STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs

PROVIDER # MULTIPLE CONSTRUCTION
345259 A. BUILDING:

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE
SAMPSON REGIONAL MEDICAL CTR 607 BEAMAN ST BOX 258
CLINTON, NC

B. WING:

DATE SURVEY COMPLETE: 5/16/2013

ID TAG SUMMARY STATEMENT OF DEFICIENCIES

F 279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:

Based on observation, interview and record review, the facility failed to develop a comprehensive care plan in regard to oral/dental status for one of three residents sampled (Resident #36).

Findings include:

Resident #36 was admitted on 11/28/2012 with diagnoses of pyleonephritis (kidney infection), acute renal failure, hematuria (blood in the urine), hypertension, anxiety and pressure ulcer.

The admission Minimum Data Set (MDS) dated 12/5/2012, noted that Resident #36 was cognitively intact, and needed one person to physically assist them in all activities of daily living (ADLs). The MDS further noted that Resident #36 had abnormal mouth tissue (described as ulcers, masses, or oral lesions.) This resident had no swelling or nutritional deficiencies.

A review of nurse notes revealed that Resident #36 stated that she has dentures, but does not like to wear them. Documentation was observed in the nurse notes that there was a small ulcer on Resident #36 's upper gum, but the area appeared to be healing.

In an interview on 5/16/2013 at 3:30 PM, the MDS nurse looked throughout the closed record for an oral/dental status care plan for Resident #36. The MDS nurse stated that she did not know why the care plan was not written and implemented.

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 99 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

The above isolated deficiencies pose no actual harm to the residents

Event ID: 824211
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(XI) PROVIDER/SUPPLIER
IDENTIFICATION NUMBER:
345289

(XIII) ID PREFIX
TAG

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

ID PREFIX
TAG

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

001 COMPLETION
DATE

NAME OF PROVIDER OR SUPPLIER:
SAMPSON REGIONAL MEDICAL CTR

STREET ADDRESS, CITY, STATE, ZIP CODE:
897 BEAMON ST BOX 259
CLINTON, NC 28328

08/12/2013

K 000 INITIAL COMMENTS

Surveyor: 27871
This Life Safety Code (LSC) survey was
conducted as per The Code of Federal Register
at 42 CFR 488.70(a); using the 2007 Existing
Health Care section of the LSC and its referenced
publications. This building is Type I construction,
three story (skilled nursing wing) with a complete
automatic sprinkler system.

The deficiencies determined during the survey
are as follows:

NFPA 101 LIFE SAFETY CODE STANDARD

K 010 Deore protecting corridor openings in other than
required enclosures of vertical openings, exits, or
hazardous areas are substantial doors, such as
those constructed of 1/8 inch solid-bonded core
wood, or capable of resisting fire for at least 20
minutes. Doors in sprinklered buildings are only
required to resist the passage of smoke. There is
no impendment to the closing of the doors. Doors
are provided with a means suitable for keeping
the door closed. Dutch doors meeting 19.3.8.3.9
are permitted. 19.3.6.3

Roller latches are prohibited by CMS regulations
in all health care facilities.

Trash cone blocking the resident's
room doors in room 288 and
room 270 on the Skilled Nursing Unit
were removed immediately on
June 12, 2013 when the
correction was identified by the
surveyor and the Hospital Director
of Facilities. Staff on duty on the
Skilled Nursing Unit were
re-educated to the requirement that
there can be no impediment to the
closing of the doors.
1) 100% of Skilled Nursing staff was
educated (Attachment I) on the
NFPA Life Safety Code requirements
that there can be no impediment to
the closing of the doors.
2) A Weekly Safety Checklist has
been implemented and is completed
weekly by the Skilled Nursing Unit
Director. The Checklist includes
direct observation/monitoring
of the Physical Environment of the
Skilled Nursing Unit, including,

This STANDARD is not met as evidenced by:

LAbORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE:

TITLE:

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 adequate protective measures are being provided to the patients. (See instructions). Except for nursing homes, the findings stated above are discloseable 60 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 discloseable 14
days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued
program participation.

FORM CMS-2581(03/05) Previous Versions Omitted Envel: 834221 Facility ID: 045465

(if continuation sheet Page 1 of 3

[Signature]
<table>
<thead>
<tr>
<th>ID</th>
<th>TAG</th>
<th>Description</th>
<th>Date</th>
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<tbody>
<tr>
<td>K018</td>
<td></td>
<td>Continued From page 1 Surveyor: 27671 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliant, specific findings include: trash cane blocking resident bedroom door from closing (268 and 270). 42 CFR 483.70(a)</td>
<td>4-13</td>
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<tr>
<td>K052</td>
<td>SS-F</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.8.1.4</td>
<td>6-19-13</td>
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<tr>
<td>K037</td>
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<td>NFPA 101 LIFE SAFETY CODE STANDARD 42 CFR 483.70(a)</td>
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This STANDARD is not met as evidenced by: Surveyor: 27671 Based on observations and staff interview at approximately 9:00 am onward, the following items were noncompliant, specific findings include: there was no audible signal on loss of power, battery and telephone at fire alarm control panel (lobby desk).
<table>
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| K067 | Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications, 19.5.2.1, 9.2, NFPA 80A, 19.5.2.2 | K087 | All return vents in the Skilled Nursing Unit were cleaned by the maintenance staff the day of the inspection. In addition,  
1) The Facilities Director completed a direct observation/rounding audit of the areas of deficiency on the Skilled Nursing Unit (Attachment 4) to ensure the deficiencies were corrected.  
2) The maintenance staff complete a scheduled Preventative Maintenance Inspection of the Skilled Nursing Unit that includes cleaning of the vents and other life safety issues. The next inspection will occur July 1, 2013.  
3) The Preventative Maintenance Inspections are completed monthly and the results of the Preventative Maintenance Inspections are reported to the Fire and Safety Committee monthly. | 4-12-13 |