PRINTED: 10/13/2014 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING			SURVEY PLETED
		345298	B. WING			09/1	C 17/2014
	PROVIDER OR SUPPLIER GTON HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP 311 S CAMPBELL STREET BURGAW, NC 28425	CODE	00/	172014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD I E APPROPR	BE	(X5) COMPLETION DATE
F 224 SS=E	The facility must de policies and proced mistreatment, negle and misappropriation	NEGLECT/MISAPPROPRIATN Evelop and implement written dures that prohibit ect, and abuse of residents on of resident property.	F 2	24			10/9/14
ADODATON	by: Based on record reresident interviews residents from misa for 4 of 4 sampled Resident #98, Resimissing property. Findings included: 1. Resident #79 was 11/29/10 with diagnontractures of both Review of his annudated 10/23/13 and MDS dated 7/16/14 long term memory as having functional on both sides include extremities. During an interview family member stath had given Resident cell phone so that he stated Resident #79	eview, staff, family and the facility failed to protect appropriation of their property residents (Resident #79, dent #143, Resident #13,) with as admitted to the facility on oses of depression, in hands and insomnia. In Minimum Data Set (MDS) his most recent quarterly revealed he had no short or problems. He was assessed il limitation in range of motion ding the upper and lower on 9/15/14 at 11:00 AM a led that another family member #79 a listening device for a led could talk to the family. She is had limited movement of his over/supplier representative's significant and the representative's significant and the representative's significant and the representative's significant and representative is significant and		For residents # 79, #98, # " For resident # 79, a 24 submitted on 9/16/14 by N initiation of investigation by Services Director/Designed Device was replaced by th 9/17.14. Burgaw police we missing items on 10/5/201 day report of the investigate submitted on 9/19/2014 by completion of the investigate missing property. Resident notified of completion of fainvestigation on 9/17/2014 administrator. " For resident #98, the fintent to replace the cell phereported loss; the purse we the posession of the reside A 24 hr report will be submit 10/05/14 by NHA with initiatinvestigation by facility Social Director/Designee. Burgue be notified of missing item by NHA. A 5 day report of investigation will be submit	A hr report HA with y facility S e. The Lis e facility of ill be notif 4 by NHA tion was y NHA follo ation for tr and fam hat and fam y by family indi none at tir y as locate ent on 9/1 hitted on ation of cial Servic gaw police on 10/5/2 the	t was Social Stening on fied of A. A 5 owing ne nilly cated me of rd in 7/14.	(X6) DATE

Electronically Signed

10/05/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		E SURVEY PLETED
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		345298	B. WING			17/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI		
LILINITINI	CTON HEALTH CARE			311 S CAMPBELL STREET		
HUNTING	GTON HEALTH CARE			BURGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORR X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 224	phone. She stated missing since August 24, 2014 du into his room and to stated he told the Slistening device on went to sleep and verification missing. Resident hands and it was verification hands to use the phomember had purch that he could common Resident #79 states for him to place in huntil someone stole informed him that hon the device and to replace it. He states and someone stole when you have to knome. " During an interview Social Worker states investigated all alleresident's property family did inform the listening device had further stated that ocalled her to come to report that he had his ear to talk to his stated she talked to have his name on the state of the stated she talked to have his name on the stated she st	ard for him to hold the cell the listening device had been ast 2014 and the facility had ere not going to replace it. 1 AM Resident #79 stated on uring 3rd shift someone came book his listening device. He social Worker he left the his bed side table when he when he woke up it was #79 stated he had contracted ery hard for him to move his none. He stated a family ased the listening device so nunicate with the family. If the stated the facility had he should have put his name hat they were not going to ed, "This room is my home what was mine. It is a shame bock up your stuff in your own on 9/16/14 at 8:23 AM the ed she was the person that gations of misappropriation of y and the resident and his e facility that Resident #79's down to Resident #79's room d a device he could place in a family had been taken. She on the resident and he did not the device and she told him the hor it and did encourage the	F 2	10/9/2014 by NHA following of the investigation for the missi Resident and family will be not completion of facility investigation for 10/9/2014 by administrator/designee). "For resident #143 a 24 hr submitted on 9/16/14 by NHA initiation of investigation by fa Services Director/Designee. police were notified of missing 9/17/14 by NHA. A 5 day reprinvestigation was submitted by NHA following completion investigation for the missing president and family notified of facility investigation on 9/20 NHA. "For resident #13 a 24 hr submitted on 10/4/14 by NHA initiation of investigation by fa Services Director/Designee. police will be notified of missing 10/5/2014 by NHA. Missing it replaced by facility on 10/6/20 report of the investigation to v submitted on 10/9/2014 by NH completion of the investigation missing property. Resident a be notified of completion of fainvestigation on or before 10/NHA. For All residents have the pot affected by deficient practice: Administrator / Designee 100% of residents and/or RPs next four weeks, 25% weekly determine if there are any alle	report was with cility Social The Burgaw gitems on ort of the oroperty. If completion 3/2014 by report was with cility Social The Burgaw ng items on ems will be only 14. A 5 day will be only 14. A 5 day will be only 14. A 5 day will be only 15/2014 by report was with cility Social The Burgaw ng items on ems will be only 16/2014 by only 16/2014 by ential to be will interview a during the sto	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		E SURVEY PLETED
		345298	B. WING				C 1 7/2014
NAME OF F	PROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	03/	1772014
TO WILL OF T	TO VIDER OR OUT FEILER				1 S CAMPBELL STREET		
HUNTING	STON HEALTH CARE				URGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 224	Continued From pa	ge 2	F 2	24			
		mily to put his name on all his Worker further stated the d the device.			misappropriation of property. If item reported missing with allegations of misappropriation of property and faunable to locate them then facility pwill be followed to include 24 hr/5 d reporting with investigation and rep to appropriate authorities as indicated	f cility is policy ay orting	
	Findings included:				 The Grievance log will be revietimes weekly times 4 weeks in daily 	wed 5	
	facility on 9/30/14 v	as originally admitted to the vith diagnoses including Walking, Muscle Weakness			departmental meeting to assure that investigations are being conducted facility policy and to identify any cort to include reporting to the HCPR whours as indicated.	at per ncerns,	
		#98's quarterly Minimum ted 6/12/14 revealed that she memory deficits.			 Administrator / Designee review facility policy r/t prohibiting mistreat neglect, and abuse of residents and misappropriation of resident proper 	ment, d	
	dated 8/7/14 which #98's family member member reports res	Complaint/Grievance Report was completed by Resident er, read in part, "Family sident is missing a black large her brown pocketbook. Unsure missing. Findings			changes made, if applicable, on 9/19/2014. - In-services on facility policy r/t prohibiting mistreatment, neglect, a abuse of residents and misappropr of resident property were initiated of	ind iation	
	investigation: Room pocketbook found. description of eithe	n searched-no phone or Resident unable to give r item, or say where she kept rhen they went missing."			9/17/2014 by SDC/Designee for all employees. Any employee not inse by 10/9/2014 will be in-serviced prid the start of their next scheduled dawork by SDC/Designee.	rviced or to	
	Resident #98 reveat pocket book and co- only had a small bla- she pulled from her				 Facility will continue to perform background checks on all potential employees. SDC / designee will instruct all hires on facility policy r/t prohibiting mistreatment, neglect, and abuse of 	new	
	facility Social Work #98 might have fou	on 9/17/14 at 1:55 PM, the er stated that Resident nd her pocketbook. She aw Resident #98 propelling			residents and misappropriation of r property as part of the orientation process. - The Administrator / designee w		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		E SURVEY PLETED
		345298	B. WING			09/1	C 1 7/2014
NAME OF	PROVIDER OR SUPPLIER	•		ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
		_		31	1 S CAMPBELL STREET		
HUNTING	GTON HEALTH CARE	<u> </u>		Вι	JRGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTIES OF T	D BE	(X5) COMPLETION DATE
F 224	with her. The Social the items were first #98's family mem items. The Social to member said that it number and the phough her another on that they searched family member's rostated that she also heads and laundry. 3. Resident # 143 8/21/14 with diagno hypertension and of the Review of her adm (MDS) dated 8/28/or long term memory. During an interview Resident # 143 sta with \$162.00 that spermanent with. Stin a folded up enverowder box inside pillow. She stated bag under three pill in on 3rd shift and envelope. She stated had money she she her. During an interview Social Worker state Resident # 143's Administrator had stated the same and the stated had money she she her.	I she had a small pocketbook al Worker revealed that when the missing, she called Resident ber to find out if he had the Worker reported that the family ne called the cell phone was cut off and he would be. The Social Worker revealed through her room and her soom to locate the items. She contified the department to keep an eye out for them. Was admitted to the facility on the sis of congestive heart failure, diabetes mellitus. It is sion Minimum Data Set 14 revealed she had no short	F 2	224	re-trained the social worker and a department managers on how to product an investigation of a grievinclude misappropriation of reside property, and the reporting of such allegations to HCPR within 24 hou indicated, by 10/8/2014. The administrator/designee without monthly times 3 months and audits thereafter to determine completeness of investigation, to 24h/5day reporting if indicated, as compliance with facility policy for allegations of mistreatment, negleabuse of residents and misapproprofor fresident property. Grievance logs as well as investigative findings, to include 2 reporting as indicated, will be reviand discussed in next scheduled committee meeting and the follow quarterly QA committee meeting taudit findings and determine need frequency of continued monitoring	oroperly vance, to ent or and	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345298	B. WING			C 17/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 311 S CAMPBELL STREET BURGAW, NC 28425	1 03/	11/2014	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICE DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 224	Continued From pa to the Police on 9/1	7/14.	F 22	24			
		as admitted to the facility on loses including Anemia and					
	Data Set (MDS) dat	recent Quarterly Minimum ted 7/23/14 identified Resident ntact and having no behaviors.					
F 225 SS=E	at 10:25AM he state 8/29/14 because a went missing last til a doctor's appoint bolted down they di stated he had talked this and they have r will not. He stated e items are not going During an interview 9/17/14 at 10:45AM file a grievance regand a utility knife. He small engines as a the facility looked in 483.13(c)(1)(ii)-(iii),	PORT	F 22	25		10/9/14	
	been found guilty of mistreating resident had a finding enterer registry concerning of residents or misa	at employ individuals who have f abusing, neglecting, or ts by a court of law; or have ed into the State nurse aide abuse, neglect, mistreatment appropriation of their property; wledge it has of actions by a					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG		PLETED
		345298	B. WING _		09/	; 7/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 311 S CAMPBELL STREET BURGAW, NC 28425	1 30	.,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 225	indicate unfitness for other facility staff to or licensing author. The facility must en involving mistreatm including injuries or misappropriation or immediately to the to other officials in through establishes State survey and of the facility must haviolations are thorough establishes of the facility must have a survey and or the facility must be a surve	t an employee, which would or service as a nurse aide or of the State nurse aide registry ities. Insure that all alleged violations nent, neglect, or abuse, if unknown source and if resident property are reported administrator of the facility and accordance with State law diprocedures (including to the ertification agency). Insure that all alleged administrator of the facility and accordance with State law diprocedures (including to the ertification agency). Insure evidence that all alleged bughly investigated, and must ential abuse while the progress.	F 22	25		
	by: Based on record r facility failed to rep Personnel Registry sampled residents	eview and staff interviews, the ort to the Health Care within 24 hours for 4 of 4 (Resident #79, Resident #98, ident #143) with missing		For residents # 79, #98, #143 and "For resident # 79, a 24 hr resubmitted on 9/16/14 by NHA with initiation of investigation by facility Services Director/Designee. The Device was replaced by the facility 9/17.14. Burgaw police will be remissing items on 10/5/2014 by N	port was th sy Social Listening ity on notified of	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		345298	B. WING			09/1	7/2014
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/	172014
					11 S CAMPBELL STREET		
HUNTING	STON HEALTH CARE				BURGAW, NC 28425		
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLETION DATE
F 225	Continued From pa	ge 6	F 2	225			
	day report of the investigation was submitted on 9/19/2014 by NHA following completion of the investigation for the missing property. Resident and family notified of completion on 9/17/2014 by Review of his annual Minimum Data Set (MDS) day report of the investigation was submitted on 9/19/2014 by NHA following completion of the investigation for the missing property. Resident and family notified of completion on 9/17/2014 by				submitted on 9/19/2014 by NHA fol completion of the investigation for the	he	
	dated 10/23/13 and	I his most recent quarterly			administrator.		
		revealed he had no short or problems. He was assessed			" For resident #98, the family ind intent to replace the cell phone at ti		
		Il limitation in range of motion			reported loss; the purse was locate	ed in	
		ding the upper and lower			the posession of the resident on 9/	17/14.	
	extremities.				A 24 hr report will be submitted on		
	During an interview	0/45/44 of 11:00 AM o			10/05/14 by NHA with initiation of		
		on 9/15/14 at 11:00 AM a ed that another family member			investigation by facility Social Servi Director/Designee. Burgaw polic		
		: #79 a listening device for a			be notified of missing item on 10/5/		
		ne could talk to the family. She			by NHA. A 5 day report of the	2014	
		9 had limited movement of his			investigation will be submitted on		
		ard for him to hold the cell			10/9/2014 by NHA following comple	etion of	
		the listening device had been			the investigation for the missing pro		
		st 2014 and the facility had			Resident and family will be notified		
	told her that they w	ere not going to replace it.			completion of facility investigation of before 10/9/2014 by	n or	
		1 AM Resident #79 stated on			administrator/designee).		
		uring 3rd shift someone came			" For resident #143 a 24 hr repo	rt was	
		ook his listening device. He			submitted on 9/16/14 by NHA with		
		social Worker he left the			initiation of investigation by facility		
		his bed side table when he			Services Director/Designee. The l		
		when he woke up it was			police were notified of missing item		
		#79 stated he had contracted			9/17/14 by NHA. A 5 day report of		
		ery hard for him to move his none. He stated a family			investigation was submitted on 9/23 by NHA following completion of the		
		ased the listening device so			investigation for the missing proper		
		nunicate with the family.			Resident and family notified of com		
		d the listening device was easy			of facility investigation on 9/23/2014	•	
		nis ear and "worked great			NHA.	,	
		e it. " He stated the facility had			" For resident #13 a 24 hr report	was	
		e should have put his name			submitted on 10/4/14 by NHA with		
	on the device and t	hat they were not going to			initiation of investigation by facility	Social	
ORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID: 1LLE11		Fac	cility ID: 953278 If continua	tion sheet	Page 7 of 27

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURV COMPLETED	
		345298	B. WING		C 09/17/20	14
NAME OF F	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/11/20	-
				311 S CAMPBELL STREET		
HUNTING	GTON HEALTH CARE		1	BURGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMP	X5) PLETION ATE
F 225	Continued From pa	age 7	F 225			
	and someone stole when you have to le home. "	ed, "This room is my home what was mine. It is a shame ock up your stuff in your own		Services Director/Designee. The police will be notified of missing item 10/5/2014 by NHA. Missing items replaced by facility on 10/6/2014. report of the investigation to will be	ms on will be A 5 day	
	Social Worker state investigated all alle resident 's property family did inform th	on 9/16/14 at 8:23 AM the ed she was the person that gations of misappropriation of y and the resident and his e facility that Resident #79's d been taken on 8/25/14. She		submitted on 10/9/2014 by NHA for completion of the investigation for missing property. Resident and far be notified of completion of facility investigation on or before 10/9/201 NHA.	the mily to	
	further stated that of called her to come to report that he had his ear to talk to his stated she talked to have his name on the facility would search resident and his far items. She stated device and had no	one of the Nursing Assistants down to Resident #79's room and a device he could place in serially had been taken. She to the resident and he did not the device and she told him the he for it and did encourage the mily to put his name on all his the facility had not found the written investigation nor had in initial report or a 5-day		For All residents have the potential affected by deficient practice: - Administrator / Designee will in 100% of residents and/or RPs durinext four weeks, 25% weekly, to determine if there are any allegation misappropriation of property. If iter reported missing with allegations of misappropriation of property and faunable to locate them then facility will be followed to include 24 hr/5 of	nterview ng the ons of ons are of acility is policy day	
	her policy and proc misappropriation of should have been t	PM the Administrator stated redure to prohibit f Resident #79's' s property to do a 24-hour initial report to the state agency.		reporting with investigation and repto appropriate authorities as indicated. The Grievance log will be reviet times weekly times 4 weeks in dail departmental meeting to assure the investigations are being conducted facility policy and to identify any conto include reporting to the HCPR whours as indicated. Administrator / Designee reviet facility policy r/t prohibiting mistreated neglect, and abuse of residents ar	ted. ewed 5 y at I per ncerns, vithin 24 wed tment,	
	facility on 9/30/14 v	vas originally admitted to the vith diagnoses including Walking, Muscle Weakness		misappropriation of resident prope changes made, if applicable, on 9/19/2014 In-services on facility policy r/t		

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			A. DOILDI	NO		С
		345298	B. WING			17/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
LULINITINI				311 S CAMPBELL STREET		
HUNTING	GTON HEALTH CARE			BURGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 225	Data Set (MDS) da had long short term Review of a facility dated 8/7/14 which #98's family mem member reports resquare phone and of when items went investigation: Room pocketbook found. description of eithe items normally or who resolve complaint for items, resident patient funds. Report Complaint/Grievant further follow-up: Complainant's Relooking for items, but the policy and proomisappropriation of have been to do a sinitiate a 24-hour in During an interview Resident #98 reveapocket book and coonly had a small blashe pulled from her	t #98's quarterly Minimum ted 6/12/14 revealed that she is memory deficits. Complaint/Grievance Report was completed by Resident ber, read in part, "Family sident is missing a black large her brown pocketbook. Unsure it missing. Findings in searched-no phone or Resident unable to give in tem, or say where she kept when they went missing. Plan int/grievance: Continue search encouraged to keep money in ortable to state agencies? No. the Resolved? No, specify ontinue to search for items. In marks: Thankful we are ut wants items found. " PM the Administrator stated edure to prohibit is resident's property should written investigation and to itial report to the state agency. If on 9/17/14 at 1:55 PM, aled that someone took her eallphone. She showed that she ack change purse left, which	F 2	,	opriation d on all serviced orior to date of rm ial all new ng e of of resident all properly evance, to ent ch ours as will weeks, d random o include as well as ect, and	
	facility Social Work	er stated that Resident #98 er pocketbook. She revealed		investigative findings, to include reporting as indicated, will be re-		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345298	B. WING			C 9/17/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST 311 S CAMPBELL STREE BURGAW, NC 28425	TATE, ZIP CODE	5/11/ 2 014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE
F 225	wheelchair and she her. The Social Wo items were first mis 's family member. The Social Worker member said that I number and the phough her another or that they searched family member 's stated that she alsheads and laundry. The Social Worker	dent #98 propelling her had a small pocketbook with orker revealed that when the ssing, she called Resident #98 to find out if he had the items. The reported that the family he called the cell phone had the cell phone had the room and her room to locate the items. She to notified the department to keep an eye out for them. The further revealed that a police it and no police report was	F 2	and discussed in ne committee meeting quarterly QA comm	and the following littee meeting to review determine need for an	
	8/21/14 with diagner hypertension and of the Review of her adm (MDS) dated 8/28/or long term memory desident # 143 star with \$162.00 that is permanent with. Slin a folded up enver powder box inside pillow. She stated bag under three pillin on 3rd shift and	ission Minimum Data Set 14 revealed she had no short				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		345298	B. WING			(17/2014	
	PROVIDER OR SUPPLIER GTON HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 311 S CAMPBELL STREET BURGAW, NC 28425			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 225	had money she shoher. During an interview Social Worker state investigated all alle resident 's property. On 9/16/14 at 1:39 her policy and procomisappropriation of have been to do a vinitiate a 24- hour resident # 143 's in Administrator had somewher so the Police on 9/1. On 9/16/14 at 1:39 her policy and procomisappropriation of have been to do a vinitiate a 24-hour in 4. Resident #13 was 10/15/13 with diagrity Hypertension. Review of his most Data Set (MDS) da #13 as cognitively in During an interview at 10:25AM he state.	ould give it to them to hold for on 9/16/14 at 8:23 AM the ed she was the person that gations of misappropriation of y. PM the Administrator stated edure to prohibit fresident's property should written investigation and eport to the state agency. You 9/17/14 at 2:20 PM the ed that staff had searched froom. She stated that the sent off a list of names and at worked the night of 9/14/14 7/14. PM the Administrator stated	F 22				

STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	` '	E SURVEY PLETED
		345298	B. WING			C
NAME OF BROV	IDED OD SUDDUED	343290	B. WIIIO .	STREET ADDRESS, CITY, STATE, ZIP CODE	09/	17/2014
	IDER OR SUPPLIER N HEALTH CARE			311 S CAMPBELL STREET		
1101411146101	TILALIII CAKL			BURGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
wer a de bold stat this will iten He offer refu wal Dur Soo inverses had or 5 On her mis be rep F 226 SS=E ABI The poli mis and This by: Ba faci	octor's appointing ted down they did ted he had talked and they have report. He stated ens are not going additionally stated the had as a mall used saying that k off with my entring an interview cial Worker stated estigated all allegited to sproperty been done nor 5-day report. 19/16/14 at 1:39 policy and procedure and procedure to the state and procedure and proc	me he went to Wilmington for ment. He stated is things are sappear in the building. He d with the Social Worker about not found anything and they everyone here knows that to walk back into the building. He d that the Social Worker box with a lock on it but he would just allow the thief to tire box of tools easily. on 9/16/14 at 8:23 AM the ed she was the person that gations of misappropriation of and no written investigation had the facility filed a 24- hour PM the Administrator stated edure to prohibit resident 's property should report and they had failed to agency.	F 2			10/9/14

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345298	B. WING			09/1	C 17/2014
NAME OF F	PROVIDER OR SUPPLIER	<u>l</u>	l I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	03/	1772014
					11 S CAMPBELL STREET		
HUNTING	STON HEALTH CARE	Ē			BURGAW, NC 28425		
(V4) ID	SI IMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 226	Continued From pa	age 12	F 2	226			
	allegation of misap	propriations of resident's			initiation of investigation by facility	Social	
		alth Care Personnel Registry			Services Director/Designee. The Li		
		4 of 4 sampled residents			Device was replaced by the facility		
		sident #98, Resident #13,			9/17.14. Burgaw police will be not		
	Resident #143) wi	th missing property.			missing items on 10/5/2014 by NH	A. A5	
					day report of the investigation was		
	Findings included:				submitted on 9/19/2014 by NHA fol		
	A	Whater and the offers to see a fine of the se			completion of the investigation for t		
		ility's policy for investigating			missing property. Resident and far	nily	
		ppropriation of resident 's irch 6, 2014 titled, " Abuse			notified of completion of facility investigation on 9/17/2014 by		
		m Guidelines " read in part, "			administrator.		
		rts of Abuse and Corrective			" For resident #98, the family inc	licated	
		s ofmisappropriation of			intent to replace the cell phone at ti		
		emptly and thoroughly			reported loss; the purse was locate		
		ility management. A 24-hour			the posession of the resident on 9/		
		be filed with the North Carolina			A 24 hr report will be submitted on		
		nnel Registry Section of the			10/05/14 by NHA with initiation of		
	Division of Facility				investigation by facility Social Servi		
		gnee within 24 hours or as			Director/Designee. Burgaw polic		
		e of all allegations related to			be notified of missing item on 10/5/	2014	
	misappropriatio	on of resident property			by NHA. A 5 day report of the		
	The individual cond	ducting the investigation will, at			investigation will be submitted on 10/9/2014 by NHA following complete.	ation of	
	a minimum:	ducting the investigation will, at			the investigation for the missing pro		
	a minimum.				Resident and family will be notified		
	Review the Compla	aint/Grievance Report (Report			completion of facility investigation of		
	may be verbal):				before 10/9/2014 by		
		nt ' s medical record to			administrator/designee).		
		eading up to the incident;			" For resident #143 a 24 hr repo	rt was	
		on(s) reporting the incident;			submitted on 9/16/14 by NHA with		
		ent (if appropriate);			initiation of investigation by facility		
		ent ' s roommate (if			Services Director/Designee. The		
	appropriate);	idente te colone de la lacción d			police were notified of missing item		
		idents to whom the accused			9/17/14 by NHA. A 5 day report of		
	employee provides				investigation was submitted on 9/2		
		nbers (on all shifts if live had contact with the			by NHA following completion of the investigation for the missing proper		
		period of the alleged incident;			Resident and family notified of com		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		345298	B. WING			C 17/2014	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD			
HUNTING	GTON HEALTH CARE	Ē		311 S CAMPBELL STREET BURGAW, NC 28425			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 226	Interview family menecessary); Review all events I incident. Witness statement and dated. When the investiga Administrator/Directinform the resident the results and the 5-day Report will b Personnel Registry of Nursing/Designeractions." 1. Resident #79 w 11/29/10 with diagractions." 1. Resident #79 w 11/29/10 with diagractions. " 1. Resident #79 w 11/29/10 with diagractions." 1. Resident #79 w 11/29/10 with diagractions. " 2. Resident #79 w 11/29/10 with diagractions. " 3. Resident #79 w 11/29/10 with diagractions. " 3. Resident #79 w 11/29/10 with diagractions. " 4. Resident #79 w 11/29/10 with diagractions. " 5. Resident #79 w 11/29/10 with diagractions. " 5. Resident #79 w 11/29/10 with diagractions. " 6. Review of his annudated 10/23/13 and MDS dated 7/16/14 long term memory as having functions on both sides includent the properties. The properties with the properties wi	embers and visitors (if eading up to the alleged as must be in writing, signed ation is completed, the ctor of Nursing/Designee will and his/her representative of corrective action taken. A e submitted to the Health Care by the Administrator/Director ewith a plan of corrective as admitted to the facility on noses of depression, h hands and insomnia. Ital Minimum Data Set (MDS) d his most recent quarterly f revealed he had no short or problems. He was assessed al limitation in range of motion ding the upper and lower on 9/15/14 at 11:00 AM a ted that another family member t #79 a listening device for a ne could talk to the family. She had limited movement of his nard for him to hold the cell the listening device had been ust 2014 and the facility had were not going to replace it.	F 2	of facility investigation on 9/23 NHA. "For resident #13 a 24 hr resubmitted on 10/4/14 by NHA initiation of investigation by facility on 10/5/2014 by NHA. Missing ite replaced by facility on 10/6/20 report of the investigation to we submitted on 10/9/2014 by NHC completion of the investigation missing property. Resident are be notified of completion of facility on 10/6/20 negotion of the investigation of property. In the followed to include 24 hreporting with investigation of the inves	eport was with cility Social The Burgaw ig items on ems will be 14. A 5 day ill be 14 following in for the ind family to cility 6/2014 by ential to be will interview during the to gations of items are ons of it		

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
			С	
345298 B. WING			09/17/2014	
•		STREET ADDRESS, CITY, STATE, ZIP CODE		
		311 S CAMPBELL STREET		
		BURGAW, NC 28425		
ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE ACTION SHOULD	BE COMPLETION	
M Resident #79 stated on g 3rd shift someone came his listening device. He al Worker he left the bed side table when he in he woke up it was a stated he had contracted hard for him to move his e. He stated a family d the listening device so cate with the family. The stated the facility had hould have put his name they were not going to they were not going to they were not going to this room is my home at was mine. It is a shame up your stuff in your own 19/16/14 at 8:23 AM the he was the person that ons of misappropriation of d the resident and his cility that Resident #79's en taken on 8/25/14. She of the Nursing Assistants on to Resident #79's room device he could place in mily had been taken. She eresident and he did not device and she told him the rit and did encourage the to put his name on all his facility had not found the ten investigation nor had tial report or a 5-day	F 2	neglect, and abuse of residents an misappropriation of resident proper changes made, if applicable, on 9/19/2014. In-services on facility policy r/t prohibiting mistreatment, neglect, a abuse of residents and misappropr of resident property were initiated of 9/17/2014 by SDC/Designee for all employees. Any employee not inse by 10/9/2014 will be in-serviced print the start of their next scheduled da work by SDC/Designee. Facility will continue to perform background checks on all potential employees. SDC / designee will instruct all hires on facility policy r/t prohibiting mistreatment, neglect, and abuse or residents and misappropriation of residents and misappropriation of residents and misappropriation of residents and investigation of a grieval include misappropriation of residents and the reporting of such allegations to HCPR within 24 hour indicated, by 10/8/2014. The administrator/designee will monitor grievance log and any investigations weekly times four we then monthly times 3 months and readitis thereafter to determine completeness of investigation, to in 24h/5day reporting if indicated, as	ty with and iation on rviced or to te of resident rill roperly ance, to the sas I reeks, andom aclude	
TESO 1 VIII ABOVE ST HIT ST WHOVE OF STRIPE	345298 ENT OF DEFICIENCIES ET BE PRECEDED BY FULL DENTIFYING INFORMATION) A Resident #79 stated on 3rd shift someone came his listening device. He all Worker he left the bed side table when he in he woke up it was stated he had contracted hard for him to move his e. He stated a family detening device was easy ar and "worked great". He stated the facility had hould have put his name they were not going to "This room is my home at was mine. It is a shame up your stuff in your own 19/16/14 at 8:23 AM the he was the person that ons of misappropriation of definition of the resident and his cility that Resident #79 's en taken on 8/25/14. She of the Nursing Assistants in to Resident #79 's room device he could place in mily had been taken. She resident and he did not levice and she told him the it and did encourage the to put his name on all his facility had not found the	A. BUILD 345298 B. WING A. BUILD 345298 B. WING A. BUILD B. WING PREFIL TAG F 2 A. BUILD B. WING F 2 F 2 A. BUILD B. WING F 2 F 2 A. BUILD B. WING F 2 F 2 F 3 F 4 A. BUILD B. WING F 2 F 4 F 5 F 5 F 6 F 6 F 7 F 7 F 8 F 8 F 9 F 9 F 9 F 9 F 9 F 9	A BUILDING 345298 STREET ADDRESS, CITY, STATE, ZIP CODE 311 S CAMPBELL STREET BURGAW, NC 28425 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPH DEFICIENCY) A Resident #79 stated on A Resident #79 stated on A resider the A Bull by the state of the state of the family A the listening device. He A burker he left the A BURGAW, NC 28425 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPH DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPH DEFICIENCY) PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPH DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPH DEFICIENCY) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPH DEFICIENCY) PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPH DEFICIENCY) PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPH DEFICIENCY) PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPH DEFICIENCY) PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPH DEFICIENCY) PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPH DEFICIENCY) PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPH DEFICIENCY) PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPH DEFICIENCY) PROVIDER'S PLAN OF CAMBOLA PROVIDER'S PLAN OF C	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		345298	B. WING				17/2014
	PROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 11 S CAMPBELL STREET BURGAW, NC 28425	1 00/	1772014
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 226	On 9/16/14 at 1:39 her policy and proc misappropriation of should have been t	PM the Administrator stated	F 2	226	abuse of residents and misappropriof resident property. - Grievance logs as well as investigative findings, to include 24 reporting as indicated, will be revie and discussed in next scheduled committee meeting and the following quarterly QA committee meeting to audit findings and determine need frequency of continued monitoring.	./5 day wed A ng review for and	
	facility on 9/30/14 w Diabetes, Difficulty and Osteoarthrosis Review of Resident Data Set (MDS) da had long short term Review of a facility dated 8/7/14 which #98's family member member reports res square phone and I of when items went investigation: Room pocketbook found. description of either items normally or w to resolve complain for items, resident of patient funds. Repo Complaint/Grievand further follow-up: C Complainant's Re	#98 's quarterly Minimum ted 6/12/14 revealed that she memory deficits. Complaint/Grievance Report was completed by Resident per, read in part, "Family sident is missing a black large ner brown pocketbook. Unsure					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		345298	B. WING _			17/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 311 S CAMPBELL STREET BURGAW, NC 28425	1 001	11/2017
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 226	her policy and procemisappropriation of should have been to and to initiate a 24-agency. During an interview Resident #98 revea pocket book and coonly had a small blashe pulled from her During an interview facility Social Worker might have found her that she saw Residwheelchair and she her. The Social Worker were first mis 's family member to The Social Worker member said that how how her another one that they searched family member 's restated that she also heads and laundry. The Social Worker	PM the Administrator stated edure to prohibit resident #98's property o do a written investigation hour initial report to the state on 9/17/14 at 1:55 PM, alled that someone took her ellphone. She showed that she ack change purse left, which	F 22	6		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	, , COV	TE SURVEY MPLETED
		345298	B. WING _			C / 17/2014
	PROVIDER OR SUPPLIER GTON HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP COD 311 S CAMPBELL STREET BURGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 226	3. Resident # 143 8/21/14 with diagnor hypertension and d Review of her admit (MDS) dated 8/28/1 or long term memo. During an interview Resident # 143 stat with \$162.00 that sipermanent with. Shin a folded up enverowder box inside I pillow. She stated shag under three pill in on 3rd shift and the envelope. She stated and money she should have stated investigated all alleresident 's property. On 9/16/14 at 1:39 her policy and procomisappropriation of should have been thand initiate a 24-h. During an interview Social Worker state and initiate a 24-h. During an interview Social Worker state Resident # 143 's resident #	was admitted to the facility on asis of congestive heart failure, iabetes mellitus. Ission Minimum Data Set 14 revealed she had no short ry problems. If on 9/17/14 at 1:41 PM 14 ted that she had an envelope the was going to use to get a restated she kept the money alope inside her makeup oner make up bag under her she slept with the make up ows and someone had come aken her money but left the red the facility told her if she build give it to them to hold for 15 on 9/16/14 at 8:23 AM the red she was the person that grations of misappropriation of 17. PM the Administrator stated redure to prohibit if resident #143's property of on a written investigation our report to the state agency. If on 9/17/14 at 2:20 PM the red that staff had searched from. She stated that the sent off a list of names and at worked the night of 9/14/14.	F 22	6		

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		345298	B. WING		C 09/17/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 311 S CAMPBELL STREET BURGAW, NC 28425	1 03/	17/2014
(X4) 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 CROSS-REFERENCED TO THE APPROPROFICIENCY)) BE	(X5) COMPLETION DATE
F 226	10/15/13 with diagn Hypertension. Review of his most Data Set (MDS) dat #13 as cognitively in During an interview at 10:25AM he state 8/29/14 because a went missing last tin a doctor's appoint bolted down they distated he had talked this and they have r will not. He stated eitems are not going During an interview Social Worker state investigated all allegresident's property had been done nor or 5-day report. On 9/16/14 at 1:39 her policy and procemisappropriation of	s admitted to the facility on oses including Anemia and recent Quarterly Minimum ted 7/23/14 identified Resident ntact and having no behaviors. with Resident #13 on 9/17/14 ed he had a grievance on utility knife, pliers and scissors me he went to Wilmington for ment. He stated is things are sappear in the building. He d with the Social Worker about not found anything and they everyone here knows that to walk back into the building. on 9/16/14 at 8:23 AM the ed she was the person that gations of misappropriation of and no written investigation had the facility filed a 24- hour PM the Administrator stated edure to prohibit resident #13's property 4-hour report and they had	F 22	26		
F 371 SS=E	483.35(i) FOOD PR STORE/PREPARE/ The facility must - (1) Procure food fro		F 37	71		10/9/14

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	(X3) DATE SURVEY COMPLETED			
		345298	B. WING		C 09/17/2014	
	PROVIDER OR SUPPLIER		3	STREET ADDRESS, CITY, STATE, ZIP CODE B11 S CAMPBELL STREET BURGAW, NC 28425	00/11/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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)		
F 371	Under sanitary cond This REQUIREMENT by:	distribute and serve food	F 371	For All residents:		
	facility failed to mai kitchen by failing to fans to prevent con microorganisms. T A review of the und Aides Weekly Clea clean Fans and (all A review of the und Cleaning Schedule	ntain sanitary conditions in the clean one of one large floor tamination from he findings included. ated facility policy Dietary ning Schedule read in part		" Dusty fan was removed from Kite area on 9/17/14 and cleaned by the Dietary Manager. " All other fans in kitchen area were inspected and cleaned if indicated by Dietary Manager on 9/17/14. " Facility policy Dietary Aides Weet Cleaning Schedule was reviewed and updated, if applicable, by Dietary Manager/Designee on 9/17/2014. " Facility policy Monthly Cleaning Schedule was reviewed and updated applicable, by dietary Manager/Designee on 9/18/2014.	re / kly d	
	Dietary manager (C) the floor fan cage we grey dust particles of cage. The floor fan prep table beside the towards a rolling me On 9/17/14 at 11:37 observation the floor same location with a three tier serving meal tray with silved dietary staff were of	chen tour with the Certified CDM) on 9/15/14 at 10:35 AM was observed covered with on the front and back of the was observed on top of a ne double oven blowing eal tray cart. 7 AM during a second or fan was observed in the the fan cage blowing towards cart that had a resident 's r ware on it. At 11:50 AM observed at the two part prep mashed potatoes. The floor		" All Dietary Staff inserviced by Die Manager/Designee on 9/18/2014. Die Aides Weekly Cleaning Schedule an Monthly Cleaning Schedule to includ cleaning of kitchen fans. Any Dietary not inservice by 10/9/2014 will be inserviced prior to start of next sched shift by Dietary Manager/Designee. " Auditing of completion of weekly cleaning schedule, to include cleaning kitchen fans, to be completed by Die Manager/Designee weekly times 4 we then at least monthly thereafter. " Auditing of completion of monthly cleaning schedule, to include cleanin	etary d e y Staff duled g of tary reeks,	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		345298	B. WING _		C 09/17/2014	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/1	1772017
LIINTING	STON HEALTH CARE			311 S CAMPBELL STREET		
HUNTING	TON HEALTH CARE			BURGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	Continued From pa	ge 20	F 37	71		
		ed with gray dust particles and tary staff mixing the mashed		kitchen fans, to be completed by Di Manager/Designee weekly times 3 months, then at least monthly there "Results of weekly and monthly	after.	
		the CDM on 9/17/14 at 11:51 staff would cut the fan off and		will be reviewed and discussed in n scheduled QA committee meeting a following quarterly QA committee m to review audit findings and determine	ext and the neeting	
	2:49 PM she stated	with the CDM on 9/17/14 at that the fan should be y basis. She indicated the fans		need for and frequency of continued monitoring.		
		ated facility policy Dietary ning Schedule read in part food carts).				
	Cleaning Schedule Hoods, Stockroom, needed.	ated facility policy Monthly read in part Freezer (2 Door), Ice machine, Fans or as				
F 431 SS=D	483.60(b), (d), (e) D LABEL/STORE DR	DRUG RECORDS, UGS & BIOLOGICALS	F 43	31		10/9/14
	a licensed pharmac of records of receip controlled drugs in s accurate reconciliat records are in order	aploy or obtain the services of ist who establishes a system t and disposition of all sufficient detail to enable an ion; and determines that drug and that an account of all maintained and periodically				
	labeled in accordan professional princip appropriate accesso	,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345298	B. WING			C 09/17/2014	
	PROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 11 S CAMPBELL STREET BURGAW, NC 28425	1 00/	1772014
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPODE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	facility must store a locked compartment controls, and permit have access to the The facility must propermanently affixed controlled drugs list Comprehensive Dr Control Act of 1976 abuse, except whe package drug districts	State and Federal laws, the all drugs and biologicals in ints under proper temperature it only authorized personnel to keys. ovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the ninimal and a missing dose can	F4	31			
	by: Based on observar failed to properly st medications on top pre-filling medicatio medication cart unl carts on Hall 100. The findings include During a medicatio at 8:18AM the med to have four (4) Exe Alzheimer's disea patch (used for che top of the medicatio from the cart. Also	tions and interviews, the facility ore medications by leaving of the medication cart, on cups and leaving a ocked for 1 or 3 medication e: n pass observation on 9/16/14 cart on hall 100 was observed elon patches (used for se) and one (1) Nitroglycerin est pain), all dated 9/16/14 on on cart with the nurse absent observed, when the was opened by the nurse,			For all facility residents: " Upon notification of incident or 9/16/14, Nurse # 1 was immediated counseled by Director of Nursing/Designee on proper storage medications on medication cart and during medication pass times. " Nurse # 1 was terminated from employment by Director of Nursing 9/18/14 for failure to properly store medications on medication cart and during medication pass times. " Facility policy on Medication Administration, to include storage of medications, reviewed and revised applicable, by DON/Designee on 9/16/2014.	ge of d on d	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345298	B. WING			09/1	D 1 7/2014
NAME OF F	PROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				3	11 S CAMPBELL STREET		
HUNTING	STON HEALTH CARE			Е	BURGAW, NC 28425		
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFI	X	PROVIDER'S PLAN OF CORRECTION		
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	≀IATE	DATE
F 431	Continued From pa	ge 22	' F 4	31			
	were individual med	dication cups with medications			" All Licensed nursing staff inser	viced	
		were eight (8) cups observed.			by Director of Nursing/SDC/Design	ee	
					beginning on 9/17/14 on facility poli		
		with Nurse #1 on 9/16/14 at			Medication Administration/proper st	orage	
		that she pre-fills the stock			of medications, to include leaving		
		use it saves time during the			medications on top of medication c		
		She also stated she dates the			pre-filling medication cups, and lear		
		use she knows who is going to and this saves time. She			medication carts unlocked. Any Lic nursing staff not inserviced by 10/9		
		ally does not leave the			will be inserviced prior to start of ne		
		ne cart and they should not be			scheduled shift by DON/SDC/Desig		
	stored on top of the				" Mandatory Licensed nurses ins		
	0.0.00 oop o				scheduled with Pharmacy Consulta		
	During an observat	ion on 9/16/14 at 8:54AM the			be conducted by 10/17/14 on Medic		
		s observed to be unlocked			Administration, to include Medication		
	without the nurse in	n sight.			Storage. Any nurses not in attenda		
		-			will be inserviced prior to start of ne	:xt	
		nterview with Nurse #1 on			scheduled shift by DON/Designee of	วท	
		she stated the cart should be			inservice materials.		
	locked when staff is	s not at the cart.			" Pharmacy Consultant to condu		
					medication pass reviews on all licer		
	•	with the Unit Nurse			nursing staff, to include observation		
		/14 at 9:10AM she stated that			medication storage, over next four		
		t to be pre-filled at any time.			beginning week of 10/5/14. Any nu		
		be taken from the bottom or			observed by end of 4 week period by		
		pensed into the medication are given. She also stated			pharmacy consultant will be observed Pharmacy Consultant/DON during to		
		ocked if the nurse is away			medication pass of next scheduled		
		nedications are at no time to			" Newly employed Licensed staff		
	be left on top of the				oriented to facility medication	WIII DO	
	22 ion on top or the				administration policy, to include		
	During an interview	with the Administrator on			medication storage, upon hire by S	DC	
		I she stated that medications			and will be observed randomly duri		
		rawn up and should be in the			orientation schedule by SDC/design		
		all times and not stored on top			ensure understanding and complian		
		art. She also stated that the			policy.		
	cart should be lock	ed at all times when the nurse			" Director of Nursing/Designee to)	
	is away from the ca	ırt.			observe 5 Medication Passes week	dy	
					times 4 weeks, then 3 Medication F	20220	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345298			C 09/17/2014		
NAME OF F	PROVIDER OR SUPPLIER	0-10200			REET ADDRESS, CITY, STATE, ZIP CODE	09/	17/2014
	GTON HEALTH CARE			31	1 S CAMPBELL STREET JRGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	Continued From pa		F 4	31	weekly times 4 weeks, then random thereafter for observation of proper medication storage. "Results of Pharmacy Consultar reviews and DON/Designee Medica Observation audits will be reviewed discussed in next scheduled QA committee meeting and the following quarterly QA committee meeting to audit findings and determine need frequency of continued monitoring.	nt ation and and review	
F 441 SS=D	SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and o to help prevent the of disease and infe (a) Infection Control The facility must es Program under whi (1) Investigates, co in the facility; (2) Decides what preshould be applied to (3) Maintains a reconstructions related to in (b) Preventing Spreading Spre	I Program tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective affections. rad of Infection ion Control Program resident needs isolation to of infection, the facility must	F 4	41			10/9/14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345298	B. WING		C 09/17/2014	
NAME OF PROVIDER OR SUPPLIER HUNTINGTON HEALTH CARE				STREET ADDRESS, CITY, STATE, ZIP CODE	00/11/2014	
				311 S CAMPBELL STREET BURGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
	Continued From page 24 direct contact will transmit the disease.		F 441			
	hands after each di	t require staff to wash their irect resident contact for which dicated by accepted be.				
		ndle, store, process and as to prevent the spread of				
	by: Based on record reinterviews the facili of infection by failin for a one of one res (Resident #4) and fresident care for two being fed breakfasts. The findings include Review of the facility Transmission-base read in part, person Contact Precaution all interactions that resident or potential resident 's environ touching the reside and articles in close gloves upon entry in whenever anticipation.			For Residents #4 and #53: " NA#1 counseled and educated in DON/Designee on 916/14 on facility regarding infection control and follow contact precautions, to include wear gown and gloves and proper hand washing between residents. " Review of Resident #4 medical by DON/Designee revealed need for contact isolation precautions was reson 9/11/14, therefore physicians ord received on 9/16/14 to discontinue of isolation precautions. For Residents #4, #53, and all other inservice education initiated for nursing staff on 9/16/14 by SDC/Desion facility policy regarding infection of and following of contact precautions include wearing of gown and gloves proper hand washing between reside inservice education for all facility held on 9/16/2014 by SDC/Designee.	policy ving of ing of record record recontact scontact s: all signee control , to and ents. y staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345298	B. WING			C 09/17/2014	
NAME OF PROVIDER OR SUPPLIER HUNTINGTON HEALTH CARE				CODE	75/11/2014		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 441	Precautions dated a be washed with soa indirect contact with removing gloves. Resident #4 was as 1/11/13 and has a conjunctivitis. During an observat 9/16/14 at 8:25AM observed to be feed a Contact Isolation s door. NA#1 was She was standing at the resident. Nurse room and asked Nagive Resident #4 he yes, she would use resident in bed B (Fobserved to walk as bedside and put on Resident #53s breathe resident. She cobetween resident company of the resident company of the resident she stated gloves and a gown during feeding becawhen giving care. Shave washed her have washed her have supervisor on 9/16.	ey policy for Standard 2/8/11 read in part hands shall ap and water after direct or a body fluids and after direct or a body fluids and after direct to the facility on current diagnosis of diagnosis diag	F 4	include wearing of gown ar proper hand washing betw Inservicing initiated on 9/16 ongoing by SDC. Any staff by 10/9/2014, will be inserviced in the inservice start of next scheduled shit. "Newly hired staff will be during orientation schedule policy regarding infection of following of contact precautinclude wearing of gown ar proper hand washing betw. "Auditing of compliance policy on infection control recontact isolation precaution wearing of gown and glove washing between residents completed 5 times weekly then 3 times weekly for 4 very monthly times 3 months to by Director of Nursing/Des will include observations of 50% of all residents on Conted will be addressed the reeducation at time of observations of the include of Auditing will and discussed in next schedular committee meeting and the quarterly QA committee meadit findings and determing frequency of continued more content of the property	een residents. 6/14 and not inserviced viced prior to ft. e inserviced e on facility control and ations, to not gloves and een residents. E with facility regarding in, to include es and hand is to be times 4 weeks, weeks and then be conducted ignee. Auditing f a minimum of intact Isolation any concerns rough ervation. be reviewed eduled QA e following eeting to review the need for and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345298	B. WING				C 1 7/2014
NAME OF PROVIDER OR SUPPLIER HUNTINGTON HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 311 S CAMPBELL STREET BURGAW, NC 28425				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 441	During an interview 9/16/14 at 11:05AM person goes into a contact isolation the followed and gowns during any type of contact isolation.	ge 26 sident on contact isolation. with the Administrator on a she stated anytime a staff room with a resident on a sign at the door should be a resident and ashed in between resident.	F 4	41			