JUN 1 8 2013

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STATEMENT OF DEFICIENCIES MAD PLANOT CORRECTION A SULDING SASSTE S	CENTER	OT OIL MEDIOVICE &	MEDIONID SELVICES			, <u>, , , , , , , , , , , , , , , , , , </u>		. 0000 0001
NAME OF PROVIDER OR SUPPLIER HARNETT WOODS NURSING AND REHABILITATION CENTER DUNN, No. 28334 F 221 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility collized a concave winged matrices that acide as a restraint without a medical symptom on 1 of 2 residents (resident #75) reviewed for restraints, relations, alloud acides, diamonal, analyst, cerebraevascular acident, demonia with behavioral disturbance, hallucinations, alcohol abuse, history of fells and impaired vision. The admission Minimum Data Set (MDS) dated 4722/13 indicated resident #75 was a drailed in resident #75 was evaluated by physical therapy on 4/18/13 but no services were indicated since level of function as at baseline. A fall risk assessment was completed on 4/18/13 indicating resident #75 was at sisk for falls. A review of the care plan dated 4/2278 indicated resident #75 was at sisk for falls with interventions to include a man to the foot obsiciot be bed, to whole, frequent monitoring and a winged mattress.								
## PARKETT WOODS NURSING AND REHABILITATION CENTER COMPAND SUMMARY STATEMENT OF DEFICIENCIES CONTINUE OF THE PROCESSOR OF THE PROPERTY OF THE PROCESSOR OF THE PROCESSOR OF THE PROCESSOR OF THE PROPERTY AND SHOULD BE CONCESSOR OF THE PROCESSOR OF THE PROC			345478	B. WING			05/	30/2013
MANNETT WOODS NUSBING AND REHABILITATION CENTER DUNN, NC 28334	NAME OF PR	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
OAJ ID PREFIX TAG SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) F221 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility utilized ac oncave winged mattress that acted as a restraint without a medical symptom on 1 of 2 residents (resident #75 was admitted into the facility on 4/18/13 with diagnoses of insomnia, anxiety, carebreavescular accident, dementle with behavioral disturbance, hallucinations, alcohol abuse, history of falls and impaired vision. The admission Minimum Data Set (MDS) dated 4/22/13 indicated resident #75 was a subsession. A fall risk assessment was completed on 4/18/13 indicated resident #75 was a stabseline. A fall risk assessment was completed on 4/18/13 indicated resident #75 was a stabseline. A fall risk assessment was completed on 4/18/13 indicated resident #75 was a stabseline. A fall risk assessment was completed on 4/18/13 indicated resident #75 was a thigh risk for falls with interventions to include a mat on the floor boside the bed, low bed, frequent monitoring and a winged mattress.	HARNETT	WOODS NURSING AND	REHABILITATION CENTER		6	04 LUCAS RD		
FREENT TAG FREGULATORY OR LSC IDENTIFYING INFORMATION FREGULATORY OR LSC IDENTIFYING INFORMATION FREGULATORY OR LSC IDENTIFYING INFORMATION FRESHORD FR					D	OUNN, NC 28334		
F 221 483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility utilized a concave winged mattress that acted as a restraint without a medical symptom on 1 of 2 residents fresident #75 reviewed for restraints. Findings include: Resident #75 was admitted into the facility on 4/18/13 with diagnoses of insomnia, amidity, cerebreavascular accident, dementia with behavioral disturbance, hallucinations, aicohol abuse, history of fails and imperied vision. The admission Minimum Data Set (MDS) dated 4/22/13 indicated resident #75 was evaluated by physical therapy on 4/18/13 but no services were indicated since level of function as at baseline. A fall risk assessment was completed on 4/18/13 indicating resident #75 was at risk for falls. A review of the care plan dated 4/22/13 indicated resident hybosa at risk for falls with interventions to include a mat on the floor besido the bed, low bed, frequent monitoring and a winged mattress.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
#75 was at risk for falls with interventions to include a mat on the floor beside the bed, low bed, frequent monitoring and a winged mattress.	тад F 221	483.13(a) RIGHT TO PHYSICAL RESTRAL The resident has the physical restraints im discipline or convenie treat the resident's m This REQUIREMENT by: Based on observation record review, the fact winged mattress that a medical symptom of #75) reviewed for resident #75 was add 4/18/13 with diagnostic cerebreavascular acceptavioral disturbance abuse, history of falls admission Minimum (4/22/13 indicated resident winged extensive asdaily living (ADL's). The restraint. A review of the medic resident #75 was evaluated on 4/18/13 but no ser level of function as at assessment was commercially was a history was a history of service of function as at assessment was commercially was a history was a history was a history was a first physical production.	BE FREE FROM INTS right to be free from any posed for purposes of ence, and not required to edical symptoms. Is not met as evidenced ns, staff interviews and stillty utilized a concave acted as a restraint without in 1 of 2 residents (resident traints. Findings include: mitted into the facility on es of insomnia, anxiety, sident, dementia with ee, hallucinations, alcohol and impaired vision. The Data Set (MDS) dated ident #75 had severe was non-ambulatory and sistance with all activities of The MDS was not coded for the Interest of the Interest included by physical therapy vices were indicated since to baseline. A fall risk inpleted on 4/18/13 indicating igh risk for falls. A review of			RESPONSE PREFACE Harnett Woods Nursing and Rehabilitation acknowledgreceipt of the Statement Deficiencies and proposet plan of correction to the extend that the summary of indings is factually corand in order to maintain compliance with applicably rules and provisions of quare of the residents. The plan of correction is submitted as a written allegation of compliance. Harnett Woods Nursing and Rehabilitation response the Statement of Deficiencies Plan of Correction does in denote agreement with the Statement of Deficiencies does it constitute an admittation and deficiency is accompliant to submit any documentation to refute a the stated deficiencies of this Statement of Deficiencies of this Statement of Deficienties of this Statement of Deficienties of the right to submit any documentation to refute a the stated deficiencies of this Statement of Deficienties of this Statement of Deficienties of the right of the informal dispresolution formal appeal procedure and/or any other statement of the statement of the presolution formal appeal procedure and/or any other statement of the statement of the presolution formal appeal procedure and/or any other statement of the statement of	es of this f rect e uality he o the and ot nor ission curate erves ny of n ncies ute	06/27/13
		#75 was at risk for fal include a mat on the	lls with interventions to floor beside the bed, low			.		
						777.5	V-W	CAS DATE

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 deficiencles are cited, an approved plan of correction is requisite to continued program participation.

Facility ID: 924467

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
		345478	B. WING			05/	30/2013	
	OVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		60	EET ADDRESS, CITY, STATE, ZIP CODE 04 LUCAS RD UNN, NC 28334			
		***************************************		ب	ONN, NO 20004			
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 221	Continued From page	3 1	F	221	The facility removed the concave winged mattress i	rom		
		ce in the medical record that			Resident #75's bed on Jur			
		tive measure other than the				ie 5,		
	winged mattress had		ľ		2013. The facility has	4.3		
	effectiveness.	boon oraliación ion			evaluated the Resident fo			
	Ondonvonded.				necessity of a less restr		e I	
	1	factures product information			device with the resident.	ı		
	indicated the defined				The facility completed by	7		
		tress) was elevated to a d to be utilized for the difficult			June 7, 2013 a 100% audit			
	patient who required			•	falls and interventions i			
	protection.	the greatest level of			the past 180 days. This			
	protection.				audit included assessing	the		
	A review of the incide			use of Physical Restraint				
		sident #75 was found on the			included the concave wing			
		out of the reclining chair.			mattress to ensure that t			
		s. The incident report			least restrictive device		06/27/13	
	indicated no intervent	tion to prevent another			fall prevention was being		00,2,,13	
	occurrence. Resident	#75 had not experienced			with no issues identified			
		from either the reclining			with no issues identified	. •		
	chair or the bed.				An in-service was begun b	w tha		
		E100440 - / 44-00 AAA			DON and ADON on June 3, 2			
		n on 5/28/13 at 11:00 AM,			with all license nurses a			
		resident #75 was observed concave winged mattress			administrative staff rega			
	was observed elevate	_			the use of alternatives f			
		the bed. The mattress was			Physical Restraints and	.01.	1	
		th an area in the middle of			· ·			
		attress cut out to allow for			assessing for the least restrictive device for fa	.11		
	care to be rendered.							
					prevention. New nurses w			
	During an observation	n on 5/29/13 at 11:20 AM,			be in-serviced on the pro	cess		
		served in the bed screaming			during orientation.			
	out and kicking her feet and pulling at the right							
	side of the concave winged mattress in an An audit tool was begun by the							
		he bed. In an interview with			QI Nurse on June 3, 2013		 -	
	nursing assistant #1 (review new falls to inclu			
	5/29/13, she indicated				Resident #75aand interver			
	attempted to get up o	ut of the bed all the time but			to ensure alternatives to)		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345478	B. WING			05/	30/2013
	OVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		6	BEET ADDRESS, CITY, STATE, ZIP CODE 04 LUCAS RD DUNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 221	she could not because mattress. NA #1 indic fallen from the bed and being on the bed since to the facility. NA #1 sexhibited behaviors to and verbal aggression witnessed at 11:20 AM for resident #75. NA # placed back into her becare and she would be lunch shortly In an interview with as (ADON) on 5/29/13 at the concave winged in after her fall from the The ADON stated rescombative and tried to ADON recalled reading tried to roll from the berecalled resident #75 previous facility but she reclining chair to date 4/18/13. In an interview with not the bed all the time #75 could throw her lemattress and if she reresident #75 could get in an interview with Name and intervie	e of the concave winged cated resident #75 had not a recalled the mattress of resident #75 was admitted attack that the resident include yelling, screaming a daily and the behavior of was not out of the ordinary that stated resident #75 was not out of the ordinary that stated resident #75 was not out of the ordinary that stated resident #75 was not out of the processistant director of nursing that the same and the sam	F	221	Physical Restraints are attempted initially. The Nurse will review falls do The audit tool will monitor Physical Restraints to ensie least restrictive device used, that there is a medisymptom, the correct coding on the MDS and there is a care plan. The DON and the ADON will review the results of the tool weekly X 4 weeks and monthly X 2 months. The I and/or the ADON will follow immediately any potential actual physical restraint concern upon identification. The results of the audit will be shared monthly with Executive QI Committee X Additional action will occide med necessary for potential actual physical restraint concerns of concerns, and to determine the need for and frequency of continued monitoring.	aily. or sure to is ical ng is audit OON ow up or use on. tool th the cur as ntial	06/27/13 hs.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			TE SURVEY MPLETED
		345478	B. WNG		Ot	5/30/2013
	ROVIDER OR SUPPLIER T WOODS NURSING AI	ND REHABILITATION CENTER	604	ET ADDRESS, CITY, STATE, ZIP CODE LUCAS RD NN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 221	#2 stated resident # out of the bed but s the mattress. During an observative resident #75 was of positioned over the crying, and moving to get over the matt. In an interview on 5 nurse stated her unconcave winged mattress ha and she did not con. In an interview on 5 of nursing (DON), A acknowledged that prevent falls from thresident #75. The D #75 would have been they not used the coindicated the conca in the bed. In an interview with 12:00PM, she state resident #75 attemps stated resident #75 her legs over the side believe resident #75 the mattress on her saw resident #75 gets.	#75 frequently attempted to get she was unable to because of tion on 5/29/13 at 1:45 PM, observed with her legs concave winged mattress, her lower body in an attempt	F 221			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345478	B. WNG			05/	30/2013
	OVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		60	EET ADDRESS, CITY, STATE, ZIP CODE 04 LUCAS RD UNN, NC 28334		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 272	at 12:30 PM, she indibe that that the least resident #75 before u 483.20(b)(1) COMPR ASSESSMENTS The facility must concac comprehensive, accreproducible assessment of a resident assessment of a resident assessment by the State. The assleast the following: Identification and dem Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior prescribed functioning a Continence; Disease diagnosis an Dental and nutritional Skin conditions; Activity pursuit; Medications; Special treatments and Discharge potential; Documentation of sunthe additional assessmens triggered by the Data Set (MDS); and	the administrator on 5/30/13 cated her expectation would restrictive device be tried for sing a restraint. EHENSIVE Juct initially and periodically curate, standardized nent of each resident's a comprehensive dent's needs, using the instrument (RAI) specified ressment must include at mographic information; atterns; ng; atterns; ng; atterns; ng; ad health conditions; status;		272	The facility removed the concave winged mattress for Resident # 75's bed on Ju 2013. The MDS Nurse has assessed Resident # 75 for necessity of a less restrated device. The facility began an 100 audit assessing the other residents for the use of restraints and concave with mattresses. The audit included checking for med symptoms, coding on the M and a correct care plan were residents made as necessathe MDS nurses. An in-service was complet June 5, 2013 by the Admin with the two MDS nurses or comprehensive assessment resident's needs and usin resident assessment (MDS) required by the state. If included that the assessment resident's status and musteflect any restraint use care plan is to be completed as a specific to the state of the st	ne 3, r the ictive % nged ical DS ith ry by ed on istrat n the of a g the t ent he t t ted	06/27/13

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345478	B. WING			05/	30/2013
	OVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		6	EET ADDRESS, CITY, STATE, ZIP CODE 04 LUCAS RD 0UNN, NC 28334	"	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 272	by: Based on observation record review, the fact least restrictive devices winged mattress for 1 (resident #75) with resident #75 was add 4/18/13 with diagnose cebrevascular accident disturbance, hallucina of falls and impaired with Minimum Data Set (Minimum Data Set (Minimum Data Set) was non-ambulatory assistance with all act The resident was cod and it was not coded facility did not assess consequences of the need for the restraint, devices, or determine mattress was treating the mattress was an expresident #75 was at rist include a mat on fice	is not met as evidenced ns, staff interviews and ility failed to assess for the e before utilizing concave of 2 sampled residents straints. Findings include: mitted to the facility on es of insomnia, anxiety, nt, dementia with behavioral ations, alcohol abuse, history vision. The admission (DS) dated 4/22/13 indicated ere cognitive impairment, and required extensive divities of daily living (ADL's), ed for one fall without injury for any restraints. The for any negative restraint, the underlying any other least restrictive what medical symptom the because the facility thought	F		An audit tool to include Resident #75 was begun on June 3, 2013 by the QI Nur to monitor the use of Phys Restraints, concave winged mattresses, medical symptofor the restraint, correct coding of the MDS and a caplan for the resident. The DON and the ADON will review the results of the audit tool weekly X4 weeks monthly X 2 months. Upon identification any concern proper assessment for the of physical restraint deviand/or the application of least restrictive device whe immediately followed upon by the DONand/or the ADON The results of the audit twill be shared monthly with Executive QI Committee X 2 months. Additional action occur as deemed necessary potential areas of concern to determine the need for or frequency of continued monitoring.	sical l oms ire and with use ces the vill oon i will for	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION	(X3) DATE	
		345478	B. WING			05/:	30/2013
	NOVIDER OR SUPPLIER	ID REHABILITATION CENTER		604 L	FADDRESS, CITY, STATE, ZIP CODE LUCAS RD IN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 272	A review of the manindicated the define (concave winged milevel of 16 inches a patient who required protection. A review of the mediates of the mediates was completed 4/18 was a high risk for form of the mediates of the mediates. During an observation of the mediates of the mediates of the mediates. During an observation of the mediates of the care to be rendered out and kicking her side of the concave attempt to get out out in an interview with (ADON) on 5/29/13	aufactures product information d perimeter mattress attress) was elevated to a and to be utilized for the difficult d the greatest level of lical record revealed that valuated by therapy on 4/18/13 e indicated since level of ine. A fall risk assessment 3/13 indicating resident #75 alls. Ilical record did not reveal any clan orders for the mattress, mattress and no physical he need for the concave on on 5/28/13 at 11:00 AM, rr, resident #75 was observed a concave winged mattress ated to each side of the fithe bed. The mattress was with an area in the middle of mattress cut out to allow for l. ion on 5/29/13 at 11:20 AM, bserved in the bed screaming feet and pulling at the right winged mattress in an	F	272			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345478	B. WING			05/	/30/2013
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		6	REET ADDRESS, CITY, STATE, ZIP CODE 04 LUCAS RD DUNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 272	ADON stated residen and tried to get out of recalled reading reported from the bed, especially but she had on admission on 4/18/13. During an observation resident #75 was observationed over the concept of the control of the contro	chair on 4/18/13. The It #75 was often combative It the bed. The ADON Its that resident #75 tried to ecially at night. She recalled It of falls from previous Inly one fall to date since her It. In on 5/29/13 at 1:45 PM, erved with her legs concave winged mattress, er lower body in an attempt iss. 9/13 at 2:05 PM, the MDS incave winged mattress kept ting up from the bed, it ded and care planned as a dated 4/22/13. 9/13 at 3:20 PM, the director ON, and MDS nurse no assessment for the least they did not think the int since resident #75 was it the bed. It is a directly the directly was in the bed. It is a directly the directly was in the bed. It is a directly was in the bed. It is a directly was It is a directly wa	F	272			
F 278 SS=D		SMENT	F	278			
77	The assessment must resident's status.	t accurately reflect the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMF	SURVEY PLETED
		345478	B. WNG			05/	30/2013
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		6	EET ADDRESS, CITY, STATE, ZIP CODE 04 LUCAS RD DUNN, NC 28334		***************************************
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F 278	A registered nurse mueach assessment with participation of health A registered nurse muassessment is completed in individual who cassessment must significant portion of the ass. Under Medicare and Millfully and knowingly false statement in a resubject to a civil mone \$1,000 for each asses willfully and knowingly to certify a material and resident assessment in penalty of not more the assessment. Clinical disagreement material and false statement in the session of the Minimum Data Set a physical restraint for	ist conduct or coordinate in the appropriate professionals. Ist sign and certify that the sted. Interpretation of the interpretati	F	278	The facility removed the concave winged mattress f Resident # 75's bed on Ju 3, 2013. The MDS Nurse h assessed Resident # 75 for necessity of a less restricted. The facility completed a audit for residents with for the past 180 days ensith that a Physical Restraint not been utilized without assessment, the correct con the MDS and a restraint care plan with revisions as necessary by the MDS nur on the MDS process, the assessment accurately reflecting the resident's status including the use Physical Restraint and a plan for the restraint. An audit tool to include Resident # 75 was begun of June 3, 2013 by QI Nurse to monitor the use of restraints, the correct con the MDS and care plann for the restraint.	ne as r the ictive 100% falls uring had an oding t made urses ed by 5, ses of a care	06/27/13

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′		CONSTRUCTION	(X3) DATE S COMPL	
		345478	B. WNG	B. WNG			30/2013
	OVIDER OR SUPPLIER WOODS NURSING AND	REHABILITATION CENTER		60	EET ADDRESS, CITY, STATE, ZIP CODE 04 LUCAS RD UNN, NC 28334		
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F 278	disturbance, hallucing of falls and impaired of falls and impaired of falls and impaired of falls and impaired of falls and impairment, required extensive as daily living (ADL's). Tone fall without injury restraints. There was completed regarding. A review of the care resident #75 was at rist to include a mat on fle frequent monitoring a There was no care pluring an observation during the initial tour, asleep in her bed. A considered was observed elevate upper/lower sides of the made of firm foam withe right ride of the made of firm foam withe right ride of the material to be rendered. During an observation resident #75 was obsout and kicking her feside of the concave wattempt to get out of the initial tour, and interview with no 11:45 AM on 5/29/13, #75 attempted to get	nt, dementia with behavioral ations, alcohol abuse, history vision. The admission MDS ed resident #75 had severe was non-ambulatory and sistance with all activities of he resident was coded for and it was not coded for and it was not coded for any no Care Area Assessment the use of restraints. I colan dated 4/22/13 indicated isk for falls with interventions for beside the bed, low bed, and a winged mattress. In on 5/28/13 at 11:00 AM, resident #75 was observed concave winged mattress ed to each side of the line bed. The mattress was then a area in the middle of attress cut out to allow for the use of screaming set and pulling at the right vinged mattress in an	IL.	278	The DON and the ADON will review the results of the audit tool weekly X4 week monthly X 2 months. Upon identification any concerthe addressing of physica restraint device on the coplan will be immediately followed up on by the DON or the ADON. The results of the audit will be discussed monthly with the Executive QI Committee X 2 months. Additional action will ocas deemed necessary for potential areas of concernand to determine the need and/or the frequency of continued monitoring.	s and n with l are and/ tool (06/27/13

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		345478	B. WING			05	3/30/2013
	OVIDER OR SUPPLIER	REHABILITATION CENTER		604 L	raddress, city, state, zip code Lucas RD In, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING 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 278	During an observation resident #75 was observationed over the corying, and moving he to get over the mattre. In an interview on 5/2 nurse stated if the coresident #75 from get should have been corestraint on her MDS. In an interview on 5/2 of nursing (DON), AD confirmed that the MI for a restraint and car. In an interview with that 12:30 PM, she indices	n on 5/29/13 at 1:45 PM, served with her legs concave winged mattress, er lower body in an attempt ess. 19/13 at 2:05 PM, the MDS encave winged mattress kept etting up from the bed, it ded and care planned as a dated 4/22/13. 19/13 at 3:20 PM, the director er DON, and MDS nurse DS should have been coded er planned as a restraint. The administrator on 5/30/13 cated her expectation would 475's MDS accurately reflect	F	278			

IDA TROGDON

FORM APPROVED

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			0	MB NO. (938-0391
CENTER	S FOR MEDICARE	& MEDICAID SERVICES	0/6\ 3/11	TIPLE CONSTRUCTION	P	(X3) DATE	SURVEY
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILO	DING 01 - MAIN BUILDING	W 国 C 国 C	COMP	
		345478	B. WING	<u> </u>	1 1111 2 4 3		0/2013
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE 3 4	013	
HARNET	T WOODS NURSING	AND REHABILITATION CENTER		DUNN, NC 28334	CONSTRUCTION	SECTION	
	OU WALDY CY	TEMENT OF DEFICIENCIES	- 10		S PLAN OF CORRECTION SHOULD	Non-marin	COMPLETION
(X4) ID PREFIX . TAG :	CAND SECOLEMON	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAC	CROSS-REFERE	NCED TO THE APPROP DEFICIENCY)	RIATE	DATE
					PREFACE	i :	
K 000:	INITIAL COMMEN	TS	X	000 Harnert Wood	s acknowledges he Statement o	ef	
	•	:		receipt of c	and proposes	this	
:	This Life Safety C	ode (LSC) survey was	•	plan of corr	and proposes		
:	conducted as net	the Code of Federal Register		owtend that	the summary of	:	1
	' ሑ ልጎ ሶሮD <i>ለ</i> ፀ3 7በ/	ar reing tub soon existing		findings is	factually corr	ect :	}
	Health Care section	n of the LSC and its referenced	•	and in order	to maintain		}
	publications. I his i	facility is Type V protected ng North Carolina Special	•	compliance w	ith applicable	:	1
	Locking attendeme	ents, and is equipped with a	:	rules and pr	ovisions of		
	complete automati	ic sprinkler system.	•	quality of c	are of the	·	
	Complete date	•		resident. T	he plan of	!	
	CFR#: 42 CFR 48	33,70 (a)			s submitted as	į	1
K 029	NEPA 101 LIFE S	AFETY CODE STANDARD	K	029 written alle	gation of	ļ	
SS≃E			:	compliance.			
	One hour fire rated	d construction (with 1/4 hour		4		*50	
	fire-rated doors) o	r an approved automatic fire		Harnett Wood	s response to	ond .	
	extinguishing systems	em in accordance with 8.4.1 otects hazardous areas. When		Statement of	Deficiencies	st.	
	*ho approved 2010	matic fire extinguishing system		Plan of Corr	ection does no ment with the	, s.	
	antion in urad the	areas are separated fivin		denote agree	Deficiencies	nor	
	whor anacae hill si	moke resisting partitions and		that any def	telaney is		,
	James Dance ore	CALL CIASING SITU HUIT-LAVER OF		independent of F	urther, Harnet	:t	
	- fold applied biote	Clive plates that no not except	•	Joods TageTV	es the right t	10	,
	48 inches from the	e pottom of the goor are		aubait docum	entation to re	fute	
	permitted. 19.3.	.2.1		any of the s	tated deficien	icies	
	4		:	on this Stat	ement of Defic	iencie	9
1				through the	informal dispu	ıte	
<u> </u>				resolution,	formal appeal		
	THIS STANDARD	is not met as evidenced by:		procedure an	d/or any other	:	i i
	· Donad on the obs	centations and stall litterview	ł		n or administr	rative	
Ì	acceleration that takes on	. 7/10/2013 the juilowing issui		degal procee	ding.		:
	Lunnatad at	AANCOMDIIANI. SUUUIIU IIIVIISY					i
	・・・・・・・・ てんへ (へん)	BK/ NOV 3 DUNGUE OF GGS(GGS	.	K 029 An in	-service was	l ho	08/01/201
	$_{\odot}$ in the combustion	chamber of the gas fired dryers	•	completed on	July 15, 2013	י טאַ	
	in the laundry.			the Administ	rator with the	, mer	;
	<u> ዕድፀ</u> ው አኝ ዕድ፬ ለ	.83 70 (a)		maintenauce	Man on the pro	'}'-~ ?	:
	CFR#: 42 CFR 4	SAFETY CODE STANDARD	. 1	(056 and timely c	Teaning or cite	· 	1 100 5 1 7 7
K 056	NERA INI LICE V	THE OFFICE ALL ALL ALL ALL ALL ALL ALL ALL ALL AL	GNATUR	E ~ TU	LE		(X6) DAYE
LABORATO	RY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI		A Amiani	aluto		724-10
	0// 7				4		المطل أسميا

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguerds 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: 924467

If continuation sheet Page 1 of 2

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

(X2) MULTIPLE CONSTRUCTION

A BUILDING 01 - MAIN BUILDING 01

PAGE 05 PRINTED: 07/14/2013 FORM APPROVED

OMB NO. 0938-0391

07/10/2013

(X3) DATE SURVEY COMPLETED

345478

(X1) PROVIDER/SUPPLIER/CLIA

IDENTIFICATION NUMBER:

B. WING

NAME OF PROVIDER OR SUPPLIER

STATEMENT OF DEFICIENCIES

AND PLAN OF CORRECTION

STREET ADDRESS, CITY, STATE, ZIP CODE

604 LUCAS RD

DUNN, NC 28334

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

HARNETT WOODS NURSING AND REHABILITATION CENTER

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X6) COMPLETION DATE

08/01/13

K 056 Continued From page 1

SS=E

. If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the 19.3.5 building fire alarm system.

This STANDARD is not met as evidenced by: Based on the observations and staff interview during the tour on 7/10/2013 the following Item was observed as noncompliant, specific findings Include: The facility did not have proper sprinkler coverage in the storage room on the 400 hallway.

CFR#: 42 CFR 483.70 (a)

combustion chamber of the gas K 056 fired dryers in laundry.

> A weekly audit tool was begun by Maintenance on July 15, 2013 to clean and monitor the combustion chambers of the gas fired dryers in the laundry.

A QI audit tool was begun on July 15, 2013 by the Administrator to review the weekly checks by Maintenance. The results of the weekly audit cool will be reviewed weekly X 4 weeks and monthly X 2 months.

K056 Sunland Fire and Sprinkler Protection came on July 19, 2013 and installed a sprinkler head 08/01/2013 for propr coverage in the storage room on the 400 Hallway.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: X8RN21

Facility ID: 924467

If continuation sheet Page 2 of 2

