MAR 1 7 2014

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/04/2014 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES	,		Omis 110, 000	0.000,
	OF DEFICIENCIES CORRECTION	(X1) PROMDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		345085	8. WING		02/20/20	114
	ROVIDER OR SUPPLIER DRIGANICTR OF SCOTLA	AND M	6	TREET ADDRESS, CITY, STATE, ZIP CODE 17 PEDEN ST AURINBURG, NC 28352		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCEO TO THE APPROPRI DEFICIENCY)	E COM	(X5) IPLETION DATE
F 272 SS=D	483,20(b)(1) COMPR ASSESSMENTS	EHENSIVE	F 272	BRANGERSON CHECKER	3/2	2/14
SS=D	The facility must cond a comprehensive, ac reproducible assessm functional capacity.  A facility must make a assessment of a resident assessment by the State, The assidentification and den Customery routine; Cognitive patterns; Communication; Vision; Mood and behavior personal and personal and nutritional skin conditions; Activity pursuit; Medications; Special treatments at Discharge potential; Documentation of su the additional assess areas triggered by the Data Set (MDS); and	nent of oach resident's  a comprehensive dent's needs, using the instrument (RAI) specified sessment must include at mographic information;  atterns; ling; and structural problems; at health conditions; I status;  mmary information regarding ment performed on the care e completion of the Minimum	F	272 Comprehensive Assessment 1. To address the resident the been affected by this alleged deficient practice, resident was assessed by therapy a picked up by OT for 5X/wl was also assessed for the presence/absence of contractures, for the need adaptive equipment (and appropriate adaptive equipment has been provide was also evaluated for and splinting needs (and appropriate services have provided). All changes to needs have been noted in care plan.	ents nat has ged t #44 and c. He I for the Ided). ROM been	
				YAN E	(X6) D.	ATE
LABORATORY	DIRECTOR'S OR PROVIDERS	BUPPYER REPRESENTATIVE'S SIGNATURE		AUCE	Viol to	

Any deficiency statement and an esterisk (\*) 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 80 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 deliciencies are cited, an approved plan of correction is requisite to continued program participation.

Fecility ID: 933446

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		YE SURVEY MPLETED
		345085	B. WNG			و ا	2/20/2014
NAME OF P	ROVIDER OR SUPPLIER			8	TREET ADDRESS, CITY, STATE, ZIP CODE		
EDWIN M	ORGAN CTR OF SCOTLA	AND M		1	17 PEDEN SY AURINBURG, NC 28352		
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F 272	Continued From page	1	F:	272			
	by: Based on observation record review, the fact resident at risk for corresident's reviewed with (ROM). The facility all for adaptive dining equival) of 30 residents reliving (ADLs).  Findings included:  1. Resident # 44 was cumulative diagnoses accident (CVA) dysphemiplegla. The quart (MDS) dated 12/3/13 is severe cognitive impains extensive assistance filling except for eating receiving any occupation restorative services extremity at the time of quarterly MDS did not restorative services and dated 11/16/13 did not ROM to the right hand.  A review of resident #4/9/12 and his annual.	ility falled to assess a stractures for 1 of 1 th Impaired range of motion so falled to assess the need supment for 1 (Resident eviewed for activities of daily admitted on 3/30/12 with of cerebral vascular agla, aphasia and right side enly Minimum Data Set indicated resident #44 had imment and required or his activities of daily Resident #44 was not lonal therapy (OT) services for his right upper if this assessment. The reflect any therapy or id a review of the care plan address the decline in			<ol> <li>To address other reside the potential to be affect this alleged deficient prother the EMC Therapy Department and serious adaptive equipment and need for range of motion services.</li> <li>To ensure that this alleged deficient practice does not reoccur, all new orders when the protential protection is a serviced on the 24-hour number orders have been and continue to be reviewed morning clinical meeting administrative team with</li> </ol>	eted by actice, tment ery or I the not will be rsing se. All during M-F by	
	risk of contractures ext with interventions were A review of the medica	ical record revealed a d 7/10/13 for occupational			appropriate notification identified as completed. new orders on the week		

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	V BOIFO		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345086	B. WING			02/	20/2014
	ROVIDER OR SUPPLIER ORGAN CTR OF SCOTLA	MO W		5	Street address, City, State, Zip Code M7 Peden St Aurinburg, NC 28352		
(X4) ID PREFIX • TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 272	contracture.  A review of the care p 9/24/13 with the activi and the social worker restorative program w ROM during routine casplint to the right lowe updated to reflect the care plan conference the director of nursing rehabilitation manage in attendance. It was a deciline and his current There was no noted oright hand ROM.  In an observation on 2 resident #44 was eating the right hand was obtingers curled inward thand. In another lunch 12:10 PM, resident #4 observed in his tap wit touching the palm of the occasions, there was in an interview on 2/16 rehabilitation manager the order for OT on 7/1 stated "It got missed. In an observation on 2 #44 was in the bed with his tap. The right hand wrist with the fifth and contracted than the oil lingers were flexed at	ian conference dated ties director, MDS nurse present indicated the as discontinued passive are and application of the r leg. The care plan was changes. A review of the dated 12/17/13 indicated (DON), the MDS nurse, the r and the social worker were noted that there was no if care plan would continue. hange in resident #44's  2/17/14 at 12:30 PM, ng lunch using his left hand, isserved in his tap with his ouching the palm of the in observation on 2/18/14 at 4's right hand was th his fingers curied inward he hand. On both no observed splint.  3/14 at 3:37 PM, the is tated the evaluation for io/13 was not done. She if 18/14 at 3:40 PM, resident th his right hand noted on was noted flexed at the forth finger more	F		have been and will continue be reviewed by the nursing supervisor with appropriat notification identified as completed. All Licensed St will be inserviced by the Dowith regards to noting new orders on the 24-hour reportand communicating any new therapy orders to the therapy orders to the therapy orders to the therapy orders appropriate designee. All nursing staff will be inservit to use the "Hey Therapy" or card to let the Therapy Department know of any resident change in condition the MDS Coordinator will follow through with complete of any comprehensive assessments as needed.	aff ON ort ew apy	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPE A BUILDING		TRUCTION	(X3) DATE COMP	SURVEY LETED	
		345085	B, WING		·	02/	20/2014	
	ROVIDER OR SUPPLIER DRIGANICTR OF SCOTLA		STREET ADDRESS, CITY, STATE, ZIP CODE 617 PEDEN ST LAURINBURG, NC 28352					
(X4) ID PREFIX . TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E TE	(X6) COMPLETION DATE	
F 272	In place.  In an Interview on 2/1 nurse stated the CAA coded for contracture did proceed to care pi living assistance but o contracture risk. The it on her own observation charting and interview assessment. The MD 12/3/13 quarterly assistance for the MDS stated it was on admission. For the assessment, she did a 7/10/13 because she that far. The MDS nurse that far. The MDS nurse that far. The MDS nurse consultant and expectation would be 14 day look back where would also be the expectation would be 14 day look back where would also be the expectation and in accurate an assessment.  2. Resident # 44 was cumulative diagnoses accident (CVA) dysphhemiplegia. The quart (MDS) dated 12/3/13 severe cognitive imparents of the contraction and in the contracti	9/14 at 10:00 AM, the MDS completed 3/27/13 was risk. The MDS stated she an for activities of daily ild not address the MDS nurse stated she relied on, chart review, staff is to determine an accurate S nurse stated for the essment, she noted resident that it could be opened. It is not bent when he came 9/17/13 quarterly not see the order dated would not have gone back rise stated when completing it at the documentation for a 2/19/14 at 1:15 PM, the administrator stated for MDS to do more than a in assessing all residents. It ectation that the MDS nurse int visually, review terview staff to determine ont.  admitted on 3/30/12 with of cerebral vascular agia, aphasia and right side erly Minimum Data Set indicated resident #44 had	F 27:	4.	The Executive Director, or appropriate designee, will monitor as follows to assur that this alleged deficient practice does not recur:  a. Compliance with plans be monitored 5 times weekly during morning Administrative meeting weeks by administrative personnel for appropria actions taken.  b. This will be followed by weekly monitoring durit morning Administrative meeting X 8 weeks by administrative personnel for appropriate actions taken.  c. This will be followed by monthly X3 months, the quarterly X2 quarters at as needed.	will g X 4 re ate		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROWDER OR SUPPLIER  DRGAN CTR OF SCOTLA	AND M	ło	6	STREET ADDRESS, CITY, STATE, ZIP CODE HT PEDEN SY AURINBURG, NO 28352 PROVIDER'S PLAN OF CORRECTION		
PREFIX . TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		CONPLETION DATE
	the resident #44 requisipervision to eat. A percutanous endosco was used for medicati water boluses three ling cardiac mechanically abed was to be at 45 diminutes after meals. Significatiles with the cur or symptoms of aspiral swallowing and report A review of the care pital 12/17/13 indicated the the MDS nurse, the rethe social worker were noted that there was noted that there was noted that there was a care plan would continue in an observation on 2 resident #44 was after barbeque ribs with a simeat was observed sliplate. There was no pinoted that the rehabilitiat the same table assiminant observation on 2 resident #44 had a plate extended 1/3 of the suithe 12: 00 o'clock posiobserved still slitting in Resident #44 was obshis left hand. When rea a spoon full on green to observed spinning around the same table assimination of the suither than the same table assimilation of the suither than the same table assimilation of the suither than the same table assimilation of the suither than than the same table assimilation of the suither than than the same table assimilation of the suither than than than than the same table assimilation of the suither than than the same table assimilation of the suither than than than the same table assimilation of the suither than than than the same table assimilation of the suither than than than the same table assimilation of the suither than the same table assimilatio	lan dated 11/15/13 indicated red no more than care plan for resident #44's ple gastrostomy (PEG) tube on administration along with mes daily and he was on a altered diet. The head of his agrees during and for 30' staff was to monitor for rent diet, monitor for rent diet, monitor for signs allon, trouble chewing or them to the physician.  Ian conference dated of director of nursing (DON), habilitation manager and in attendance, it was no decline and his current nue.  1/17/14 at 12:30 PM, applied to eat pureed poon with his left hand. The liding off to right side of ate guard in use. It was action managor was sitting sting another resident.  1/18/14 at 12:10 PM, are guard on his plate that rface edge of the plate at lion. The plate was side the plate warmer, erved using a spoon with sident #44 attempted to get beans, the plate was und and the plate guard	V p	rog ctic	d. The QM committee will discuss the compliance the audits in the facility monthly QA meeting X months, then quarterly quarters and document such discussion in the facility QM meeting minutes.  e. Revisions will be made a documented in the meeting minutes as needed by C committee members.  f. Appropriate employees be re-inserviced to applicable revisions. Revisions in the plan will require monitoring to be again at 4a, 4b and 4c.  the the exception of the monitoring ram outlined above, all other ons will be completed on or beforch 20, 2014.	with 's 6 X 2 and eting M will	
	observed spinning are was observed at the 9:			١			

		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE	SURVEY
EDWIN MORGAN CTR OF SCOTLAND M  (X4) ID PRETX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION)  F 272  Continued From page 5  12:13 PM, the administrator was observed turning the plate still restling in the plate warmer so that the plate guard was in the 3:00 o'clock position. At 12:15 PM, resident #44 again attempted to get a spoon full of green beans when the plate turned to the 12:00 o'clock position. The green beans were observed fulling into resident #44 * lap. He was able to eat about 75% of the green beans. At 12:20 PM, resident #44 attempted to use the spoon to pick up a bite of zlii. He was unable to get the ziti onto his spoon. The plate guard was observed in the 12:00 o'clock position. Resident #44 taid the spoon down and picked up the cookie and ate it. Nursing assistant #4 was at another table in the dining room feeding another resident.  In an interview on 2/19/14 10:00 AM, the MDS nurse stated she coded resident #44's quarterly MD assessment as independent with eating. The			345085	B. WING			02	20/2014
CAU II   CAUCH DEFICIENCY MUST BE PRECIDED BY FULL TAG   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDED BY FULL TAG   CROSS-REFERENCE OT OTHER PROPROPRIATE   CROSS-REFERENCE	NAME OF P	ROMDER OR SUPPLIER						
PREFIX TAG PRECIDENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF THE APPROPRIATE DA	EDMIN W	ORGAN CTR OF SCOTLA	AND M					
12:13 PM, the administrator was observed turning the plate still resting in the plate warmer so that the plate guard was in the 3:00 o'clock position.  At 12:15 PM, resident #44 again attempted to get a spoon full of green bosens when the plate turned to the 12:00 o'clock position. The green beans were observed falling into resident #44 ' s tap. He was able to eat about 75% of the green beans. At 12:20 PM, resident #44 attempted to use the spoon to pick up a bite of zlit. He was unable to get the ziti onto his spoon. The plate guard was observed in the 12:00 o'clock position. Resident #44 laid the spoon down and picked up the cookie and ate it. Nursing assistant #4 was at another table in the dining room feeding another resident.  In an interview on 2/19/14 10:00 AM, the MDS nurse stated she coded resident #44's quarterly MD assessment as independent with eating. The	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL.	PREFI	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE
change with eating that she was aware of and she coded the MDS the way the aides documented during the look back period. She stated resident #44 did not require any staff assistance with meals and staff only periodically checked on him. She stated staff only periodically checked on him. She stated staff one on one staff observation would be coded as supervision. The MDS nurse stated his weight was stable and he consistently consumed 50-75% of his meals. The MDS nurse stated she relied on her own observation, chart review, staff charting and interviews to determine an accurate assessment. The MDS nurse stated she coded resident #44 as supervision for eating for the quarterly assessment dated 9/17/13. She was unable to explain why supervision was needed on the September assessment and independent on the 12/3/13 quarterly assessment. The MDS nurse	₽ 272	12:13 PM, the administrate plate still resting in the plate still resting in the plate guard was in Al 12:15 PM, resident a spoon full of green it to the 12:00 o'clock powere observed falling was able to eat about 12:20 PM, resident #4 spoon to pick up a bite get the zitl onto his spobserved in the 12:00 #44 faid the spoon do cookie and ate it. Nursanother table in the direction.  In an interview on 2/19 nurse stated she code MD assessment as in MDS nurse stated the change with eating the she coded the MDS the documented during the stated resident #44 did assistance with meals checked on him. She sobservation would be MDS nurse stated she observation, chart revillaterviews to determine The MDS nurse stated she observation, chart revillaterviews to determine The MDS nurse stated she observation for eating assessment dated 9/1 explain why supervision September assessment	strator was observed turning in the plate warmer so that in the 3:00 o'clock position.  #44 again attempted to get beans when the plate turned besition. The green beans into resident #44 's lap. He 75% of the green beans. At 4 attempted to use the e of ziti. He was unable to con. The plate guard was o'clock position. Resident with an and picked up the sing assistant #4 was at ning room feeding another.  #414 10:00 AM, the MDS of resident with eating. The re had been no functional at she was aware of and the way the aides to look back period. She don't require any staff and staff only periodically stated staff one on one staff coded as supervision. The weight was stable and he is 50-75% of his meals. The relied on her own lew, staff charting and e an accurate assessment, if she coded resident #44 as for the quarterly 7/13. She was unable to an was needed on the int and independent on the	F	272			

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	of deficiencies F correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 * * *	ECONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345085	B. WNG		02/	20/2014
	ROVIDER OR SUPPLIER ORGAN CTR OF SCOYLA	AND M		STREET ADDRESS, CITY, STATE, ZIP CODE 547 PEDEN ST LAURINBURG, NC 28352		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	e Vie	(X5) COMPLETION DATE
F 272	Continued From page stated she updated the occurred and she add resident #44's care plus in an interview on 2/1 consultant and the adexpectation was for the problem with eating disassessment and reside supervision for all med 483.20(d), 483.20(k)(*COMPREHENSIVE COMPREHENSIVE COMPRE	re care plan when changes led the plate guard to an yesterday.  9/14 1:15 PM, the nurse infinistrator stated the MDS nurse assessed a uning the 12/3/13 quarterly lent #44 and receive ass.  1) DEVELOP CARE PLANS  results of the assessment of revise the resident's of care.  Itop a comprehensive care that includes measurable bies to meet a resident's mental and psychosocial ed in the comprehensive escribe the services that are in or maintain the resident's sysical, mental, and and as required under vices that would otherwise 13,25 but are not provided	F 273	279 Care Plans  1. To address the resident the been affected by this alleged deficient practice, resident was assessed by therapy as picked up by OT for 5X/wk. was also assessed for the new for adaptive equipment and appropriate adaptive equipment has been provided. All changes to his	at has ed #44 hd He eed d the led. ROM	3/20/14
	by:	is not met as evidenced		needs have been noted in h care plan.	is	
1	Based on observation	n, staff interviews and				

Event ID: 97PZ11

	OF DEFICIENCIES F CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345085	B. WNG		REET ADDRESS, CITY, STATE, ZIP CODE	02	20/2014
	ROVIDER OR SUPPLIER ORGAN CTR OF SCOTLA	ND M					
(X4) 1D PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
	to develop intervention risk for contractures for impaired range of also failed to provide it who needed adaptive (Resident #44) of 30 ractivities of daily living Findings Included:  1. Resident # 44 was cumulative diagnoses accident (CVA) dysphhemiplegla. The quart (MDS) dated 12/3/13 it severe cognitive impaired extensive assistance for its processiving any occupation restorative services extremity at the time of quarterly MDS did not restorative services and dated 11/15/13 did not ROM to the right hand.  A review of resident #4/9/12 and his annual assessment (CAA) dates as a service of the servic	lilly failed to he facility failed as for a resident identified at or 1 of 1 resident reviewed motion (ROM). The facility interventions for a resident dining equipment for 1 esidents reviewed for (ADLs).  admitted on 3/30/12 with of cerebral vascular agia, aphasia and right side erly Minimum Data Set indicated resident #44 had from and required or his activities of dally resident #44 was not onat therapy (OT) services for his right upper fithis assessment. The reflect any therapy or dia review of the care plan address the decline in	F 2		2. To address other residents of the potential to be affected this alleged deficient practice once the EMC Therapy Department has screened/evaluated every resident for the presence/absence of contractures, the need for adaptive equipment and the need for range of motion services, the care plans will adjusted for every resident having a new need in any of these areas.  To ensure that this alleged deficient practice does not reoccur, all new orders will be	by ce, be	
	with interventions were A review of the medica	I record revealed a 7/10/13 for occupational ident #44's right hand		.1	noted on the 24-hour nursing report by the charge nurse. A new orders have been and wi continue to be reviewed during morning clinical meeting M-F	S All ill ng	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:		PLE CONS	TRUCTION	(X3) DATE SURVEY COMPLETED	
		345085	B. WING_				20/2014
	ROVIDER OR SUPPLIER ORGAN CTR OF SCOTL	NO M	STREET ADDRESS, CITY, STATE, 2IP CODE 617 PEDEN ST LAURINBURG, NC 28352				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	COMPLETION DATE
F 279	9/24/13 with the active and the social worker restorative program were applied to the restorative program were updated to reflect the care plan conference the director of nursing rehabilitation manage in attendance. It was decline and his currer There was no noted oright hand ROM.  In an observation on resident #44 was eating the right hand was of fingers curled inward hand. In another luncting the palm of the cocasions, there was in an interview on 2/1 rehabilitation manage the order for OT on 7/2 stated "it got missed in an interview on 2/1 nurse stated the CAA coded for contracture did proceed to care pliving assistance but contracture risk. The on her own observation and interview assessment. The MD	tiles director, MDS nurse present indicated the ras discontinued passive are and application of the rieg. The care plan was changes. A review of the dated 12/17/13 indicated (DON), the MDS nurse, the rand the social worker were noted that there was no at care plan would continue. The the resident #44's  2/17/14 at 12:30 PM, anglunch using his left hand, aserved in his lap with his touching the palm of the resident was the his fingers curied inward the hand. On both ano observed splint.  8/14 at 3:37 PM, the related the evaluation for 10/13 was not done. She is a first and the stated the evaluation for 10/13 was not done. She are for activities of daily did not address the MDS nurse stated she relied on, chart review, staff as to determine an accurate	F 2	79	administrative team with appropriate notification identified as completed. In new orders on the weeke have been and will continue reviewed by the nursing supervisor with appropriate notification identified as completed. All Licensed Swill be inserviced by the Ewith regards to noting new orders on the 24-hour repand communicating any nutherapy orders to the their program manager or appropriate designee. All nursing staff will be inserviced to use the "Hey Therapy" card to let the Therapy Department know of any resident change in conditional The MDS Coordinator will follow through with update care plans of any resident receiving a new order and change to their plan of care.  The Executive Director, or appropriate designee, will	nd ue to gg te taff ON w oort ew rapy riced notice any re.	

monitor as follows to assure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLEYED	
Ĺ		345085	B, WNG			02/		
	ROVIDER OR SUPPLIER  ORGAN CTR OF SCOTLA  SUMMARY STA	AND M	ID	517	REET ADDRESS, CITY, STATE, ZIP CODE PEDEN ST URINBURG, NC 28352 PROVIDEN'S PLAN OF CORRECTI		(X4) COMPLETION	
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	PREFI	$\perp$	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO- DEFICIENCY)		DATE	
	#44's right hand bent MDS stated it was not admission For the 9/ essessment, she did 17/10/13 because she of that far. The MDS nur a MDS, she looks bac 14 days.  In a in an interview on nurse consultant end expectation would be each resident visually, interview staff to deter with appropriate interview staff to deter with appropriate interview accident (CVA) dyspin hemiplegia. The quark (MDS) dated 12/3/13 is evere cognitive impairment in the resident #44 requires extensive assistance filling except for eating independent.  A review of the care plithe resident #44 requires used for medicality appropriate interview as used for medicality at the cardiac mechanically a bed was to be at 45 deminutes after meals. Sidifficulties with the curi	but it could be opened. The tent when he came on 17/13 quarterly not see the order dated would not have gone back se stated when completing it at the documentation for 2/19/14 at 1:15 PM, the administrator stated for the MDS nurse assess a review documentation and mine accurate a care plan rentions.  admitted on 3/30/12 with of cerebral vascular agis, aphasia and right side erly Minimum Data Set indicated resident #44 had irment and required for his activities of daily for which he was coded as an dated 11/16/13 indicated red no more than care plan for resident #44's being gastrostomy (PEG) tube on administration along with the date of his egrees during and for 30 staff was to monitor for rent diet, monitor for signs tion, trouble chewing or	F	279	that this alleged deficient practice does not recur:  a. Compliance with plan be monitored 5 times weekly during mornin Administrative meeti weeks by administrati personnel for appropactions taken.  b. This will be followed weekly monitoring dumorning Administrati meeting X 8 weeks by administrative person for appropriate action taken.  c. This will be followed the monthly X3 months, the quarterly X2 quarters as needed.	n will ing ng X 4 ive riate by ring ve nel is		

	ENT OF DEFICIENCIES W OF CORRECTION	(X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION		SURVEY PLETED
		345085	B. WING			02	/20/2014
	OF PROVIDER OR SUPPLIER IN MORGAN CYR OF SCOTLA	AND M	STREET ADDRESS, CITY, STATE, ZIP CODE 617 PEDEN ST LAURINBURG, NC 28352				
(X4) PRE TA	IX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		CAN CANE
F:	the MDS nurse, the re- the social worker were noted that there was re- care plan would continued that there was a care plan would continued that there was attentioned that the same table assisted that the rehability at the same table assisted that the same table to o'clock positions as soon full on green to be served at the 9: 12:13 PM, the administed plate still restling in the plate guard was in At 12:15 PM, resident the plate guard was in the plate guard was able to eat about 12:20 PM, resident #44 spoon to pick up a bite get the zill onto his spo	lan conference dated a director of nursing (DON), shabilitation manager and a in attendance. It was no decline and his current nue.  2/17/14 at 12:30 PM, mpting to eat pureed poon with his left hand. The iding off to right side of late guard in use. It was lation manager was sitting sting another resident.  2/18/14 at 12:10 PM, lite guard on his plate that rface edge of the plate at lition. The plate was side the plate warmer. lerved using a spoon with sident #44 attempted to get leans, the plate was und and the plate guard 00 o'clock position. At litrator was observed turning the plate warmer so that lithe 3:00 o'clock position.  #44 again attempted to get leans when the plate turned silion. The green beans into resident #44's lap. He leans when the plate turned silion. The green beans into resident #44's lap. He leans when the plate turned silion. The green beans into resident #44's lap. He leans when the plate turned silion. The green beans into resident #44's lap. He leans when the plate turned silion. The green beans into resident #44's lap. He leans when the plate turned silion. The green beans. At lite attempted to use the lite of ziti. He was unable to	F	pr ac	d. The QM committee wild discuss the compliance the audits in the facility monthly QA meeting X months, then quarterly quarters and documen such discussion in the facility QM meeting minutes.  e. Revisions will be made documented in the members.  f. Appropriate employees be re-inserviced to applicable revisions.  Revisions in the plan will require monitoring to be again at 4a, 4b and 4c.  With the exception of the monitoring regram outlined above, all other stions will be completed on or be arch 20, 2014.	e with y's 6 7 X 2 t and eting QM s will	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIENCLIA . IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED
		345085	B. WING		02/	20/2014	
	ROVIDER OR SUPPLIER ORGAN CYR OF SCOTLA	ND M		517	REET ADDRESS, CITY, STATE, ZIP CODE PEDEN ST URINBURG, NC 28352		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	VEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
	another table in the di- resident.  In an interview on 2/16 was assigned the dini- again on 2/18/14 state aware when a change was ordered for a resi- aware that resident #4 it should be set up to e effectively.  In an interview on 2/16 restorative aide stated resident on restorative only had resident #44 splinting of his right le employed by the thera been at the facility for  In an interview on 2/16 nurse stated she code MD assessment as inc MDS nurse stated ther change with eating the she coded the MDS th documented during the stated resident #44 did assistance with meals checked on him. The h updated the care plant and added plate guard yesterday. The MDS r diet tolerance as stated 11/15/13, did not mean The MDS nurse stated	aning room feeding another  8/14 at1:00 PM, NA #4 who are room on 2/17/14 and ad normally she was made was made or a new device dent but she was not made 4 had a plate guard or how enable him to eat  8/14 at 2:09 PM, the she did not have any dining. She stated she briefly in September for p. She stated she was py department and had approximately one year.  8/14 10:00 AM, the MDS d resident #44's quarterly dependent with eating. The e had been no functional at she was aware of and e way the aides look back period. She inot require any staff and staff only periodically MDS nurse stated she when changes occurred to resident #44's care plan aurse stated monitoring for if in care plan dated the required supervision, she updated the care plan d and she added the plate	F:	279			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIEWOLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING		STRUCTION	SURVEY PLETED		
		345085	B, WNG			02/	20/2014	
NAME OF PROVIDER OR SUPPLIER					TADDRESS, CITY, STATE, ZIP CODE		1	
EDWIN MORGAN CTR OF SCOTLAND M			547 PEDEN ST LAURINBURG, NC 26352					
(XALID SUMMARY STATEMENT OF DEFICIENCIES			ID.	1	PROVIDER'S PLAN OF CORRECTION		(XS) COMPLETION	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG					
				+-		-		
F 279	Continued From page	12	F 27	9			l.	
		9/14 1:15 PM, the nurse		1				
	consultant and the ad	ministrator stated to MDS nurse to have care					1 1	
	expectation was for the	supervision for all meals with						
	the 12/17/13 quarterly			1	•			
F 311	483.25(a)(2) TREATM	IENT/SERVICES TO	F 31	1	BITHARI NI HARVARAN NA BORGA	9	3/90/14	
SS=D	IMPROVE/MAINTAIN	ADLS			- In the Milanter		' '	
	A resident is given the	appropriate treatment and	F	311 °	Treatment/Services			
	services to maintain o	r Improve his or her abilities						
	specified in paragraph	(a)(1) of this section.		1.	To address the resident tha			
					been affected by this allege	:d		
:	,	is not met as evidenced			deficient practice, resident	#44		
	by: Based on observation	n claff intandaws and			was assessed by therapy an	ıd		
	record review the faci	lity failed to provide adaptive			picked up by OT for 5X/wk.	He		
	dining equipment to n	naintain independent			was also assessed for the ne			
	feeding for 1 of 30 res	idents (Resident #44)			for adaptive equipment and			
	sampled for activities	of daily living (ADLs).				i the		
	Findings included:	, i			appropriate adaptive			
		, , , , , , , , , , , , , , , , , , ,			equipment has been provid			
	Resident # 44 was ad cumulative diagnoses	mitted on 3/30/12 with			He was also evaluated for R	OM		
	accident (CVA) dysph	agla, aphasia and right side			and splinting needs and			
	hemiplegia. The quart	erly Minimum Data Set			appropriate services have b	een		
	(MDS) dated 12/3/13 severe cognitive impa	indicated resident #44 had			provided. All changes to his	s		
	severe cognitive impa	for his activities of daily		٠.	needs have been noted in h			
	living except for eating	g. Resident #44 was coded			care plan.		1	
	as Independent for ea	ting.			care plant			
	A review of the care p	lan dated 11/15/13 Indicated		2.	To address other residents	with		
	the resident #44 requi	red no more than			the potential to be affected			
	supervision to eat. A	care plan for resident #44's plc gastrostomy (PEG) tube			•	-		
	was used for medical	on administration and water			this alleged deficient practic	ie,		
				_	once the EMC Therapy			
COOL CLIC OF	2/02-09) Provious Versions Obs	olete Event ID: 97PZ11		Fé	Department has		tPage 13 of 19	

screened/evaluated every

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
345085		345085	B, WING	B. WING			02/20/2014	
NAME OF P	ROVIDER OR SUPPLIER	94000	1	STREET	ADDRESS, CITY, STATE, ZIP CODE	VZI	1012014	
EDWIN MORGAN CTR OF SCOTLAND M			617 PEDEN ST LAURINBURG, NC 28352					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROVIDENCE) DEFICIENCY)				(X6) COMPLETION DATE	
F311	(HOB) was to be at 44 and for 30 minutes all monitor for difficulties monitor for signs or sy trouble chewing or sw the physician. A revier over the last year individual had a significant welg. In an observation on a resident #44 was altered barbeque ribs with a streement was observed of plate. There we was noted that the relisiting at the same lab resident.  In an observation on a resident #44 had a plate extended 1/3 of the streement was observed still sitting in Resident #44 was observed still sitting in Resident #44 was observed spinning are was observed at the 912:13 PM, the administ the plate still resting in the plate guard was in At 12:15 PM, resident a spoon full of green to the 12:00 o'clock powere observed falling	ras on a cardiac fiet. The head of his bed fiet degrees during the meal for meals. Staff was to with the current diet, reptoms of aspiration, allowing and report them to w of resident #44 's weights cated the resident had not ht loss.  2/17/14 at 12:30 PM, mpting to eat pureed spoon using his left hand, ed sliding off to the right as no plate guard in use. It habilitation manager was ble assisting another  2/18/14 at 12:10 PM, ate guard on his plate that inface edge of the plate at lition. The plate was halde the plate warmer. Herved using a spoon with sident #44 attempted to get boans, the plate was hand and the plate guard coo o'clock position. At extrator was observed turning the plate warmer so that the 3:00 o'clock position. #44 again altempted to get leans when the plate turned bostion. The green beans into resident #44's lap. He 75% of the green beans. At	F3	3.	resident for the presence/absence of contractures, the need for adaptive equipment and the need for range of motion services, treatments/service will begin for every resider having a new need in any of these areas.  To ensure that this alleged deficient practice does not reoccur, all new orders will noted on the 24-hour nurs report by the charge nurse new orders have been and continue to be reviewed demorning clinical meeting to administrative team with appropriate notification identified as completed. And the eviewed by the nursing supervisor with appropriate notification identified as completed. All Licensed States in the event of the eviewed by the nursing supervisor with appropriate notification identified as completed. All Licensed States in the event of the eviewed by the nursing supervisor with appropriate notification identified as completed. All Licensed States in the eviewed States in the event of the eve	ne ces nt of libe ling liwill uring A-F by		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIERCLIA IDENTIFICATION NUMBER:  345086			(X2) MULTIPLE CONSTRUCTION  A BUILDING			COMPLETED		
		B. WING			02/20/2014			
NAME OF PROVIDER OR SUPPLIER  EDWIN MORGAN CTR OF SCOTLAND M				STREET ADDRESS, CITY, STATE, 2IP CODE 517 PEDEN ST LAURINBURG, NC 26352				
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	36	(XII) COMPLETION DATE	
	spoon to pick up a bit get the ziti onto his spoons do poserved in the 12:00 #44 taid the spoon do cookie and ate it. Nurse another table in the diresident.  In an interview on 2/14 dietary manager stated order yesterday for a manager stated she with facility and her facility 2013 to provide meats facility. She stated she eating problems regar stated she relied on a the staff to report need in an interview on 2/14 was assigned the dinkagain on 2/18/14 state aware when a change was ordered for a resil aware that resident #4 it should be set up to effectively.  In an interview on 2/16 #1stated resident #44 that there was a plate morning. She was une should be set up to manager in an interview on 2/16 morning. She was une should be set up to manager in an interview on 2/16 occupational therapist aware of any change in the possible part of any change in the zero control of the zero coupational therapist aware of any change in the zero control of the zero control of the zero coupational therapist aware of any change in the zero control of the zero coupational therapist aware of any change in the zero control of the zero coupational therapist aware of any change in the zero control of the zero	e of zili. He was unable to oon. The plate guard was o'clock position. Resident with and placed up the sing assistant #4 was at ning room feeding another.  8/14 at 12:28 PM, the distance of a nursing plate guard. The dietary was contracted in October for the residents at this awas unaware of any ding resident #44. She review of the weights and ded interventions.  8/14 at1:00 PM, NA #4 who are room on 2/17/14 and dinormally she was made was made or a new device dent but she was not made 4 had a plate guard or how anable him to eat.  8/14 at 2:15 PM, NA ate ell of his breakfast and guard on his plate this bie to state how the plate eximize the benefit of the	F	311	will be inserviced by the I with regards to noting ne orders on the 24-hour regard communicating any resident change in condit. The Therapy Manager wi initiate any new treatment/service as determined appropriate it evaluation and assessment.  4. The Executive Director, or appropriate designee, will monitor as follows to asset that this alleged deficient practice does not recur:  g. Compliance with plant be monitored 5 times weekly during morning Administrative meetic.	w port new rapy l viced notice ion.		
PRIA CMS-2697(02-99) Provious Versiona Obsolete Event ID: 97PZ11				Faci	weeks by administrat	ive	'age 15 of 19	

h. This will be followed by weekly monitoring during morning Administrative meeting X 8 weeks by administrative personnel for appropriate actions taken.

actions taken.

personnel for appropriate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDEN/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING_			COMPLETED		
		345085	8. WING			021	20/2014	
	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			i. j.	nen en exp			
F 311	evaluating resident #- eating difficulties. The hospital was providing plates that were divid started providing the on a plate with no rais in an interview on 2/1 stated he was assign everyday. NA #3 state eats 75% of his break required set up and s stated there was a plate breakfast plate this m not given any directio be placed to prevent confirmed that plates were divided and resi	continued From page 15 evaluating resident #44 for a plate guard and eating difficulties. The OT stated when the hospital was providing meals, it was on different plates that were divided but since the new facility started providing the meals, the food was served on a plate with no raised edges.  In an interview on 2/19/14 at 8:30 AM, NA# 3 stated he was assigned to work with resident #44 everyday. NA #3 stated resident #44 normally eats 75% of his breakfast and lunch and only required set up and supervision for eating. NA #3 stated there was a plate guard on resident #44 breakfast plate this morning. He stated he was not given any directions on how the plate should be placed to prevent food spillage. NA #3 confirmed that plates provided by the hospital were divided and resident #44 was likely spilling more of his meals with the new flat plates.		k.	documented in the me minutes as needed by committee members.			
F318 SS≐D	He stated he was una the flat plates for resident In an interview on 2/1- administrator and the interviewed on 2/19/1- resident #44's need for been identified earlier 483,25(e)(2) INCREA IN RANGE OF MOTION Based on the compre- resident, the facility mand the standard of with a limited range of	ne dietary services espital ended on 10/15/13. ware of any problems with lent #44.  9/14 1:16 PM, the nurse consultant were 1 1:15 PM. They indicated ar a plate guard should have SE/PREVENT DECREASE DN hensive assessment of a ust ensure that a resident	F 318	prog actio	applicable revisi Revisions in the require monitor again at 4a, 4b a the exception of the man ram outlined above, all ins will be completed on th 20, 2014.	plan will ing to be nd 4c. onitorin other	egin ng	

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OWR MO	<i>J.</i> 0938-0391				
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIET/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A BUILDING			SURVEY PLETED			
		345085	B, WNG			02/20/2014				
NAME OF PROVIDER OR SUPPLIER EDWIN MORGAN CYR OF SCOTLAND M				STREET ADDRESS, CITY, STATE, ZIP CODE  517 PEDEN ST  LAURINBURG, NC 28352						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)						
F 318	Continued From page range of motion and/o decrease in range of	r to prevent further		318 F 3	18 Range of Motion					
	by: Based on observation record review, the fact decline in range of mothand for 1 (resident #-for impaired ROM. Findings included Resident # 44 was add 3/30/12 with cumulative vascular accident (CV right side hemiplegia, Data Set (MDS) dated #44 had severe cognitivensive assistance fiving except for eating not reflect any therapy review of the care plan address the decline in A review of the OT hos dated 3/30/12 indicate	is not met as evidenced  n, staff interviews and lity falled to prevent a silon (ROM) of the right falled to the facility on re diagnoses of cerebral A) dysphagia, aphasia and The quarterly Minimum 12/3/13 indicated resident live impairment, required or his activities of daily The quarterly MDS did or restorative services. A or dated 11/16/13 did not ROM to right hand.  spital discharge summary d that resident #44 required tretching and positioning to		manus particular de la constantina della constan	<ol> <li>To address the resident that been affected by this alleged deficient practice, resident was assessed by therapy as picked up by OT for 5X/wk. was also assessed for the new for adaptive equipment and appropriate adaptive equipment has been provided. He was also evaluated for fand splinting needs and appropriate services have been provided. All changes to his needs have been noted in facare plan.</li> </ol>	ed #44 nd He eed d the ded. ROM				
	prevent a contracture, assessment to the fact resident #44 presented right hand. A review of summary dated 5/24/1 at this time. The reaso resident #44 became it participation and it was	The admission nursing lity dated 3/30/12 indicated d with no contracture to his the facility OT discharge 2 indicated therapy ended in Indicated by OT was that inconsistent with					-			

OF IA 1PT	TO LOW MICHIGANE OF	MIEDIONID SEKVICES				OMBIA	0.0938-0391		
	ATEMENT OF DEFICIENCIES (X1) PROVIDENSUPPLIERCLIA (DENTIFICATION NUMBER:		(X2) MUS A. BUILD			(X3) DATE SURVEY COMPLETED			
L		345085	B. WING			02	/20/2014		
NAME OF PROVIDER OR SUPPLIER EDWIN MORGAN CTR OF SCOTLAND M				STREET ADDRESS, CITY, STATE, ZIP CODE  617 PEDEN ST  LAURINBURG, NC 28352					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL, SC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION PREFEX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			COMPLETION DATE		
	motivated to continue mention of a right han referral to restorative it was no record of any at the medical record uningly on a resident #44 was eating the right hand was obtingers curied inward thand. In another lunch 12:10 PM, resident #4 observed in his lap will touching the paim of the occasions, there was a rehabilitation manager evaluation on 7/10/13 will got missed. "  In an observation on 2/#44 was in the bed will his lap. The right hand frontracted than the oth fingers were flexed at the appearing about 60% of in place.  In an interview on 2/18/stated she was not noting evaluation for resident #44 from his acting the the oth stated she was not noting evaluation for resident in each of the contracted than the other in place.  In an interview on 2/18/stated she was not noting evaluation for resident in each of the contracted than the other in place.  In an interview on 2/18/stated she was not noting evaluation for resident in each of the contracted than the other in place.  In an interview on 2/18/stated she was not noting evaluation for resident in the contracted than the other in place.  In an interview on 2/18/stated she was not noting evaluation for resident in the contracted than the other in place.  In an interview on 2/18/stated she was not noting evaluation for resident in the contracted than the other in the contracted than the contracted than the other in the contracted than t	with therapy. There was no discontracture and no for ROM services. There additional OT services in the additional of the right.  //17/14 at 12:30 PM, agriculture in this lap with his outling the palm of the observation on 2/18/14 at 4's right hand was the his fingers curied inward to hand. On both to observed splint.  //14 at 3:37 PM, the stated the order for the OT was not done. She stated "  18/14 at 3:40 PM, resident the his right hand noted on was noted flexed at the orth finger more fingers. All of the he knuckles with the hand losed. There was no splint if 4 at 4:35 PM, the OT fied of an order for an OT fied. The OT recalled dimission and stated the	EL.		<ol> <li>To address other residents the potential to be affected this alleged deficient practionce the EMC Therapy Department screens/evaluate every resident for the need range of motion services, Reservices will begin for every resident having a new need this area.</li> <li>To ensure that this alleged deficient practice does not reoccur, all new orders will noted on the 24-hour nursing report by the charge nurse, new orders have been and continue to be reviewed du morning clinical meeting Madministrative team with appropriate notification identified as completed. All new orders on the weekend have been and will continue be reviewed by the nursing.</li> </ol>	t by ce, ates for OM / I in be All will ring -F by			

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING\_ 345085 02/20/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 517 PEDEN ST EDWIN MORGAN CTR OF SCOTLAND M LAURINBURG, NC 28352 ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY Continued From page 18 F 318 his bed side table. supervisor with appropriate On 2/18/14 at 5:33 PM, an observation of the OT notification identified as evaluating the right hand was done. The OT . completed. All Licensed Staff described resident #44 as having increased flexor tone in his right hand and that a contraction was will be inserviced by the DON fixed. The OT stated the increased flexor tone with regards to noting new could lead to a contracture if untreated. The OT was able to open resident #44 's hand but it had orders on the 24-hour report to be done slowly. Next the OT attempted to and communicating any new abduct (move the arm away from the body) the therapy orders to the therapy shoulder when resident #44 expressed pain. program manager or In an Interview on 2/19/14 at 8:30 AM, NA #3 appropriate designee. All stated he was assigned resident #44 everyday and he was always able to open resident #44 's nursing staff will be inserviced hand enough to ensure it was clean and that to use the "Hey Therapy" notice there no breakdown. NA #3 stated resident #44 had never had a splint for his right hand. NA #3 card to let the Therapy recalled therapy made aware of his right hand Department know of any contracture but could not recall how long ago resident change in condition. therapy was made aware or who made them aware. The Therapy Manager will initiate any new ROM as In an interview on 2/19/14 at 1:15 PM, the nurse consultant and administrator stated expectation determined by the evaluation would be no resident to have a functional decline while residing at the facility and assessment. In an Interview on 2/19/14 at 3:00 PM, the physician stated someone saw a need in July 2013 and it was overlooked. The physician stated he could not recall if resident #44 was admitted with a right hand contracture.

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FORM APPROVED