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

(X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 345245 06/15/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **507 FREMONT STREET** PENDER MEMORIAL HOSP SNF BURGAW, NC 28425 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X6) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Corrective Action Accomplished by: F 157 F 157 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) SS=D MD notified on June 15, 2011 of 6-15-11 Resident #7 refusing daily weights. A facility must immediately inform the resident; New order received to Discontinue consult with the resident's physician; and if daily weights. New order to weigh known, notify the resident's legal representative weekly and notify MD of weight gain of or an interested family member when there is an 5 lbs or more in one week. accident involving the resident which results in (Attachment #A1) injury and has the potential for requiring physician intervention; a significant change in the resident's Resident #7 Weight obtained and physical, mental, or psychosocial status (i.e., a 6-15-11 documented in the Medical Record deterioration in health, mental, or psychosocial June 15th of 168 lbs. (Attachment status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an Resident #7 Weight obtained and existing form of treatment due to adverse 6-22-11 documented in the Medical Record consequences, or to commence a new form of treatment); or a decision to transfer or discharge June 22nd of 166.2 lbs. (Attachment the resident from the facility as specified in #A2) Resident #7 Weight obtained and §483.12(a). 6-29-11 documented in the Medical Record June 29th of 165 lbs. (Attachment The facility must also promptly notify the resident and, if known, the resident's legal representative #A2) 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 A Policy was drafted to standardize 6-30-11 regulations as specified in paragraph (b)(1) of weights on June 15, 2011. This policy this section. was revised on June 30, 2011 to address resident refusals. (Attachment The facility must record and periodically update #A3) the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced Based on medical record review and staff interview the facility failed to notify the physician

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,

Facility ID: 955685 If continuation sheet Page 1 of 5

(X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345245	B. WIN			06/1	5/2011	
	ROVIDER OR SUPPLIER			507	EET ADDRESS, CITY, STATE, ZIP CODE 7 FREMONT STREET JRGAW, NC 28425	, , , , , , , , , , , , , , , , , , , ,		
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F 157	resident (resident # 7 daily weights. The fir Resident # 7 was adr 2/24/11 with diagnosi Insufficiency, Corona Fibrillation with pacer Failure, Dementia, Dr Gastroesophagal Rei A review of Resident Physicians Order dat Weigh daily @ (at) 06 doctor) of 3 lbs (pour			does not ill be the Weight July 13, All new ethe Weight ring New ually per the Annual Checklist.				
F 272 SS=D	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. 483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically		F	272	Plans to Monitor Performant All weights will be monitored Random Spot checks using Weight Documentation Spot Tool. (Attachment #A7) All concerns will be monitored for 3 months then monthly months through the Quality Assessment/Assurance Communities (Attachment #A8) Weekly Weight Quality Ass Tool (Attachment #A9)	d through the the weight weekly for 6 mmittee using the	7-13-11	
	The facility must con	duct initially and periodically						

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		345245	B. WING	3		06/	15/2011
	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 607 FREMONT STREET BURGAW, NC 28425				
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F 272	a comprehensive, ac		F2	272	Corrective Action Accomplish affected residents as well as residents having the potential affected by:		
	resident assessment	a comprehensive dent's needs, using the instrument (RAI) specified sessment must include at			Resident #10 MDS assessment CAAS were placed on the characteristics.		6-15-11
	least the following: Identification and der Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior p Psychosocial well-be	nographic information; patterns;		- constraint of the constraint	MDS Coordinator audited 100 charts to ensure timely completion/placement of requ MDS Assessments [ie, comprehensive, quarterly, etc each patient medical record [applicable] (Attachment #B1)	ired] in	7-1-11
	Continence; Disease diagnosis ar Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments a Discharge potential; Documentation of su the additional assess areas triggered by th Data Set (MDS); and	nd health conditions; I status; Ind procedures; Ind pro		The state of the s	A "MDS Chain of Command I was put into place to establish guidelines for communication MDS issues to the CFO and/or President without punitive act (Attachment #B2)	of or	7-1-11
	This REQUIREMEN	T is not met as evidenced					

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F 272	facility failed to comp Minimum Data Set (M fourteen days of adm 10) of ten (10) sampli included: Resident #10 was ad 05/16/2011 with cum Knee replacement, D Osteoarthritis, Hypoth Resident #10 was dis 06/04/2011. Medical record review Set (MDS) assessment The MDS Coordinated assessments that mig not yet available on the records. On 06/15/20 Coordinator stated side completed MDS assess On 06/15/2011 at 12 stated there had bee Nurse Executive post beginning to get thing organization. She stated that the Minimum Dat completed as required When asked if there of action initiated who problem, she stated of On 06/15/2011 at 12	iew and staff interview, the lete an initial comprehensive MDS) assessment within ission for one (Resident # ed residents. Findings mitted to the facility ulative diagnoses: Total inabetes Mellitus, hyroidism and Hypertension. Scharged from the facility w revealed no Minimum Data ent on the chart. or was interviewed about ght have been completed but the residents' medical 2011 at 11:50 AM., the MDS are did not have any essments in the computer. 100 PM., the Administrator in a change in the Chief ition and the facility was just go in place for better ated she had not been aware the Sets had not been ad by regulation until recently, had been a corrective plan en she became aware of the no.	F 2	772	All current MDS personnel will educated on DHSR Regulation F272, F275, F276, F286, F280 and "MDS Chain of Command Policy" by 7-13-11 and then annually. All new MDS person will be educated/in-serviced of New Hire Orientation and annual per the Unit Specific Orientation/Annual Competer Validation checklist. (Attachm #B3) Measures/Systemic Changes ensure deficient practice does recur: * MDS Coordinator position increased from 32 hours per valours per week * MDS Computer upgrade * MDS Computer upgrade * Hired 2nd MDS Coordinator * Mobile laptop for real time Nodata entry	ons 7, F490 d onnel during hually ent to s not week to	7-13-11 10/10 11/10 12/10 1/11 2/11	
ſ	Nursing (DON) state	d she was the staff member						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345245	B. WIN	IG		06/15/2011	
	OVIDER OR SUPPLIER			51	EET ADDRESS, CITY, STATE, ZIP CODE 07 FREMONT STREET URGAW, NC 28425		
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F 272	Set (MDS) Coordinate began falling behind in On October 1, 2010, management and the experienced an increastated she became in and remained clinical	assist the Minimum Data or if the MDS Coordinator n completing assessments. there was a change in skilled nursing unit ase in census. The DON terim DON in October 2010 coordinator over the skilled unable to assist the MDS	F	272	* iPad with software application faster, more efficient real times data entry * President-Administrator attention DHSR MDS Training [Raleight MDS coordinator and Nurse Manager attended "Update in 3.0 Implementation" presented Cindy DePorter * RN with MDS 3.0 experience	e MDS ended n] n MDS ed by	5/11 6/11 6/11
	assessments. On 06/15/2011 at 12: Coordinator stated pr 2010. A decision had census on the skilled	00 noon, the MDS oblems began in October I been made to increase the nursing unit and residents			been hired to fill previously va clinical coordinator position to as back up/additional MDS Personnel Plans to Monitor Performance	acant o serve	
	than the staff had the MDS's. The MDS Costruggled to keep the was unable to do so. her concerns to the passistance. The MDS not receive assistance the facility hired anott as needed (PRN) bas given the MDS sched MDS Coordinator for assessments. The Mochecked the charts all half (1 ½) weeks ago assessments for May scheduled. When as that assessments we transmitted, she state completed timely from	assessments up to date but She stated she verbalized revious DON and asked for 6 Coordinator stated she did e until February 2011 when her MDS Coordinator on an sis. She stated she had lule for May 2011 to the prn her to complete the IDS Coordinator stated she pproximately one and one and realized all the had not been completed as ked regarding a time frame			MDS assessments will be more for completion/placement in medical record through Rand Spot Checks. (Attachment #I relevant MDS due dates/comdates will be discussed week months then monthly for 6 more the Quality Assessment/Assu Committee Meeting using the Calendar Tool. (Attachment #6-15-11	esident om B4) All pletion ly for3 onths in irance	7-13-11
F 275	2011. 483.20(b)(2)(iii) COM	PREHENSIVE ASSESS AT	F	275			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII	LDING		(X3) DATE SURVEY COMPLETED	
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F 275 SS=E	LEAST EVERY 12 M A facility must conduc	ontinued From page 5 EAST EVERY 12 MONTHS facility must conduct a comprehensive ssessment of a resident not less than once very 12 months.		275	Corrective Action Accomplished affected residents as well as potential residents by: Annual Assessments were performed and placed on the medical record for Resident # 2 and 9.	vell as were on the	
	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, #9). Findings included:				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
	Resident #2 was a 01/14/2008. Medical record review Minimum Data Set (Nature 1)				A "MDS Chain of Command Powas put into place to establish guidelines for communication of MDS issues to the CFO and/or President without punitive actic (Attachment #B2)	of	7-1-11
	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				All current MDS personnel will educated on DHSR Regulation F272, F275, F276, F286, F287 and "MDS Chain of Command Policy" by 7-13-11 and then annually. All new MDS person will be educated/in-serviced du New Hire Orientation and annu per the Unit Specific Orientation/Annual Competence Validation checklist. (Attachme #B3)	ns r, F490 nnel uring ually	7-13-11

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F 275 Continued From page 6 completed as required by re. When asked if there had bee of action initiated when she I problem, she stated no. On 06/15/2011 at 12:00 PM. Nursing (DON) stated she w who was supposed to assist Set (MDS) Coordinator if the began falling behind in come On October 1, 2010, there w management and the skilled experienced an increase in c stated she became interim D and remained clinical coordi nursing unit and was unable Coordinator in performing/ c assessments. On 06/15/2011 at 12:00 noo Coordinator stated problems 2010. A decision had been census on the skilled nursing were admitted to the skilled than the staff had the capab MDS's. The MDS Coordinal struggled to keep the assess was unable to do so. She si her concerns to the previous assistance. The MDS Coord not receive assistance until the facility hired another MD as needed (PRN) basis. Sh given the MDS schedule for MDS Coordinator for her to assessments. The MDS Co checked the charts approxim half (1 ½) weeks ago and re	A., the Director of was the staff member at the Minimum Data are MDS Coordinator apleting assessments. Was a change in ad nursing unit a census. The DON DON in October 2010 dinator over the skilled le to assist the MDS completing ator stated she saments up to date but stated she verbalized us DON and asked for ordinator stated she did I February 2011 when DS Coordinator on an offer stated she had or May 2011 to the procomplete the coordinator stated she imately one and one	F	275	Measures/Systemic changes to ensure deficient practice does recur: * MDS Coordinator position increased from 32 hours per well 40 hours per week * MDS Computer upgrade * MDS Software upgrade * Hired 2nd MDS Coordinator * Mobile laptop for real time Midata entry * iPad with software application faster, more efficient real time data entry * President-Administrator attern DHSR MDS Training [Raleigh] * MDS coordinator and Nurse Manager attended "Update in 3.0 Implementation" presented Cindy DePorter * RN with MDS 3.0 experience been hired to fill previously vac Clinical Coordinator position to as back up/additional MDS personnel Plans to Monitor Performance MDS assessments will be more for completion/placement in remedical record through Rando Spot Checks. (Attachment #B relevant MDS due dates/comp dates will be discussed weekly months then monthly for 6 monthe Quality Assessment/Assur Committee Meeting using the Calendar Tool. (Attachment #B Calendar Tool. (Attachment #B Calendar Tool. (Attachment #B Calendar Tool.)	not eek to DS n for MDS ded MDS by has cant serve ittored sident m 4) All eletion for 3 nths in ance MDS	10/10 11/10 12/10 1/11 2/11 5/11 5/11 7/11 7-13-11	

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F 275	scheduled. When a that assessments we transmitted, she state completed timely fro 2011. 2. Resident #3 was: 03/23/2010. Medical record revied dated 1/26/2011 and dated 04/23/2011. The MDS Coordinate assessments that mot yet available on records. On 06/15/2000 Coordinator stated scompleted MDS assessments that mot yet available on records. On 06/15/2011 at 12 stated there had be not stated there had be not seen that the Minimum Discompleted as required when asked if there of action initiated with problem, she stated On 06/15/2011 at 12 Nursing (DON) state who was supposed Set (MDS) Coordinate began falling behind	y had not been completed as sked regarding a time frame ere not completed and ed assessments were not m October 2010 through May admitted to the facility we revealed a quarterly MDS an annual MDS assessment or was interviewed about eight have been completed but the residents' medical 2011 at 11:50 AM., the MDS she did not have any essments in the computer. 2:00 PM., the Administrator en a change in the Chief esition and the facility was just eggs in place for better tated she had not been eata Sets had not been ed by regulation until recently. In had been a corrective planter she became aware of the	F	275				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MI IDENTIFICATION NUMBER: A. BUIL		E CONSTRUCTION	(X3) DATE S COMPLI	
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F 275	experienced an indicated she became and remained clinic nursing unit and ware Coordinator in perfassessments. On 06/15/2011 at 1 Coordinator stated 2010. A decision has census on the skille were admitted to the than the staff had the MDS's. The MDS struggled to keep the was unable to do sher concerns to the assistance. The Monot receive assistante facility hired an as needed (PRN) to given the MDS scheduled. When the checked the chartshalf (1 ½) weeks a assessments for Moscheduled. When that assessments transmitted, she strompleted timely for 2011. 3. Resident #9 was 01/29/2010.	he skilled nursing unit rease in census. The DON interim DON in October 2010 cal coordinator over the skilled as unable to assist the MDS	F 275			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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Resident #9's third dated 10/28/2010. The MDS Coordina assessments that it not yet available or records. On 06/15 Coordinator stated completed MDS as On 06/15/2011 at stated there had be Nurse Executive pubeginning to get the organization. She that the Minimum It completed as requevalent when asked if their of action initiated we problem, she stated the supposed Set (MDS) Coordinated began falling behird on October 1, 201 management and the experienced an incention of the stated she became and remained clinical nursing unit and we coordinator in perferences on 16/15/2011 at 16/15/20	(MDS) dated 03/20/2011. quarterly assessment was ator was interviewed about night have been completed but in the residents' medical //2011 at 11:50 AM., the MDS she did not have any esessments in the computer. 12:00 PM., the Administrator een a change in the Chief position and the facility was just ings in place for better stated she had not been aware Data Sets had not been ired by regulation until recently. ee had been a corrective plan when she became aware of the	F 275			

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F 275	census on the skilled were admitted to the than the staff had the MDS's. The MDS Costruggled to keep the was unable to do so, her concerns to the passistance. The MD not receive assistance the facility hired anot as needed (PRN) ba given the MDS sched MDS Coordinator for assessments. The Mochecked the charts a half (1 ½) weeks ago assessments for May scheduled. When as that assessments we transmitted, she state	d been made to increase the nursing unit and residents skilled nursing unit quicker capability of completing pordinator stated she assessments up to date but She stated she verbalized previous DON and asked for S Coordinator stated she did to until February 2011 when ther MDS Coordinator on an asis. She stated she had dule for May 2011 to the proher to complete the MDS Coordinator stated she pproximately one and one	<u>;</u>	275			
	2/10/2009. Medical record reviet Minimum Data Set (1/1/31/2010. Quarterly the record and dated 10/10/2010 and 3/22	admitted to the facility on ew revealed an annual MDS) assessment dated MDS assessments were in 4/22/2010, 7/16/2010, /2011. The most recent ment was dated 5/31/2011.					
	assessments that mi	or was interviewed about ght have been completed but he residents ' medical 11 at 11:50 AM, the MDS					The state of the s

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F 275	On 6/15/2011 at 12:0 stated there had been Nurse Executive positive positive positive positive positive progranization. She stated the Minimum Darcompleted as require When asked if there for action initiated whe problem, she stated in On 6/15/2011 at 12:0 Nursing (DON) stated who was supposed to Set (MDS) Coordinate began falling behind on October 1, 2010, management and the experienced an increstated she became in and remained clinical nursing unit and was Coordinator in performassessments. On 6/15/2011 at 12:0 Coordinator stated pr 2010. A decision had census on the skilled were admitted to the than the staff had the MDS's. The MDS C struggled to keep the was unable to do so.	ne did not have any essments in the computer. 10 PM, the Administrator in a change in the Chief ition and the facility was just go in place for better ated she had not been aware ta Sets had not been ad by regulation until recently, had been a corrective plan en she became aware of the no. 10 PM, the Director of dishe was the staff member to assist the Minimum Data for if the MDS Coordinator in completing assessments, there was a change in eskill nursing unit ase in census. The DON in October 2010 Il coordinator over the skilled unable to assist the MDS ming/ completing	LL.	275			

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	OVIDER OR SUPPLIER		507	ET ADDRESS, CITY, STATE, ZIP CODE 7 FREMONT STREET JRGAW, NC 28425	
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F 275 F 276 SS=E	not receive assistant the facility hired and as needed (PRN) be given the MDS sche MDS Coordinator for assessments. The final checked the charts a half (1 ½) weeks aga assessments for Mascheduled. When as that assessments we transmitted, she state completed timely fro 2011. 483.20(c) QUARTER LEAST EVERY 3 Me	S Coordinator stated she did ce until February 2011 when ther MDS coordinator on an isis. She stated she had dule for May 2011 to the promoter her to complete the MDS Coordinator stated she approximately one and one of and realized all the sy had not been completed as sked regarding a time frame ere not completed and ed assessments were not m October 2010 through May CLY ASSESSMENT AT ONTHS	F 275	Corrective Action Accomplishe	ed for
		rument specified by the State IS not less frequently than s.		Corrective Action Accomplishe affected residents as well as residents with the potential to affected by:	
	by:	T is not met as evidenced s admitted to the facility on		Quarterly Assessments were performed and placed on the Medical Record for Resident # and 7.	6-15-11 ¢ 4, 5,
		w revealed an admission 010. The next quarterly MDS 1.			
	assessments that m not yet available on	or was interviewed about ight have been completed but the residents' medical 11 at 11:50 AM, the MDS whe did not have any			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING B. WING			
		345245	B. WING		06/15/2	2011
	OVIDER OR SUPPLIER		50	EET ADDRESS, CITY, STATE, ZIP CODE 17 FREMONT STREET URGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLO BE	(X5) COMPLETION DATE
F 276	On 6/15/2011 at 12:0 stated there had bee Nurse Executive pos beginning to get thing	essments in the computer. O PM, the Administrator n a change in the Chief ition and the facility was just gs in place for better	F 276	MDS Coordinator audited 10 charts to ensure timely completion/placement of req MDS Assessments [ie, comprehensive, quarterly, el each patient medical record applicable] (Attachment #B1	uired c] in [as	7-1-11
	that the Minimum Da completed as require When asked if there of action initiated who problem, she stated if	d by regulation until recently. had been a corrective plan en she became aware of the no.		A "MDS Chain of Command was put into place to establis guidelines for communication MDS issues to the CFO and President without punitive ac (Attachment #B2)	sh n of /or	7-1-11
	Nursing (DON) stated who was supposed to Set (MDS) Coordinate began falling behind On October 1, 2010, management and the experienced an increstated she became in and remained clinica nursing unit and was Coordinator in perfor assessments. On 6/15/2011 at 12:00 Coordinator stated possible coordinator of the coordinator of the coordinator of the coordinator stated possible coordinator stated possible coordinator stated possible coordinator of the	ase in census. The DON Interim DON in October 2010 I coordinator over the skilled Unable to assist the MDS Imming/ completing		All current MDS personnel weducated on DHSR Regulati F272, F275, F276, F286, F2 and "MDS Chain of Commar Policy" by 7-13-11 and then annually. All new MDS perswill be educated/in-serviced New Hire Orientation and an per the Unit Specific Orientation/Annual Competer Validation checklist. (Attachrum)	ons 87, F490 and onnel during inually	7-13-11
	census on the skilled were admitted to the than the staff had the MDS's. The MDS of struggled to keep the was unable to do so, her concerns to the p	I nursing unit and residents skilled nursing unit quicker a capability of completing Coordinator stated she assessments up to date but She stated she verbalized previous DON and asked for S Coordinator stated she did				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345245	B. WING	·		06/1	5/2011
NAME OF PROVIDER OR SUPPLIER PENDER MEMORIAL HOSP SNF			50	EET ADDRESS, CITY, STATE, ZIP CODE 7 FREMONT STREET JRGAW, NC 28425		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
the facility hired another as needed (PRN) basing given the MDS scheduled. MDS Coordinator for his assessments. The ME checked the charts appeared half (1 ½) weeks ago as assessments for May be scheduled. When ask that assessments were transmitted, she stated completed timely from 2011. 5. Resident #5 was accompleted timely from 2011. The MDS Coordinator assessments that might not yet available on the records. On 6/15/2011. Coordinator stated she completed MDS assessmented there had been Nurse Executive positions organization. She stated the Minimum Data completed as required	e until February 2011 when er MDS coordinator on an is. She stated she had ule for May 2011 to the properties of the provided and one and realized all the had not been completed as the regarding a time frame enot completed and disassessments were not october 2010 through May dmitted to the facility on revealed an annual MDS next quarterly MDS was Twas interviewed about the have been completed but e residents in medical 1 at 11:50 AM, the MDS edid not have any esments in the computer. DPM, the Administrator a change in the Chiefion and the facility was just in place for better ted she had not been aware	F 2	276	Measures/Systemic Changes ensure deficient practice does recur: * MDS Coordinator position increased from 32 hours per value to the MDS Computer upgrade * MDS Computer upgrade * MDS Software upgrade * Hired 2nd MDS Coordinator * Mobile laptop for real time was data entry * iPad with software application faster, more efficient real time data entry * President-Administrator attended and the modern to the modern the modern to the modern them the modern them modern them the modern them the modern them the modern them the modern them them them them them them them them	MDS Inded Index Inded Index In	10/10 11/10 12/10 1/11 5/11 6/11 7/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345245	B. WING		06	/15/2011
	OVIDER OR SUPPLIER		507 F	ADDRESS, CITY, STATE, ZIP CODE REMONT STREET GAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 276	Nursing (DON) state who was supposed Set (MDS) Coordinate began falling behind On October 1, 2010 management and the experienced an increase and remained clinic nursing unit and wa Coordinator in performance assessments. On 6/15/2011 at 12: Coordinator stated 13: Coordinator stated 14: Coordinator stated 15: Coordinator stated 16: Coordinato	no. 00 PM, the Director of ed she was the staff member to assist the Minimum Data ator if the MDS Coordinator I in completing assessments. I there was a change in the skill nursing unit ease in census. The DON interim DON in October 2010 all coordinator over the skilled is unable to assist the MDS arming/ completing	F 276			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345245	B. WING			06/1	5/2011
	NOVIDER OR SUPPLIER			507 FR	ADDRESS, CITY, STATE, ZIP CODE REMONT STREET GAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 276	transmitted, she state completed timely from 2011. 6. Resident # 7 was 02/24/2011. Medical record review assessment dated 03 further assessments On 6/15/11 at 4:00 P stated Resident # 7 is we should be working the building we have The MDS Coordinate assessments that mignot yet available on the records. On 6/15/20 Coordinator stated should be completed MDS assessments that mignot yet available on the records. On 6/15/20 Coordinator stated should be completed MDS assessments that the mignor of the position or ganization. She stated there had been hurse Executive posponding to get thing organization. She stated the Minimum Dacompleted as required when asked if there of action initiated who problem, she stated on 6/15/2011 at 12:00 Nursing (DON) states who was supposed to the record of the	admitted to the facility w revealed an admission 8/07/2011. There were no in the chart. M, the MDS Coordinator due an MDS assessment, gon it but with the state in not started yet. or was interviewed about ght have been completed but the residents ' medical 11 at 11:50 AM, the MDS ne did not have any essments in the computer. O PM, the Administrator on a change in the Chiefition and the facility was just go in place for better ated she had not been aware ta Sets had not been ad by regulation until recently. had been a corrective plan en she became aware of the	F 2	76			

	NT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED				
		345245	B. WIN	3		06/	15/2011
	NOVIDER OR SUPPLIER			507 F	ADDRESS, CITY, STATE, ZIP CODE REMONT STREET GAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 276	began falling behind On October 1, 2010, management and the experienced an increstated she became ir and remained clinical nursing unit and was Coordinator in performassessments. On 6/15/2011 at 12:0 Coordinator stated pr 2010. A decision had census on the skilled were admitted to the than the staff had the MDS's. The MDS ostruggled to keep the was unable to do so, her concerns to the passistance. The MDS not receive assistance the facility hired anothas needed (PRN) bas given the MDS scheet MDS Coordinator for	in completing assessments. Ithere was a change in a skill nursing unit ase in census. The DON interim DON in October 2010 decordinator over the skilled unable to assist the MDS ming/ completing. It noon, the MDS roblems began in October dependent began in Octobe	F	276			
	checked the charts a half (1 1/2) weeks ago assessments for May scheduled. When as that assessments we transmitted, she state completed timely fror 2011. Based on record revi	pproximately one and one	to the same of the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345245	8. WING		06	/15/2011	
	OVIDER OR SUPPLIER		507 8	TADDRESS, CITY, STATE, ZIP CO FREMONT STREET RGAW, NC 28425	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 276	residents (Resident #5, #6, #7). Finding: 1. Resident #1 was a 09/27/2010. Medical record revie admission Minimum 10/06/2010. The ne Set (MDS) assessmith that minot yet available on records. On 06/15/2 Coordinator stated s completed MDS ass On 06/15/2011 at 12 stated there had bee Nurse Executive post beginning to get thin organization. She sithat the Minimum Dacompleted as require When asked if there of action initiated who problem, she stated On 06/15/2011 at 12 Nursing (DON) state who was supposed to Set (MDS) Coordinate began falling behind On October 1, 2010, management and the	six (6) of ten (10) sampled # 1, #3, #4, s included: admitted to the facility w revealed Resident #1's Data Set (MDS) was dated xt quarterly Minimum Data ent was dated 03/22/2011. or was interviewed about ight have been completed but the residents' medical 1011 at 11:50 AM., the MDS he did not have any essments in the computer. 1:00 PM., the Administrator en a change in the Chief sition and the facility was just gs in place for better tated she had not been ed by regulation until recently. had been a corrective plan en she became aware of the	F 276				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345245	B. WING		06/	15/2011
	OVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE 507 FREMONT STREET BURGAW, NC 28425	Ī	And the second s
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 276	and remained clinica nursing unit and was Coordinator in perfor assessments. On 06/15/2011 at 12 Coordinator stated p 2010. A decision har census on the skilled were admitted to the than the staff had the MDS's. The MDS Costruggled to keep the was unable to do so, her concerns to the passistance. The MD not receive assistance the facility hired anot as needed (PRN) ba given the MDS schee MDS Coordinator for assessments. The Mochecked the charts a half (1 ½) weeks ago assessments for Mascheduled. When as that assessments we transmitted, she state completed timely from 2011.	nterim DON in October 2010 I coordinator over the skilled unable to assist the MDS ming/ completing 200 noon, the MDS roblems began in October d been made to increase the I nursing unit and residents skilled nursing unit quicker capability of completing pordinator stated she assessments up to date but She stated she verbalized previous DON and asked for S Coordinator stated she did be until February 2011 when her MDS Coordinator on an sis. She stated she had dule for May 2011 to the pro her to complete the MDS Coordinator stated she approximately one and one	F 2	76		
	Medical record revie a quarterly MDS ass	w revealed Resident #3 had essment dated 09/19/2010. erly assessment was dated	7.7			

STATEMENT OF DEFICIENCIES WID PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345245	B. WING		06	/15/2011	
	ROVIDER OR SUPPLIER MEMORIAL HOSP SNF		507	T ADDRESS, CITY, STATE, ZIP CO FREMONT STREET RGAW, NC 28425	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 276	O1/26/2011. The MDS Coordinat assessments that mot yet available on records. On 06/15/2 Coordinator stated is completed MDS associated there had been beginning to get thir organization. She is that the Minimum Docompleted as requir When asked if there of action initiated who problem, she stated On 06/15/2011 at 11 Nursing (DON) state who was supposed Set (MDS) Coordinated Set (MDS) Coordinated Set (MDS) Coordinated an increase and remained clinic nursing unit and was Coordinator in performance of the coordinator stated 2010. A decision here cordinator stated 2010. A decision in the coordinator stated 2010.	or was interviewed about ight have been completed but the residents' medical 2011 at 11:50 AM., the MDS she did not have any ressments in the computer. 2:00 PM., the Administrator en a change in the Chief sition and the facility was just ags in place for better tated she had not been aware at Sets had not been are do by regulation until recently. In had been a corrective plan and she became aware of the no. 2:00 PM., the Director of ed she was the staff member to assist the Minimum Data attor if the MDS Coordinator of the most in completing assessments. In the most in completing unit ease in census. The DON interim DON in October 2010 at coordinator over the skilled sunable to assist the MDS	F 276				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING				
		345245	B. WING		06/	15/2011	
	ROVIDER OR SUPPLIER		50	EET ADDRESS, CITY, STATE, ZIP CODE 7 FREMONT STREET URGAW, NC 28425			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 276	were admitted to the stand the staff had the MDS's. The MDS Costruggled to keep the was unable to do so. her concerns to the passistance. The MDS not receive assistance the facility hired anoth as needed (PRN) bas given the MDS sched MDS Coordinator for assessments. The Monder of the charts as half (1 ½) weeks ago assessments for May scheduled. When as that assessments we transmitted, she state completed timely from 2011. 3. Resident #6 was an 12/10/2010. Medical record review MDS dated 12/22/20 assessment was dated. The MDS Coordinato assessments that mignot yet available on the records. On 06/15/20 Coordinator stated shoon 06/15/2011 at 12:	skilled nursing unit quicker capability of completing pordinator stated she assessments up to date but She stated she verbalized revious DON and asked for a Coordinator stated she did to e until February 2011 when the man and the complete she had build for May 2011 to the proper that the proper stated she approximately one and one and realized all the shad not been completed as the proximately one and one and realized all the shad not been completed as the proximately one and one and realized all the shad not been completed and and assessments were not an October 2010 through May dmitted to the facility or revealed an admission 10. The next quarterly and 04/13/2011. The was interviewed about the properties of the completed but the residents' medical 2011 at 11:50 AM., the MDS	F 276				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345245	B. WING		06/1	5/2011
	OVIDER OR SUPPLIER		50	EET ADDRESS, CITY, STATE, ZIP CODE 07 FREMONT STREET URGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD 8E	(X5) COMPLETION DATE
F 276	Nurse Executive posibeginning to get thing organization. She stathat the Minimum Dat completed as require. When asked if there to action initiated whe problem, she stated r. On 06/15/2011 at 12: Nursing (DON) stated who was supposed to Set (MDS) Coordinatibegan falling behind in On October 1, 2010, management and the experienced an increstated she became in and remained clinical nursing unit and was Coordinator in performassessments. On 06/15/2011 at 12: Coordinator stated pr 2010. A decision had census on the skilled were admitted to the than the staff had the MDS's. The MDS Costruggled to keep the was unable to do so, her concerns to the p assistance. The MDS	tion and the facility was just as in place for better at ted she had not been aware a Sets had not been ad by regulation until recently. The she became aware of the set of the	F 276			
	as needed (PRN) bas	ner MDS Coordinator on an sis. She stated she had fule for May 2011 to the prn				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345245	B. WING		06/	15/2011
	ROVIDER OR SUPPLIER		5	EET ADDRESS, CITY, STATE, ZIP CODE 07 FREMONT STREET BURGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 276 F 281 SS=D	checked the charts at half (1 ½) weeks ago assessments for May scheduled. When as that assessments we transmitted, she state completed timely from 2011. 483.20(k)(3)(i) SERV PROFESSIONAL ST.	her to complete the IDS Coordinator stated she pproximately one and one and realized all the had not been completed as ked regarding a time frame re not completed and ad assessments were not n October 2010 through May ICES PROVIDED MEET ANDARDS d or arranged by the facility	F 276	Corrective Action accom		
	This REQUIREMENT by: Based on record rev facility failed to ensur (resident # 5) receiving the amount of water of physician. The finding of the thick that t	is not met as evidenced iew and staff interviews the te that 1 of 10 residents to tube feedings were given flush as ordered by the the that include: admitted to the facility on the stat include Peg Tube 7, Aphasia, Vascular tion, Hypokalemia, tent Ischemic Accident and flux Disorder. tician 's Order recap sheet ted an order for Fibersource tiliter/ hour) (4 A-10PM) = te) Flush 100 ML/ H2O		those residents found to by: MD notified of transcripti 6-15-11. New order received. (Att #E1) New Tube Feeding Adm Record was initiated. (A #E2)	ion error on achment inistration	6-15-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345245	B, WING		06/1	5/2011
	ROVIDER OR SUPPLIER		50	EET ADDRESS, CITY, STATE, ZIP CODE 07 FREMONT STREET URGAW, NC 28425	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFIGIENCY)	OULD BE	(X6) COMPLETION DATE
F 281	A review of the mon'th Administration Record June 14, 2011 reveal Feeding Administration. ML of water was given a review of the Tube Record for the month Flush Tube with 200 The Tube Feeding Amonth of June 2011, indicating 200 ML fluwere given every 6 h 14th and on June 15. A review of Resident Physician's order de 200cc (cubic centime GT (gasteroenteral to START NOW." In an interview with MAM she stated, "This August 5, 2009 a characterist orders were not char recap orders I do not not say why we did run an interview on 6/revealed she spoke Physician and he sai Feeding flush to 100. In an interview on 6/reverence of 6/10.	thly Tube Feeding rds from August 5, 2009 thru led staff initialed the Tube on Record indicating the 200 an every six hours. Feeding Administration of June 2011 reads as, "ML water every SIX hours." dministration Record for the revealed staff initials shes shours from June 1st thru the that 12AM and 6 AM. L's # 5 chart revealed a lated 8/05/09 which reads, "leters) NS (normal saline) via labe) ever 4 hrs. (hours) Nurse # 1 on 6/15/11 at 10:20 is flush change dates back to large from 200 cc every 6 levery 4 hours. As to why the lated on the Physician's taknow. The pharmacy can not catch it for 2 years." 15/11 at 11:10 AM, Nurse # 1 with Resident # 5 's id to change the Tube cc's of water every 4 hours.	F 281	Corrective Action Accompthose residents having pole be affected by: All resident tube feeding flowers reviewed for accuracy 28, 2011. All current Tube Feeding Forders re-verified with MD accuracy on 7-1-11. (Attactive Heat, E4, E5, and E6) Measures/Systemic Changensure deficient practice or recur: Nurse responsible for End Physican Order Review worrent flush order for accuranscribe flush orders on Feeding Administration Resolution (Attachment #E7 and #E8) Plans to Monitor Performation Resolution (Attachment #E7 and E8)	ush orders by on June Flush for chment of Month fill verify uracy and o Tube ecord. off on Tube ecord for	6-28-11 7-1-11 7-1-11
•	Director of Nursing s at the end of the mor	stated, " I would expect staff on the staff or transferring orders only changes in the orders.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345245	B. WNG		06/1	5/2011
	OVIDER OR SUPPLIER		507	ET ADDRESS, CITY, STATE, ZIP CODE FREMONT STREET RGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 286 SS=E	onto the computer an one who transfers the computer to the resid 483.20(d) MAINTAIN RESIDENT ASSESS A facility must maintal completed within the resident's active reconstruction. This REQUIREMENT by: Based on record revised facility failed to maintain resident Minimum Dain the active medical sampled residents (Fig. #7, #8, #9, #10). Findings included: 1. Resident #1 was a 09/27/2010.	d the Tube Feeding orders d the ward secretary is the information from the ent' record." 15 MONTHS OF MENTS in all resident assessments previous 15 months in the rd. is not met as evidenced liew and staff interview, the ain fifteen (15) months of ta Set (MDS) assessments record for ten (10) of ten resident #1, #2, #3, #4, #5, dmitted to the facility on	F 286	Corrective Action Accomplist affected residents as well as residents with the potential to affected by: MDS Coordinator audited 10 charts to ensure timely completion/placement of req MDS Assessments [ie, comprehensive, quarterly, et each patient medical record applicable] (Attachment #B1 A "MDS Chain of Command was put into place to establist guidelines for communication MDS issues to the CFO and President without punitive act (Attachment #B2) All current MDS personnel we educated on DHSR Regulations.	o be 0% of uired c] in [as) Policy" sh o of for ction.	7-1-11 7-1-11
	Minimum Data Set (No chart: an admission a quarterly MDS date. The MDS Coordinate assessments that minot yet available on trecords. On 06/15/2 Coordinator stated strompleted MDS assessments assessments.	or was interviewed about ght have been completed but he residents' medical 011 at 11:50 AM., the MDS he did not have any essments in the computer.		F272, F275, F276, F286, F2 and "MDS Chain of Commar Policy" by 7-13-11 and then annually. All new MDS pers will be educated/in-serviced New Hire Orientation and an per the Unit Specific Orientation/Annual Compete Validation Checklist. (Attachment #B3)	87, F490 nd onnel during nually	
	On 06/16/2011 at 12	00 PM., the Administrator	1 1			-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		345245	B. WING		06/15	/2011
	OVIDER OR SUPPLIER		50	EET ADDRESS, CITY, STATE, ZIP CODE 17 FREMONT STREET URGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 286	Nurse Executive posibeginning to get thing organization. She stat that the Minimum Darcompleted as require When asked if there of action initiated who problem, she stated in On 06/15/2011 at 12: Nursing (DON) stated who was supposed to Set (MDS) Coordinate began falling behind On October 1, 2010, management and the experienced an increstated she became in and remained clinica nursing unit and was Coordinator in perfor assessments. On 06/15/2011 at 12 Coordinator stated performance on the skilled were admitted to the than the staff had the MDS's. The MDS Costruggled to keep the was unable to do so, her concerns to the gassistance. The MD not receive assistance the facility hired another stated as the staff had the facility hired another stated performance.	n a change in the Chief tion and the facility was just gs in place for better ated she had not been aware ta Sets had not been d by regulation until recently. had been a corrective plan en she became aware of the no. 100 PM., the Director of d she was the staff member of assist the Minimum Data for if the MDS Coordinator in completing assessments. Ithere was a change in e skilled nursing unit hase in census. The DON interim DON in October 2010 It coordinator over the skilled unable to assist the MDS ming/ completing	F 286	Measures/Systemic Changes ensure deficient practice does recur: * MDS Coordinator position increased from 32 hours per 40 hours per week * MDS Computer upgrade * MDS Software upgrade * Hired 2nd MDS Coordinatofor Mobile laptop for real time in data entry * iPad with software applicate faster, more efficient real time data entry * President-Administrator att DHSR MDS Training [Raleige MDS coordinator and Nursemanager attended "Update in 3.0 Implementation" present Cindy DePorter * RN with MDS 3.0 experient been hired to fill previously were Clinical Coordinator position as back up/additional MDS personnel. Plans to Monitor Performance MDS assessments will be madical record through Ranges Completion/placement in medical record through Ranges Completion were formational modern to the Quality Assessment/Assection Committee Meeting using the Calendar Tool. (Attachment)	week to r MDS ion for e MDS ended h] e n MDS ed by ce has racant to serve ce: onitored resident dom #B4) All inpletion kly for 3 nonths in urance e MDS	10/10 11/10 12/10 1/11 2/11 5/11 6/11 7/11

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE S COMPLE	
		345245	B. WING		06/	15/2011
	NAME OF PROVIDER OR SUPPLIER PENDER MEMORIAL HOSP SNF			T ADDRESS, CITY, STATE, ZIP CO FREMONT STREET RGAW, NC 28425	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 286	MDS Coordinator for assessments. The M checked the charts all half (1 ½) weeks ago assessments for May scheduled. When as that assessments we transmitted, she state completed timely from 2011. 2. Resident #2 was a 01/14/2008. Medical record review MDS assessments on assessment dated 05 MDS assessment dated 05 MDS assessment that mignot yet available on the records. On 06/15/20 Coordinator stated she completed MDS assessments that mignot yet available on the records. On 06/15/20 Coordinator stated she completed MDS assessments that the the Minimum Da completed as require When asked if there	lule for May 2011 to the pro- her to complete the IDS Coordinator stated she pproximately one and one and realized all the had not been completed as ked regarding a time frame re not completed and ad assessments were not n October 2010 through May dmitted to the facility on vervealed the following the chart: a quarterly MDS 0/07/2010 and an annual ted 03/03/2011. In was interviewed about ght have been completed but the residents' medical 2011 at 11:50 AM., the MDS the did not have any the essments in the computer. IOO PM., the Administrator on a change in the Chief tition and the facility was just the sin place for better ated she had not been aware that Sets had not been and by regulation until recently. The she became aware of the	F 286			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345245	8. WING			06/1/	06/15/2011	
	OVIDER OR SUPPLIER			5	REET ADDRESS, CITY, STATE, ZIP CODE 507 FREMONT STREET BURGAW, NC 28425			
(X4) ID PREFIX TAG			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			LD BE	(X5) COMPLETION DATE	
F 286	Nursing (DON) stated who was supposed to Set (MDS) Coordinate began falling behind it On October 1, 2010, management and the experienced an increastated she became in and remained clinical nursing unit and was Coordinator in performassessments. On 06/15/2011 at 12: Coordinator stated pr 2010. A decision had census on the skilled were admitted to the stand the staff had the MDS's. The MDS Costruggled to keep the was unable to do so, her concerns to the passistance. The MDS not receive assistance the facility hired anott as needed (PRN) bas given the MDS sched MDS Coordinator for assessments. The Mchecked the charts ap half (1 ½) weeks ago assessments for May scheduled. When as that assessments we transmitted, she states	she was the staff member assist the Minimum Data or if the MDS Coordinator in completing assessments, there was a change in skilled nursing unit ase in census. The DON terim DON in October 2010 coordinator over the skilled unable to assist the MDS ming/ completing 00 noon, the MDS oblems began in October I been made to increase the nursing unit and residents skilled nursing unit quicker capability of completing ordinator stated she assessments up to date but She stated she verbalized revious DON and asked for 6 Coordinator stated she did the until February 2011 when her MDS Coordinator on an asis. She stated she had ule for May 2011 to the proher to complete the DS Coordinator stated she oproximately one and one and realized all the had not been completed as ked regarding a time frame	F	286				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING		JRVEY TED
		345245	B. WING	B. WNG		15/2011
	NAME OF PROVIDER OR SUPPLIER PENDER MEMORIAL HOSP SNF			ET ADDRESS, CITY, STATE, ZIP CO 7 FREMONT STREET JRGAW, NC 28425	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 286	2011. 3. Resident #3 was a 03/23/2010. Medical record review MDS assessments o assessment dated 0% assessment dated 0% assessment dated 0% assessment dated 0% MDS assessment dated 0% MDS assessment that minot yet available on trecords. On 06/15/20 Coordinator stated sl completed MDS assessments that minot yet available on trecords. On 06/15/20 Coordinator stated sl completed MDS assessments that the MDS assessments that the stated there had bee Nurse Executive possible beginning to get thing organization. She stated the Minimum Date of action initiated who problem, she stated On 06/15/2011 at 12 Nursing (DON) state who was supposed to Set (MDS) Coordinator began falling behind On October 1, 2010, management and the experienced an increase.	w revealed the following in the chart: a quarterly MDS 6/19/2010, a quarterly MDS 6/19/2011, and an annual ted 04/23/2011. In was interviewed about ght have been completed but the residents' medical 011 at 11:50 AM., the MDS are did not have any essments in the computer. If the Administrator in a change in the Chief ition and the facility was just ges in place for better ated she had not been aware ated she had not been aware ated by regulation until recently, had been a corrective plan en she became aware of the mo. If the MDS Coordinator in completing assessments, there was a change in	F 286			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345245 8. WING			06/15/2011			
	OVIDER OR SUPPLIER		,	5	REET ADDRESS, CITY, STATE, ZIP CODE 07 FREMONT STREET SURGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X6) COMPLETION DATE
F 286	Continued From page	30	F	286			
	nursing unit and was Coordinator in perforr assessments.						
	2010. A decision had census on the skilled	00 noon, the MDS oblems began in October I been made to increase the nursing unit and residents skilled nursing unit quicker					
	than the staff had the MDS's. The MDS Co struggled to keep the	capability of completing					
	her concerns to the passistance. The MDS	revious DON and asked for 6 Coordinator stated she did e until February 2011 when					
	as needed (PRN) bas	ner MDS Coordinator on an sis. She stated she had ule for May 2011 to the prn					
	assessments. The M	DS Coordinator stated she oproximately one and one					
	scheduled. When as that assessments we	had not been completed as ked regarding a time frame re not completed and d assessments were not					
	2011.	n October 2010 through May					
	4. Resident #6 was a 12/10/2010.	·					
	MDS assessments or	/10/2010, an admission	Vertical	٠			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345245	B. WIN	G		06/	15/2011
	OVIDER OR SUPPLIER		•	507	T ADDRESS, CITY, STATE, ZIP CODE FREMONT STREET RGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		OULD BE	(X5) COMPLETION DATE	
F 286	The MDS Coordinato assessments that mignot yet available on the records. On 06/15/20 Coordinator stated she completed MDS assessments at the Minimum Data completed as require When asked if there to faction initiated whe problem, she stated recordinator stated the Was supposed to Set (MDS) Coordination began falling behind on October 1, 2010, management and the experienced an increstated she became in and remained clinical nursing unit and was Coordinator in performassessments. On 06/15/2011 at 12: Coordinator stated precordinator stated precordinat	r was interviewed about the residents' medical of 11 at 11:50 AM., the MDS are did not have any assments in the computer. OO PM., the Administrator in a change in the Chief tion and the facility was just as in place for better ated she had not been aware at Sets had not been aware of the about the facility was just as the became aware of the about the facility was just as the sets had not been aware at Sets had not been aware at Sets had not been aware of the facility was just as the sets and not been aware of the facility was just as the set of the modern aware of the facility was the set of the was the staff member of assist the Minimum Data for if the MDS Coordinator in completing assessments, there was a change in eskilled nursing unit as in census. The DON atterim DON in October 2010 accordinator over the skilled unable to assist the MDS ming/ completing	F	286			
	Serious on the station	and and tools and		Ì			

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345245	B. WNG		06	/15/2011
	OVIDER OR SUPPLIER	IF	607 F	ADDRESS, CITY, STATE, ZIP COD REMONT STREET GAW, NC 28425	E	
(X4) ID PREFIX TAG	(EACH DEFICE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 286	than the staff had MDS's. The MDS struggled to keep was unable to do her concerns to the assistance. The finot receive assist the facility hired a as needed (PRN) given the MDS so MDS Coordinator assessments. The checked the chart half (1 ½) weeks assessments for fischeduled. Where that assessments transmitted, she is completed timely 2011. 5. Resident #9 was 01/29/2010. Medical record re MDS assessment dated MDS assessment that not yet available or records. On 06/1 Coordinator state completed MDS as	he skilled nursing unit quicker the capability of completing a Coordinator stated she the assessments up to date but so. She stated she verbalized he previous DON and asked for MDS Coordinator stated she did ance until February 2011 when nother MDS Coordinator on an basis. She stated she had hedule for May 2011 to the profer her to complete the eMDS Coordinator stated she is approximately one and one ago and realized all the May had not been completed as a asked regarding a time frame were not completed and tated assessments were not from October 2010 through May as admitted to the facility view revealed the following is on the chart: a quarterly MDS of 10/28/2010 and an annual and dated 03/20/2011. The tor was interviewed about might have been completed but on the residents' medical 5/2011 at 11:50 AM., the MDS of she did not have any assessments in the computer.	F 286			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUIL		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345245	B. WING	}		06/	15/2011
	NAME OF PROVIDER OR SUPPLIER PENDER MEMORIAL HOSP SNF		·	607 F	TADDRESS, CITY, STATE, ZIP CODE FREMONT STREET RGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 286	Nurse Executive positive positive positive positive programization. She stated that the Minimum Date completed as require When asked if there of action initiated who problem, she stated in On 06/15/2011 at 12: Nursing (DON) stated who was supposed to Set (MDS) Coordinate began falling behind On October 1, 2010, management and the experienced an increstated she became in and remained clinical	n a change in the Chief tion and the facility was just gs in place for better ated she had not been aware ta Sets had not been d by regulation until recently, had been a corrective plan en she became aware of the no. 100 PM., the Director of d she was the staff member to assist the Minimum Data or if the MDS Coordinator in completing assessments, there was a change in e skilled nursing unit ase in census. The DON in coordinator over the skilled unable to assist the MDS	F	286			
	2010. A decision had census on the skilled were admitted to the than the staff had the MDS's. The MDS Construggled to keep the was unable to do so, her concerns to the passistance. The MD not receive assistance the facility hired anot	roblems began in October d been made to increase the I nursing unit and residents skilled nursing unit quicker e capability of completing					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPLE		
		345245	B. WING)	06	06/15/2011	
	NAME OF PROVIDER OR SUPPLIER PENDER MEMORIAL HOSP SNF			STREET ADDRESS, CITY, STATE, ZIP 507 FREMONT STREET BURGAW, NC 28425	CODE		
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F 286	MDS Coordinator for assessments. The Month of the charts at half (1 ½) weeks ago assessments for May scheduled. When as that assessments we transmitted, she state completed timely from 2011. 6. Resident #10 was 05/16/2011. Residen the facility 06/04/201 Medical record review admission Minimum on the chart. The MDS Coordinator assessments that mignot yet available on the records. On 06/15/20 Coordinator stated show the completed MDS assessments that mignot yet available on the completed MDS assessments that mignot yet available on the records. On 06/15/2011 at 12: stated there had been Nurse Executive possibeginning to get thing organization. She stated the Minimum Dacompleted as require When asked if there was the control of the completed as required when asked if there was the control of the control o	dule for May 2011 to the pro- her to complete the IDS Coordinator stated she proximately one and one and realized all the r had not been completed as ked regarding a time frame re not completed and ed assessments were not in October 2010 through May admitted to the facility t #10 was discharged from 1. In vervealed there was not an Data Set (MDS) assessment or was interviewed about ght have been completed but the residents' medical 2011 at 11:50 AM., the MDS the did not have any the sesments in the computer. OO PM., the Administrator on a change in the Chief tition and the facility was just the properties of the session of the the sests had not been aware the sets had not been aware of the	F 2	286			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345245	B. WN	B. WNG		06/15/2011	
	NAME OF PROVIDER OR SUPPLIER PENDER MEMORIAL HOSP SNF			50	REET ADDRESS, CITY, STATE, ZIP CODE 07 FREMONT STREET BURGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 286	Nursing (DON) stated who was supposed to Set (MDS) Coordinate began falling behind in On October 1, 2010, management and the experienced an increastated she became in and remained clinical nursing unit and was Coordinator in performassessments. On 06/15/2011 at 12: Coordinator stated pr 2010. A decision had census on the skilled were admitted to the than the staff had the MDS's. The MDS Costruggled to keep the was unable to do so, her concerns to the passistance. The MDS not receive assistance the facility hired anoth as needed (PRN) bas given the MDS scheol MDS Coordinator for assessments. The Mochecked the charts a half (1 ½) weeks ago assessments for May scheduled. When as that assessments we transmitted, she state	on PM., the Director of a she was the staff member of assist the Minimum Data or if the MDS Coordinator in completing assessments, there was a change in eskilled nursing unit ase in census. The DON atterim DON in October 2010 coordinator over the skilled unable to assist the MDS ming/ completing On noon, the MDS oblems began in October a been made to increase the nursing unit and residents skilled nursing unit quicker acapability of completing pordinator stated she assessments up to date but She stated she verbalized arevious DON and asked for She coordinator stated she did the until February 2011 when ther MDS Coordinator on an asis. She stated she had alule for May 2011 to the proproximately one and one	F	286			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345245	8. WING	<u>.</u>	06/	15/2011	
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F 286	Medical record review MDS assessments or assessment dated 11 MDS assessment dated 11 MDS assessment date quarterly MDS assessments that mignot yet available on the records. On 6/15/201 Coordinator stated shoompleted MDS assessments that mignot yet available on the records. On 6/15/201 Coordinator stated shoompleted MDS assessments that the records as the records of 6/15/2011 at 12:00 stated there had been hurse Executive positions beginning to get thing organization. She stated the Minimum Da completed as require When asked if there of action initiated who problem, she stated in On 6/15/2011 at 12:00 Nursing (DON) stated who was supposed to Set (MDS) Coordinate began falling behind On October 1, 2010, management and the experienced an increent.	admitted to the facility on In the chart: an entry MDS I/15/2010, an admission ted 11/27/2010 and a sment dated 3/27/2011. In was interviewed about ght have been completed but the residents ' medical 11 at 11:50 AM, the MDS the did not have any the sesments in the computer. If o PM, the Administrator in a change in the Chief Ition and the facility was just togs in place for better that Sets had not been aware that Sets had not been and by regulation until recently, that been a corrective plan ten she became aware of the the sassist the Minimum Data or if the MDS Coordinator in completing assessments, there was a change in	F 286				

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	NOVIDER OR SUPPLIER			507 f	T ADDRESS, CITY, STATE, ZIP CODE FREMONT STREET RGAW, NC 28425		·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ŧ	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 286	nursing unit and was Coordinator in performassessments. On 6/15/2011 at 12:0 Coordinator stated presents on the skilled were admitted to the than the staff had the MDS 's. The MDS of struggled to keep the was unable to do so, her concerns to the passistance. The MD not receive assistance the facility hired anot as needed (PRN) bargiven the MDS sched MDS Coordinator for assessments. The Mochecked the charts a half (1 ½) weeks ago assessments for May scheduled. When as that assessments we transmitted, she state completed timely from 2011. 8. Resident # 5 was 1/07/2007.	coordinator over the skilled unable to assist the MDS ming/ completing 10 noon, the MDS roblems began in October of been made to increase the nursing unit and residents skilled nursing unit quicker capability of completing coordinator stated she assessments up to date but She stated she verbalized previous DON and asked for S Coordinator stated she did be until February 2011 when ther MDS coordinator on an sis. She stated she had dule for May 2011 to the proher to complete the MDS Coordinator stated she pproximately one and one	F	286				
	MDS assessments o assessment dated 10	n the chart: an annual MDS 0/28/2010, a Quarterly MDS 0/15/2011 and a Quarterly	4-11-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345245	B. WIN	G		06/	15/2011	
	NOVIDER OR SUPPLIER			507	ET ADDRESS, CITY, STATE, ZIP CODE FREMONT STREET FREAW, NC 28425			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X6) COMPLETION DATE	
F 286	stated during the time went through two diff. The current Point-Clithey could import all into their program, winformation was drop annual MDS assess. The MDS Coordinate assessments that minot yet available on trecords. On 6/15/20 Coordinator stated significant completed MDS assessments that minot yet available on trecords. On 6/15/2011 at 12:0 stated there had been Nurse Executive positional beginning to get thin organization. She significant the Minimum Dacompleted as require When asked if there of action initiated who problem, she stated. On 6/15/2011 at 12:0 Nursing (DON) state who was supposed to Set (MDS) Coordinal began falling behind. On October 1, 2010, management and the	AM, the MDS Coordinator e change to MDS 3.0 they ferent computer programs. ck-Care programmers said our MDS information over hich they didn't. All that oped, if I had realized the oped I would have done an ment. Or was interviewed about ght have been completed but the residents' medical 11 at 11:50 AM, the MDS he did not have any ressments in the computer. OD PM, the Administrator on a change in the Chief sition and the facility was just ges in place for better reated she had not been aware and by regulation until recently. had been a corrective plan en she became aware of the no. OD PM, the Director of d she was the staff member to assist the Minimum Data tor if the MDS Coordinator in completing assessments. there was a change in	F	286				

NAME OF PROVIDER OR SUPPLIER PENDER MEMORIAL HOSP SNF SUMMAY STATEMENT OF GENERATION SUMMAY STATEMENT OF GENERATION (AV.) 10 SUMMAY STATEMENT OF GENERATION (EACH CONNECTION (EACH CONNECTION REGULATORY OR LSC (DENTIFYING INFORMATION) F 286 Continued From page 39 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 6115/2011 at 12:00 noon, the MDS Coordinator stated problems bogan in October 2010. A decision had been made to increase the census on the skilled nursing unit and residants were admitted to the skilled nursing unit and residants were admitted to the skilled nursing unit and residants were admitted to the stated she but vars unable to do so. She stated she set whealized her concerns to the previous DON and asked for assistance. The MDS Coordinator stated she had given the MDS schedule for May 2011 when the facility hirde another MDS coordinator as the de- sessments. The MDS Coordinator stated she had given the MDS schedule for May 2011 to the pro MDS Coordinator for her to complete the assessments. The MDS Coordinator stated she had given the MDS schedule for May 2011 to the pro MDS Coordinator for her to complete the assessments. The MDS Coordinator stated she checked the charts approximately one and one half (13) weeks age and realized all the assessments. The MDS Coordinator stated she checked the charts approximately one and one half (13) weeks age and realized all the assessments for May had not been completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011. 9. Rosidon! #8 was admitted to the facility on 2/10/2009. Medical record review revealed the following MDS assessment of the 1/3/2010, Quarterly MDS assessment dated 1/3/2010, Quarterly MDS		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE S COMPL	
PENDER MEMORIAL HOSP SNF MAJ 10 SUMMARY STATEMENT OF DEFICIENCIES REACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REQUIATORY ORLS DIBENTERMS MYCRMANON PREFIX PREFIX PREFIX REQUIATORY ORLS DIBENTERMS MYCRMANON PREFIX PREFIX REACH DORRECTIVE ACTION SHOULD BE STATEMENT OF THE PROPRIATE PREFIX PREFIX			345245	8. WING		06	/15/2011
F 286 Continued From page 39 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 stated problems bogan 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 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 were halized 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. MoS 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 schoduled. When asked regarding a time farme that assessments were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011. 9. Resident # 8 was admitted to the facility on 2/10/2009. Medical record review revealed the following MDS assessments to in the chart: an annual MDS					507 FREMONT STREET	DDE	
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 6/15/2011 at 12:00 noon, the MDS Coordinator stated problems bogan 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 pr 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 were not completed and transmitted, she stated assessments were not completed timely from October 2010 through May 2011. 9. Resident #8 was admitted to the facility on 2/10/2009. Medical record review revealed the following MDS assessments on the chart: an annual MDS	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETION
	F 286	stated she became ir and remained clinical nursing unit and was Coordinator in performassessments. On 6/15/2011 at 12:0 Coordinator stated pr 2010. A decision had census on the skilled were admitted to the than the staff had the MDS 's. The MDS ostruggled to keep the was unable to do so, her concerns to the passistance. The MD not receive assistance the facility hired anot as needed (PRN) bargiven the MDS sched MDS Coordinator for assessments. The Mochecked the charts a half (1 ½) weeks ago assessments for May scheduled. When as that assessments we transmitted, she state completed timely from 2011. 9. Resident # 8 was 2/10/2009. Medical record review MDS assessments of	nterim DON in October 2010 I coordinator over the skilled unable to assist the MDS ming/ completing IO noon, the MDS roblems began in October Id been made to increase the nursing unit and residents skilled nursing unit quicker e capability of completing coordinator stated she assessments up to date but She stated she verbalized previous DON and asked for S Coordinator stated she did the until February 2011 when ther MDS coordinator on an sis. She stated she had dule for May 2011 to the prn ther to complete the MDS Coordinator stated she pproximately one and one and realized all the or had not been completed as sked regarding a time frame are not completed and and assessments were not on October 2010 through May werevealed the following on the chart: an annual MDS	F 2	86		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345245	B. WIN	G		06/14	5/2011
	OVIDER OR SUPPLIER			51	EET ADDRESS, CITY, STATE, ZIP CODE 07 FREMONT STREET BURGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 286	assessment dated 5/3 The MDS Coordinato assessments that mig not yet available on the records. On 6/15/2011 Coordinator stated she completed MDS asses On 6/15/2011 at 12:0 stated there had been Nurse Executive positive beginning to get thing organization. She stated the Minimum Data completed as require. When asked if there is of action initiated when problem, she stated in On 6/15/2011 at 12:0 Nursing (DON) stated who was supposed to Set (MDS) Coordinate began falling behind in On October 1, 2010, management and the experienced an incresistated she became in and remained clinical	22/2010, 7/16/2010, 2011 and an annual MDS 31/2011. In was interviewed about the residents is medical at 11:50 AM, the MDS are did not have any assments in the computer. O PM, the Administrator in a change in the Chief at the facility was just as in place for better at the standard at the facility was just as in place for better at Sets had not been aware at Sets had not been above the set of the standard at the facility was just as in place for better at the standard at the facility was just as in place for better at the set of th	F	286			
		oblems began in October					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345245	B. WIN	G		06/18	5/2011
-	OVIDER OR SUPPLIER			50	EET ADDRESS, CITY, STATE, ZIP CODE 07 FREMONT STREET URGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X6) COMPLETION DATE
F 286 F 287 SS=E	census on the skilled were admitted to the than the staff had the MDS's. The MDS C struggled to keep the was unable to do so. her concerns to the p assistance. The MDS not receive assistance the facility hired anoth as needed (PRN) bas given the MDS sched MDS Coordinator for assessments. The M checked the charts aphalf (1 ½) weeks ago assessments for May scheduled. When as that assessments we transmitted, she state completed timely from 2011. 483.20(f) ENCODING RESIDENT ASSESS	I been made to increase the nursing unit and residents skilled nursing unit quicker capability of completing coordinator stated she assessments up to date but She stated she verbalized revious DON and asked for a Coordinator stated she did to until February 2011 when the MDS coordinator on an ansis. She stated she had ule for May 2011 to the proper to complete the DS Coordinator stated she approximately one and one and realized all the had not been completed as ked regarding a time frame re not completed and assessments were not an October 2010 through May MENT		286	Corrective Action Accomplishe		
	(1) Encoding Data. We completes a resident' must encode the follor resident in the facility (i) Admission assessment (ii) Annual assessment (iii) Significant change (iv) Quarterly review (v) A subset of items reentry, discharge, and (vi) Background (face is no admission assessment).		and and any other states of the states of th	residents with the potential to the affected by: MDS Coordinator audited 100° charts to ensure timely completion/placement of required MDS Assessments [ie, comprehensive, quarterly, etc] each patient medical record [a applicable] (Attachment #B1)	% of red in	7-1-11	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345245	B. WIN	G		06/1	5/2011
	OVIDER OR SUPPLIER			50	EET ADDRESS, CITY, STATE, ZIP CODE D7 FREMONT STREET URGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.0 8E	(X5) COMPLETION DATE
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			287	A "MDS Chain of Command F was put into place to establish guidelines for communication MDS issues to the CFO and/o President without punitive acti (Attachment #B2)	of or	7-1-11
	passes standardized the State. (3) Transmittal requir a facility completes a facility must electroni accurate, and complet system, including the (i) Admission assessine (ii) Annual assessme (iii) Significant change (iv) Significant correct assessment. (vi) Quarterly review. (vii) A subset of items reentry, discharge, and (viii) Background (fact initial transmission of does not have an admitted that an alternate RAI format specified by the CMS.	ements. Within 14 days after resident's assessment, a cally transmit encoded, etc MDS data to the CMS efollowing: ment. Int. e in status assessment. tion of prior full assessment. ion of prior quarterly supon a resident's transfer, and death. Ite-sheet) information, for an MDS data on a resident that mission assessment. Ifacility must transmit data in by CMS or, for a State which approved by CMS, in the ne State and approved by			All current MDS personnel will educated on DHSR Regulatio F272, F275, F276, F286, F28 and "MDS Chain of Command Policy" by 7-13-11 and then annually. All new MDS person will be educated/in-serviced defined New Hire Orientation and annual per the Unit Specific Orientation/Annual Competen Validation Checklist. (Attachment #B3)	ns 7, F490 I nnel uring ually	7-13-11
	by:	is not met as evidenced ecord review and staff					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		345245	B. WING		06/18	5/2011
	OVIDER OR SUPPLIER		56	EET ADDRESS, CITY, STATE, ZIP CODE 07 FREMONT STREET URGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 287	(10) of ten residents (#6, #7, #8, #9, #10). 1. Resident #1 was an 09/27/2010. Medical record review Minimum Data Set (Minimum Data Set (Minimum Data Set) (Minimum	ailed to electronically nnual and quarterly IDS) assessments for ten Resident #1, #2, #3, #4, #5, Findings included: dmitted to the facility on v revealed the following IDS) assessments on the MDS dated 10/06/2010 and d 03/22/2011. Database on 06/15/2011 at e any transmissions for the oper 2010 and March 2011 00 PM., the Administrator in a change in the Chief tion and the facility was just as in place for better ated she had not been aware as Sets had not been and by regulation until and if there had been a on initiated when she problem, she stated no.	F 287	Measures/Systemic Changes ensure deficient practice does recur: * MDS Coordinator position increased from 32 hours per 40 hours per week * MDS Computer upgrade * MDS Software upgrade * MDS Software upgrade * Hired 2nd MDS Coordinator * Mobile laptop for real time in the data entry * iPad with software application faster, more efficient real time data entry * President-Administrator attendate entry * President-Administrator attendate entry * MDS coordinator and Nurse Manager attended "Update in 3.0 Implementation" presented Cindy DePorter * RN with MDS 3.0 experience been hired to fill previously vanching Coordinator position in as back up/additional MDS personnel. Plans to Monitor Performance MDS assessments will be more for completion/placement in redical record through Rand Spot Checks. (Attachment # relevant MDS due dates/com dates will be discussed week months then monthly for 6 more the Quality Assessment/Assection (Attachment # Calendar Tool. (Attachment # Calendar Tool.)	week to MDS on for MDS onded ond	10/10 11/11 12/10 1/11 5/11 6/11 7/11 7-13-11

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
		345245	B. WING	3 <u></u>		06/1	5/2011
	OVIDER OR SUPPLIER			50	EET ADDRESS, CITY, STATE, ZIP CODE 07 FREMONT STREET URGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD 8E	(X5) COMPLETION DATE
F 287	Medical record review MDS assessments of assessment dated 09 MDS assessment dated 09 MDS assessment dated 12:36 PM. did not have period between Octofor Resident #2. On 06/15/2011 at 12: stated there had been Nurse Executive posibeginning to get thing organization. She stated the Minimum Datransmitted as require recently. When aske corrective plan of act became aware of the On 06/15/2011 at 12: Coordinator stated precently. The MDS Coot of keep the assessment assessmen	dmitted to the facility on It revealed the following In the chart: a quarterly MDS I/07/2010 and an annual Ited 03/03/2011. Database on 06/15/2011 at Ite any transmissions for the Ite	F	287			
	3. Resident #3 was a 03/23/2010.	dmitted to the facility	•				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		CONSTRUCTION	(X3) DATE SU: COMPLET	
		345245	B. WIN	G		06/1	5/2011
	OVIDER OR SUPPLIER			507	I ADDRESS, CITY, STATE, ZIP CODE FREMONT STREET RGAW, NC 28425	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 287	MDS assessments of assessment dated 00 assessment dated 00 MDS assessment dated 2:36 PM. did not have period between Octofor Resident #3. On 06/15/2011 at 12 stated there had been Nurse Executive posteginning to get thin organization. She stated the Minimum Date of	w revealed the following on the chart: a quarterly MDS 19/19/2010, a quarterly MDS 1/26/2011 and an annual atted 04/23/2011. Database on 06/15/2011 at the any transmissions for the other 2010 and March 2011 E:00 PM., the Administrator of the chart and the facility was just go in place for better that a change in the Chief sition and the facility was just go in place for better that a sets had not been aware at a Sets had not been red by regulation until the difference of the problem, she stated no.	F	287			
	to keep the assessmunable to do so. Whe frame that assessment transmitted, she state	nents up to date but was nen asked regarding a time ents were not completed and led assessments were not m October 2010 through May	and the state of t				
	11/15/2010. Medical record revie	admitted to the facility w revealed the following on the chart: an entry MDS					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SUF COMPLET	
		345245	B. WIN	G		06/1	5/2011
	ROVIDER OR SUPPLIER			50	EET ADDRESS, CITY, STATE, ZIP CODE 07 FREMONT STREET SURGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 287	MDS assessment dat quarterly MDS assess. A query of the State I 2:36 PM. did not have period between Octol for Resident #4. On 06/15/2011 at 12: stated there had been Nurse Executive posi beginning to get thing organization. She stathat the Minimum Dat transmitted as require recently. When asked corrective plan of actil became aware of the On 06/15/2011 at 12: Coordinator stated pr 2010. The MDS Cooto keep the assessment unable to do so. Whe frame that assessment transmitted, she state completed timely from 2011. 5. Resident #5 was an 01/07/2007. Medical record review MDS assessments or assessment dated 100	/15/2010, an admission fed 11/27/2010 and a fement dated 03/27/2011. Database on 06/15/2011 at the any transmissions for the foer 2010 and March 2011 00 PM., the Administrator in a change in the Chief tion and the facility was just igs in place for better fated she had not been aware that Sets had not been aware that Sets had not been a for initiated when she problem, she stated no. 00 noon, the MDS oblems began in October redinator stated she struggled tents up to date but was ten asked regarding a time fints were not completed and that assessments were not in October 2010 through May definited to the facility of revealed the following in the chart: an annual MDs finite/2010, a quarterly MDS finite/2011 and a quarterly	F	287			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345245	B. WING		06/1	15/2011
	ROVIDER OR SUPPLIER		507	ET ADDRESS, CITY, STATE, ZIP COD FREMONT STREET RGAW, NC 28425	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X6) COMPLETION DATE
F 287	A query of the State It 2:36 PM. did not have period between Octol for Resident #5. On 06/15/2011 at 12: stated there had been Nurse Executive posibeginning to get thing organization. She stated the Minimum Data transmitted as require recently. When asked corrective plan of actibecame aware of the On 06/15/2011 at 12: Coordinator stated pr 2010. The MDS Cooto keep the assessme unable to do so. Whe frame that assessme	Database on 06/15/2011 at eany transmissions for the ber 2010 and March 2011 00 PM., the Administrator in a change in the Chief tion and the facility was just gis in place for better ated she had not been aware that Sets had not been ed by regulation until ed if there had been a ion initiated when she problem, she stated no.	F 287			
	completed timely from 2011. 6. Resident #6 was a 12/10/2010. Medical record review MDS assessments of assessment dated 12 MDS assessment dated quarterly MDS asses A query of the State I	n October 2010 through May dmitted to the facility v revealed the following the chart: an entry 2/10/2010, an admission				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING			X3) DATE SURVEY COMPLETED	
		345245	8. WN	8. WING		06/15/2011		
	NOVIDER OR SUPPLIER			50	EET ADDRESS, CITY, STATE, ZIP CODE 07 FREMONT STREET URGAW, NC 28425			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 287	for Resident #6. On 06/15/2011 at 12: stated there had been Nurse Executive positive beginning to get thing organization. She stat that the Minimum Dall transmitted as require recently. When aske corrective plan of active became aware of the On 06/15/2011 at 12: Coordinator stated precently. The MDS Cooto keep the assessment ansmitted, she state completed timely from 2011. 7. Resident #7 was a 02/24/2011. Medical record review MDS assessment dated 03 A query of the State I 2:36 PM. did not have period between Octol for Resident #7. On 06/15/2011 at 12:	oor 2010 and March 2011 00 PM., the Administrator in a change in the Chief tion and the facility was just is in place for better ated she had not been aware ta Sets had not been ad by regulation until ad if there had been a tion initiated when she problem, she stated no. 00 noon, the MDS oblems began in October ordinator stated she struggled tents up to date but was ten asked regarding a time into were not completed and and assessments were not in October 2010 through May admitted to the facility of revealed the following in the chart: a MDS entry on and an admission MDS	F	287				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CON	TRUCTION (X3) DATE SURVEY COMPLETED		
		345245	B. WING	·		06/	15/2011
	ROVIDER OR SUPPLIER			607 FRE	DRESS, CITY, STATE, ZIP CODE MONT STREET W, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S. CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 287	beginning to get thing organization. She stathat the Minimum Dal transmitted as require recently. When aske corrective plan of act became aware of the On 06/15/2011 at 12: Coordinator stated pr 2010. The MDS Coot to keep the assessme unable to do so. Whiframe that assessme transmitted, she state completed timely from 2011. 8. Resident #8 was a 02/10/2009. Medical record review MDS assessments dated of assessment dated of	tion and the facility was just us in place for better ated she had not been aware ta Sets had not been aware ta Sets had not been a do y regulation until ad if there had been a sion initiated when she problem, she stated no. On noon, the MDS coblems began in October ordinator stated she struggled ents up to date but was en asked regarding a time ants were not completed and ad assessments were not in October 2010 through May dmitted to the facility We revealed the following in the chart: an annual MDS 1/31/2010, Quarterly MDS 1/22/2010, 07/16/2010, 2/2011 and an annual MDS 5/31/2011. Database on 06/15/2011 at the any transmissions for the ber 2010 and March 2011	F2	287			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		345245	8. WNG		06/15/2011	
	ROVIDER OR SUPPLIER		56	EET ADDRESS, CITY, STATE, ZIP CODE 07 FREMONT STREET URGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X6) COMPLETION DATE
F 287	that the Minimum Dat transmitted as require recently. When asked corrective plan of action became aware of the On 06/15/2011 at 12: Coordinator stated program in the coordinator	ated she had not been aware a Sets had not been aware a Sets had not been a set by regulation until ad if there had been a son initiated when she problem, she stated no. On noon, the MDS oblems began in October redinator stated she struggled ents up to date but was an asked regarding a time ants were not completed and diassessments were not in October 2010 through May demitted to the facility of revealed the following and the chart: a quarterly MDS 1/28/2010 and an annual ed 03/20/2011. Obstabase on 06/15/2011 at the any transmissions for the per 2010 and March 2011 On PM., the Administrator and change in the Chief tion and the facility was just as in place for better ated she had not been aware as Sets had not been and by regulation until	F 287			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CO AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		PLE CONSTRUCTION 3	(X3) DATE SUF COMPLET				
		345245	B. WING			06/15/2011	
	NOVIDER OR SUPPLIER			51	REET ADDRESS, CITY, STATE, ZIP CODE 107 FREMONT STREET BURGAW, NC 28426		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 287	Decame aware of the On 06/15/2011 at 12: Coordinator stated pr 2010. The MDS Coo to keep the assessme unable to do so. Whe frame that assessme transmitted, she state completed timely from 2011. 10. Resident #10 was 05/16/2011. Resident the facility 06/04/2012 Medical record review admission Minimum E on the chart. A query of the State E 2:36 PM. did not have period between Octol for Resident #10. On 06/15/2011 at 12: stated there had beer Nurse Executive posi beginning to get thing organization. She sta that the Minimum Dat transmitted as require recently. When aske corrective plan of acti	on initiated when she problem, she stated no. 00 noon, the MDS oblems began in October rdinator stated she struggled ents up to date but was an asked regarding a time into were not completed and ind assessments were not in October 2010 through May admitted to the facility at 10 was discharged from the control of the co	F	287			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345245	B. WING		06/15/2011	
	OVIDER OR SUPPLIER		5	REET ADDRESS, CITY, STATE, ZIP CODE 07 FREMONT STREET BURGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 287	2010. The MDS Coo to keep the assessme unable to do so. Who frame that assessme transmitted, she state	e 52 roblems began in October rdinator stated she struggled ents up to date but was en asked regarding a time nts were not completed and ed assessments were not in October 2010 through May	F 287			
F 325 SS=D	483.25(i) MAINTAIN UNLESS UNAVOIDA Based on a resident's assessment, the facil resident - (1) Maintains accepts status, such as body unless the resident's demonstrates that thi	s comprehensive ity must ensure that a able parameters of nutritional weight and protein levels, clinical condition	F 325	Corrective Action Accomplish Resident #1 weight obtained documented in the Medical F for June is 126.8 lbs (Attachr #H1) Resident #2 weight obtained documented in the Medical F for June is 173.8 lbs (Attachr #H2)	and Record ment and Record	6-30-11 6-28-11
	by: Based on medical reinterview, the facility weights for two (2) of (Resident #1, #2). Fit Resident #1 was a 09/27/2010. Cumula Dementia with behav Anxiety, Glaucoma, Ealbumin (02/22/2011)	admitted to the facility on tive diagnoses included: ioral problems, Depression, Diabetes Mellitus and low				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345245	B. WING		06/1	5/2011	
	ROVIDER OR SUPPLIER		507	ET ADDRESS, CITY, STATE, ZIP CODE 7 FREMONT STREET JRGAW, NC 28425			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 325	long term memory im moderately impaired required total assistan #1 was on a mechani diet. Weight loss was A review of the weight chart revealed no weit resident's admission. A review of the facility from January 2011 the weight of 139.2 pound 127.6 pounds for April	Resident #1 had short and pairment and was n decision-making. She noe with eating. Resident cally altered/ therapeutic noted on the MDS. It record in Resident #1's ghts recorded since n September 2010. It's weight record log book rough June 2011 revealed a dis for March 1, 2011 and	F 325	A Policy was drafted to stan weights on June 15, 2011. policy was revised on June 3 to address resident refusals (Attachment #A3) Measures/Systemic Change ensure deficient practice do recur: All SNF staff members will be educated/in-serviced on the Policy and Procedure by Jul 2011 and then annually. All SNF staff members will be educated/in-serviced on the Policy and Procedure during	This 30, 2011 es to es not Weight y 13, new Weight y New	6-30-11 7-13-11	
	blank. On 6/15/2011 at 11:3 she looked at the wei periodically (approxin recorded the weights record. She stated st there was not a weight record log book. The weight record log book to record the weights 2011 for Resident #1. On 06/15/2011 at 11: nursing assistants ob gave the information on the unit. The lice weights in the weight transcribed the weight to the resident's medithere was no one assistants on a second to the second the weight there was no one assistants.	O AM., the unit clerk stated ght record log book nately every two weeks) and in the resident's medical ne did not notify anyone if at recorded in the weight unit clerk reviewed the k and stated she had failed for March 2011 and April		Hire Orientation and annual Unit Specific Orientation/Ani Competency Validation Che (Attachment #A4, A5, and A Plans to Monitor Performance All weights will be monitored Random Spot Checks using Weight Documentation Spot Tool. (Attachment #A7) All concerns will be monitored of for 3 months then monthly for months through the Quality Assessment/Assurance Cor (Attachment #A8) using the Weight Quality Assurance T (Attachment #A9)	y per the nual acklist. 6) ce: d through the t Check weight weekly or 6 mmittee Weekly	7-13-11 +	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SI COMPLE		
			A. BUILDING				
	***************************************	345245	B. WING	B. WNG		06/15/2011	
	OVIDER OR SUPPLIER		50	EET ADDRESS, CITY, STATE, ZIP CODE 7 FREMONT STREET JRGAW, NC 28425			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 325	expected the weights log book and on the record by stated obtained for all reside otherwise specified be DON said the weights nursing assistants. Very the weight record log nursing staff and transmedical record by the Nurse #1 checked the ensure all weights has stated she expected least monthly and domedical record. 2. Resident #2 was a 01/14/2008. Cumula Cerebrovascular accided Aphasia, Diabetes Metube. A quarterly Minimum Resident #2 was aler independent in decision required total assistancontinuous gastrostor weight loss was noted. A review of the weight chart revealed no we 2011 through June 20	ok. Nurse #1 indicated she to be recorded in the weight esident's medical record. 2:30 PM., the Director of dishe expected weights to be ents at lest monthly unless by physician's order. The sewere obtained by the Weights were documented in book by the licensed scribed in the resident's equit clerk. The DON stated exweight record log book to be been obtained. She the weights to be obtained at currented on the resident's endmitted to the facility on tive diagnoses included: dent (CVA), Quadriplegia, ellitus and Gastrostomy Data Set (MDS) indicated the and oriented and con-making. Resident #2 ince with eating and received my tube feedings. No districted in Resident #2's lights recorded from January	F 325				
		rough June 2011 revealed a				B	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345245	B. WING			06/15/2011	
	OVIDER OR SUPPLIER			5	REET ADDRESS, CITY, STATE, ZIP CODE 607 FREMONT STREET BURGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 325	Continued From page weight of 178.4 pound 175.6 pounds for May January, February, Alblank. On 6/15/2011 at 11:3 she looked at the weights recorded the weights record. She stated st there was not a weight record log book. The weight record log book to record the weights 2011 for Resident #2. On 06/15/2011 at 11: nursing assistants ob gave the information on the unit. The licer weights in the weight transcribed the weight to the resident's medit there was no one ass the weight record boo expected the weights log book and on the record of 120 of 15/2011 at 112 Nursing (DON) stated obtained for all reside	ds for March, 2011 and volume 2011. Weights for 2011. Weights for 2011 and 3 a		325	DEFICIENCY)		
	nursing assistants. V the weight record log nursing staff and tran-	were obtained by the leights were documented in book by the licensed scribed in the resident's unit clerk. The DON stated					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DA CO				
		345245	B. WING		06/15/2011	
	NOVIDER OR SUPPLIER		50	EET ADDRESS, CITY, STATE, ZIP CODE 07 FREMONT STREET URGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO BE	(X5) COMPLETION DATE
F 325	ensure all weights ha stated she expected t	e 56 e weight record log book to ve been obtained. She the weights to be obtained at cumented on the resident's	F 325			
	483.75 EFFECTIVE ADMINISTRATION/F A facility must be adm	ESIDENT WELL-BEING ninistered in a manner that esources effectively and	F 490	Corrective Action Accomplis affected residents as well as residents with the potential t affected by:	o be	
	well-being of each res	mental, and psychosocial		MDS Coordinator audited 16 charts to ensure timely completion/placement of rec MDS Assessments [ie, comprehensive, quarterly, e each patient medical record applicable] (Attachment #B1	quired tc] in [as	7-1-11
	MDS assessments of record dated 02/24/24 assessment dated 03	v revealed the following n the chart: a MDS entry 011 and an admission MDS		A "MDS Chain of Command was put into place to establiguidelines for communicatio MDS issues to the CFO and President without punitive ac (Attachment #B2)	Policy" sh n of l/or	7-1-11
	2:36 PM. did not have period between Octor for Resident #7. On 06/15/2011 at 12: stated there had been Nurse Executive positions beginning to get thing organization. She stated the Minimum Datransmitted as require recently. When asket	e any transmissions for the ber 2010 and March 2011 00 PM., the Administrator a change in the Chief tion and the facility was just as in place for better ated she had not been aware ta Sets had not been		All current MDS personnel veducated on DHSR Regulat F272, F275, F276, F286, F2 and "MDS Chain of Comma Policy" by 7-13-11 and then annually. All new MDS perswill be educated/in-serviced New Hire Orientation and arper the Unit Specific Orientation/Annual Competed Validation checklist. (Attachment #B3)	ions 287, F490 nd sonnel during nnually	7-13-11

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345245	8. WNG		06/1	5/2011
	OVIDER OR SUPPLIER		507	ET ADDRESS, CITY, STATE, ZIP CODE 7 FREMONT STREET JRGAW, NC 28425	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 490	On 06/15/2011 at 12 Coordinator stated p 2010. The MDS Co to keep the assessn unable to do so. WI frame that assessm transmitted, she sta	e problem, she stated no.	F 490	Measures/Systemic Change ensure deficient practice direcur: * MDS Coordinator position increased from 32 hours per week * MDS Computer upgrade * MDS Coordinator increased incr	tor et MDS attended igh] rse e in MDS nted by	10/10 11/11 12/10 1/11 2/11 5/11 6/11 7/11
				Plans to Monitor Performa MDS assessments will be for completion/placement i medical record through Ra Spot Checks. (Attachmen relevant MDS due dates/c dates will be discussed we months then monthly for 6 the Quality Assessment/A Committee Meeting using Calendar Tool. (Attachment)	monitored n resident indom t #B4) All completion ekly for 3 months. in essurance the MDS	7-13-11

PRINTED.	07/12/2011
FORM	APPROVED
OMB NO.	0938-0391

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X3) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

345245

A HUILDING 01 - MAIN BUILDING 01

8 WING_

07/08/2011

AME OF PROVIDER OR SUPPLIER

ATEMENT OF DEFICIENCIES

D PLAN OF CORRECTION

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 DE 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)	COMPLETION DATE
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	K 038	K 038 Corrective Action Accomplished by: 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.	7-18-11
K 061 SS=D	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) NFPA 101 LIFE SAFETY CODE STANDARD 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	K 061	All exits throughout the building were checked to assure this special locking does not occur elsewhere. Measures/Systemic Changes to ensure deficit practice does not recur: Education was provided to all Plant Operations employees concerning this code standard.	7-18-11
	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 out side) 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)		Plans to Monitor: 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	7-18-11
PRATOR	Y DIREKTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE	(X6) DATE

ABORATORY DIRER WOTES OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

my deficiency statement anding with an accorde (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther saleguards provide sufficient protection to the patients. (See instructions) Except for numbing homes, the findings stated above are disclosured and ollowing the date of survey whether or not a plan of correction is provided. Por nursing names, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If delicionales are cited, an approved plan of correction is requisite to continued irogram participation.

F-424 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO 0938-0391 DENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X3) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA ATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER 01 - MAIN BUILDING 01 ID PLAN OF CORRECTION A BUILDING B WING _ 07/08/2011 345245 STREET ADDRESS, CITY, STATE, ZIP CODE JAME OF PROVIDER OR SUPPLIER 507 FREMONT STREET PENDER MEMORIAL HOSP SNF BURGAW, NC 28425 (XS) PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REPERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **DEFICIENCY**) TAG K 061 Corrective Action Accomplished by: K 061 K 061 Continued From page 1 42 CFR 483 70 (a) 3 tamper switches for the back flow 7-29-11 valves will be installed. The PTV's tamper alarm will be repaired. 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. Measures/Systemic Changes to ensure deficit practice does not 7-29-11 recur: Tamper switches will remain in place at all times. Education was provided to Plant Operations employees of the code regulations concerning these tamper alarms. Plans to Monitor:

Care committee

Results of the inspections will be

Environment of Care Committee. An annual testing will be completed

reported through the Environment of

on these tamper switches and

reported through the next

7-29-11