K062) Continued From page 3

was found that a smoke head sensitivity inspection and/or report has not been conducted in the last two years.

42 CFR 483.70(a)

(K058) 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. 19.3.6

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**Provider's Plan of Correction**

(K062) Correction Action:

Sprinklers will be installed under exterior roofs on 300 and 400 Hall exits.

Potential Affect:

All residents have the potential to be affected by this alleged deficient practice.

Systemic Changes:

Sprinklers will be installed under exterior roofs exceeding 4 foot in depth.

Monitoring:

Maintenance Director will monitor 500 and 400 Hall exterior sprinklers when he performs the monthly building inspection and report to QOL committee.

Date of Completion:

5/29/11

(K069) NFPA 101 LIFE SAFETY CODE STANDARD

Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 90

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**Correction Action:**

Negative pressure in kitchen repaired. The two kitchen doors close, latch and seal properly. Kitchen exhaust hoods exhaust fumes properly from the environment.

Potential Affect:

All residents have the potential to be affected by this alleged deficient practice.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

**SHORELAND HLTH CARE & RETIREME**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

200 FLOWER-PRIDGEN DR

WHITEVILLE, NC 28472

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| K 069 |        |     | Continued From page 4
This STANDARD is not met as evidenced by:
Surveyor: 26594
Based on observation on Thursday 4/14/11 between approximately 10:15 AM and 2:00 PM the following was noted:
1) The kitchen is operating under a severe negative pressure resulting in two of the doors to the kitchen not able to close, latch and seal and the negative pressure is also preventing the kitchen exhaust hoods not able to properly exhaust fumes from the environment.
42 CFR 483.70(a) | 04/14/2011 |

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| K 069 |        |     | Systemic Changes:
The kitchen fan on the roof was re-wired to prevent negative pressure in the kitchen.
The kitchen exhaust hood was repaired so fumes are properly removed from the environment.
Two kitchen doors were repaired and close, latch and seal properly. |                 |

Monitoring:
Maintenance Director will monitor pressure in the kitchen, doors closing, latching and sealing properly and exhaust hoods exhausting fumes properly when the monthly building inspection and report to QOL committee.

Date of Completion:
4/26/11 |

K 144 |        |      | Corrective Action:
Percent rated load and temperature rise was added to the monthly documentation for the generator testing. A load bank test will be completed yearly. |

Potential Affect:
All residents have the potential to be affected by this alleged deficient practice.

Systemic Changes:
The generator was exercised with loads at 0 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes for a total of 2 continuous hours. Monthly documentation was changed to reflect percent rated load and temperature rise.

NFPA 99 3.4.4.2 Record keeping. A written record of inspection, performance, exercising period, and repairs shall be regularly maintained.
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<tr>
<td>K 144</td>
<td>Continued From page 5 and available for inspection by the authority having jurisdiction.</td>
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NFPA 110 6-4.2 (1999 edition) generator sets in Level 1 and Level 2 service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:
(a) Under operating temperature conditions or at not less than 30 percent of the EPS nameplate rating
(b) Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer.

NFPA 110 6-4.2.2 (1999 edition) Diesel-powered EPS installations that do not meet the requirements of 6-4.2 shall be exercised monthly with the available EPPS load and exercised annually with supplemental loads at 25 percent of nameplate rating for 30 minutes, followed by 50 percent of nameplate rating for 30 minutes, followed by 75 percent of nameplate rating for 60 minutes, for a total of 2 continuous hours. (load bank testing)

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<tr>
<td>K 144</td>
<td>Monitoring: Maintenance Director will monitor this yearly for load bank testing and document monthly on the percent rated load and temperature thereafter.</td>
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</tbody>
</table>

Date of Completion: 5/4/11

K 147

42 CFR 483.70(a)

NFPA 101 LIFE SAFETY CODE STANDARD

Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 8.1.2

This STANDARD is not met as evidenced by:
Surveyor: 28594
Based on observation on Thursday 4/14/11 between approximately 10:15 AM and 2:00 PM the following was noted:
1) The normal power/utility light on the automatic...
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<tr>
<td>K 147</td>
<td>Continued From page 6 transfer switch was not operational at the time of the survey. 42 CFR 483.70(a)</td>
<td>K 147</td>
<td>Systemic Changes: The power/utility light was repaired using the proper light on the automatic transfer switch. Monitoring: Maintenance Director will monitor this monthly on his monthly preventive maintenance report. Date of Completion: 4/25/11</td>
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