		AND HUMAN SERVICES			FORM	: 05/11/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVE COMPLETED C	
		345315	B. WING _			16/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
HIGHLA	ND ACRES NURSING	AND REHABILITATION CENTER		1170 LINKHAW ROAD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 312 SS=D	483.25(a)(3) ADL C DEPENDENT RES	CARE PROVIDED FOR	F 31	2		4/22/15
	daily living receives	nable to carry out activities of the necessary services to tion, grooming, and personal				
	by: Based on observation interviews the facility of 1 residents reviee (Resident #11) The Resident #11 was a 5/5/10 and re-admit The resident had di Cerebrovascular Ac Hemiplegia (paralys The most recent M revealed the reside with personal hygie upper extremities of revealed the reside The resident 's Ca 2/25/15 revealed the personal hygiene a Review of the Nail #11 's nails were la On 4/15/15 at 3:251 observed with the le extended but the le were curled into the resident 's fingerna 1/4 " beyond the en finger. On 4/16/15 at 9:58/ (OT) #1 was observed	admitted to the facility on tted to the facility on 3/16/15. iagnoses that included ccident (Stroke) with Left sis). DS (Quarterly) dated 2/23/15 nt required total assistance ne and had impairment of the n both sides. The MDS nt received hospice care. re Plan last reviewed on e resident was total care for		Resident #11 had his fingernails of by the Director of Nursing on 4-16 A 100 % audit of all resident1 s fin was completed by the supply mar on 4-18-15. All residents with nai concerns were addressed upon identification. A 100 % in I service was complet the Director of Nursing, the Assist Director of Nursing, and the Staff Facilitator on 4-17-15 with the nur and the certified nursing assistant ADL care, to include fingernail care. Th Hospice Nurse in I serviced the faides and the hospice nurses on ADL ca include fingernail care on 4-17-15 hires will be in-serviced by the sta facilitator during orientation on AD to include fingernail care. Adminis staff will observe fingernails to en- care has been completed 5 times for 8 weeks utilizing a QI tool and them into the Administrator and / or t will review the QI tool daily for 8 w Any identified concerns with finge	ed by ant ses s on e nospice are, to . All new ff L care trative sure a week turn the he DON reeks.	(X6) DATE

05/05/2015

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.

**Electronically Signed** 

ND PLAN C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
				3	С	
		345315	B. WING		04/*	16/2015
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1170 LINKHAW ROAD LUMBERTON, NC 28358		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIOI DATE
F 312	left hand contractur partially open the res The palm of the res to have indentions i he saw the indentio fingernails. The res hand was observed fingernails extended the end of the contr Nurse #1 stated in a 10:11AM the admin every morning and the NA know if a res trimmed. The Nurse supposed to look at (morning) care and Nurse stated the ho AM care during the On 4/16/15 at 10:34 (DON) stated in an Assistants) provided ultimately trimmed in DON stated the tran supposed to spot cl at resident 's nails be trimmed and if s stated the hospice a The DON stated in 11:18AM that Resid trimmed and she ha and trim the resider stated an employee the hall where the resident	e. The OT was able to esident 's contracted fingers. ident 's hand was observed in the palm and the OT stated is from the resident 's ident 's skin in the palm of the to be intact. The resident 's d approximately 1/4 " beyond acted fingers. an interview on 4/16/15 at istrative staff made rounds looked at the residents and let sident 's nails needed to be e stated the NAs were t resident 's nails during AM trim the nails if needed. The ospice aide had been doing week. AM the Director of Nursing interview the NAs (Nursing d care every day and resident 's fingernails. The nsportation aide was neck one hall a week to look to see if the nails needed to o, she would do it. The DON aide did not trim nails. an interview on 4/16/15 at lent #11 's nails needed to be ad a staff member go down nt 's fingernails. The DON e from payroll was assigned to esident resided and last made on 4/7/15. The DON stated she	F 312		The will review ting and for any n and cut ek and part of ovement ns for nittee will the s for the	

		AND HUMAN SERVICES & MEDICAID SERVICES		FOR	ED: 05/11/201 RM APPROVE O. 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			OATE SURVEY OMPLETED C	
		345315	B. WING		4/16/2015	
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1170 LINKHAW ROAD LUMBERTON, NC 28358		
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
F 312 F 317 SS=G	able to get down the Employee stated sh on 4/7/15 and the n resident 's nails we Payroll Employee s needed to be cut sh Payroll Employee s 2 rounds per day an saw the resident 's would go back to th get with the NA to n The Administrator state (very day and personal care i Administrator state every day. The Adm the NA should have fingernails. 483.25(e)(1) NO RE UNAVOIDABLE Based on the comp resident, the facility who enters the facil motion does not ex motion unless the r demonstrates that a is unavoidable. This REQUIREMEN by: Based on observat interviews the facility prevent the develop	ge 2 day but was busy and not e halls every day. The Payroll he last did rounds on that hall ail care book showed the ere last cut on 4/3/15. The tated if a resident 's nails he would notify the nurse. The tated she was supposed to do nd on the second round if she nails had not been cut she e nurse who would have to nake sure the nails got cut. tated in an interview on administrative rounds were to check the resident 's room including fingernails. The d each room was not checked hinistrator stated the nurse and picked up on the long EDUCTION IN ROM UNLESS rehensive assessment of a must ensure that a resident ity without a limited range of perience reduction in range of esident's clinical condition a reduction in range of motion	F 31		e	

Facility ID: 923071

If continuation sheet Page 3 of 11

		& MEDICAID SERVICES	(X2) MULTI	IPL			0938-039
	OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
						С	
		345315	B. WING _			04/1	6/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HIGHLAND ACRES NURSING AND REHABILITATION CENTER					170 LINKHAW ROAD UMBERTON, NC 28358		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETIO DATE
F 317	Continued From pa	ige 3	F 31	17			
	(Resident #11). The	e findings included: admitted to the facility on			of Nursing on 4-16-15. Resident # 1 stated	11	
	5/5/10 and re-admi	tted on 3/16/15. The resident Cerebrovascular Accident			he wanted therapy. Hospice was ca and	lled	
	The most recent M	lemiplegia (paralysis). DS (Quarterly) dated 2/23/15			Resident number 11 was discontinue from		
	memory loss but wa	nt had short and long term as able to make decisions.			hospice services on 4-17-15. Resid		
	assistance for all a	the resident required total ctivities of daily living except			was referred to and placed on therap 4-16-15	py on	
		impairment of the upper sides. The MDS revealed the			A 100 % audit for contractures was completed on all residents on 4-16-15 by the hall nurs		
	The resident 's Ca	re Plan last reviewed on o information regarding			using a skin assessment tool and turned ir		
	contractures or ran	ge of motion for the resident ' sident ' s Care Guide revealed			Director of Nursing. From the 100%		
		ted to contractures or range of			4-17-15 any identified residents at ris were referred to therapy. All new	sk	
	A Nursing Admissio	on & Re Entry form dated nically signed by Nurse #1			admissions will be assessed by the nurse using a skin assessment tool		
		ments read: "Full ROM			48 hours of their admission and will turned into the Director of Nursing da	be	
	On 4/15/15 at 3:25	PM, Resident #11 was ne left index finger and thumb			The Director of Nursing, The Assista Director of Nursing, and the Staff		
	extended and was	observed to use the fingers to ers. The left middle, ring and			Facilitator completed a 100% in L se on 4-22-15 on contractures, range o		
	little fingers were of	bserved to be curled inward the hand. The resident was			motion, communication of what is fo during the assessment to ensure		
	observed to use the	e right hand to try to open the and but was not able to do so.			implementation of interventions, and ensuring that all interventions are	d on	
		I his hand had been like this			implemented with all Nurses which included hospice employee's. The st	taff	
		ress notes for Resident #11 5/15 revealed no			facilitator completed a 100 % in I se with all c.n.a.I s on range of motion	ervice	
	left hand.	problem with the resident ' s			on communication of contractures to hall nurse. Hospice completed an in	o their	
		PM an interview was NA (nursing assistant)			I service on 4-17-15 by the RN Hosp Nurse with the hospice aides of the 1		

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If continuation sheet Page 4 of 11

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION		SURVEY
ND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED C 04/16/2015	
		345315	B. WING				
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	04/1	0/2013
HIGHLAN	ID ACRES NURSING	AND REHABILITATION CENTER		11	170 LINKHAW ROAD UMBERTON, NC 28358		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 317	Continued From pa	ae 4	F 3 <sup>2</sup>	17			
	assigned to the res NA #1 stated when s left hand the resid	assigned to the resident on the 3PM-11PM shift. NA #1 stated when she tried to open the resident s left hand the resident would say that it hurt. The			on range of motion and on commun on contractures to their hall nurse. All r	new	
	NA stated the resident did not receive range of motion to the hand and did not have a splint. The Director of Nursing (DON) stated in an interview on 4/16/15 at 9:47AM that Resident #11				c.n.a.'s will be in-serviced on range motion and on communication of contractures to their hall nurse durin orientation process. All new nurses	ng the	
	did not have a hand DON stated the res	d splint or a hand roll. The ident had been on hospice he resident 's condition had			in-serviced on contractures, range motion, communication of what is fo during the assessment to ensure	of	
	discontinuing hospi new contracture an	had been a discussion about ce. The DON stated this was a d hospice would be therapy referral would being			implementation of interventions, and ensuring that all interventions are implemented during the orientation process. The MDS nurse will asses	ntions are orientation	
	made regarding the On 4/16/15 at 9:58/				residents during the resident assessment period for new contract using a QI tool and will turn it into th	tures	
	bed. The Occupation observed to evaluate	onal Therapist (OT) was te the resident ' s left hand T stated the resident ' s left			Director of Nursing or the Administrator daily weeks, weekly for 4 weeks, and mo	for 4	
	partially open the le	ed and was observed to ft middle, ring and little nt was observed to use the left			for 3 months. MDS Nurse or the Dir of Nursing will make a referral to therapy for ar		
	on the bed and ass	nger to hold onto the side rail ist the OT to turn over in bed. e therapist his hand had been			of concerns. The hall Nurses will asse residents	ess	
	the resident if he wa	weeks. The Therapist asked anted to work with therapy to y in the hand and the Resident			weekly and ongoing for contractures a skin assessment tool. The Asses for contractures will be a weekly dut	sment	
	recommend a doub	e OT stated he would le hand roll and would need to asure the resident for a splint.			the hall nurses and will be monitored the Administrator and / or the DON All identified concerns will be referred	daily.	
	An interview was co that provided AM ca	onducted with the hospice aide are for the resident regularly AM. The Hospice Aide stated			therapy. The assessment tool will be turned in daily for 4 Weeks to The D of Nursing or the	е	
	she had been work	ing with Resident #11 for a pice Aide stated she noted the			Administrator, weekly for 8 weeks,a monthly	nd	

Facility ID: 923071

		E & MEDICAID SERVICES	0.00		OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C 04/16/2015	
		345315	B. WING			
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
HIGHLAI	ND ACRES NURSING	AND REHABILITATION CENTER		1170 LINKHAW ROAD LUMBERTON, NC 28358		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 317	Continued From pa	age 5	F 31	7		
	months. The Hosp	ice Aide stated she spent		or the Administrator will revie	ew the QI	
		the resident in the morning		tools	<b>.</b>	
		give the resident a bath. The d she had not had a		at the weekly QI meeting for monthly for 3 months for area		
		any of the staff regarding the		concern. All identified areas		
	resident 's hand co			will be addressed as they are		
	The DON stated in	an interview on 4/16/15 at		The Executive Quality Improv	/ement	
		provide care every day and if a		Committee will review the res		
		e of motion was observed, the		Meeting minutes for the conti		
		to the nurse and the nurse tral to therapy and notify the		and frequency of monitoring months.	monthly for 4	
	physician.	that to therapy and notify the		monuis.		
		interview on 4/16/15 at				
		was frequently assigned to				
		NA stated after the resident				
		e hospital she saw the fingers				
		re bent and told Nurse #2 and				
		NA stated she had not been sident all week but when she				
		esident she did range of motion				
	with the left fingers					
		2AM Nurse #1 stated in an				
		resident was re-admitted on				
		e resident 's left fingers curled				
		esident was still able to pick up left hand. The Nurse stated				
		hand was contracted until she				
		he resident 's contracture on				
		e stated on 4/16/15 she looked				
		and and asked him if he				
		the resident stated: "No."				
		she looked around the room				
		plint. The Nurse stated she did but the contracture because the				
		spice and she knew he was				
		ind of therapy. The Nurse				
	stated the NAs had	I not said anything to her				
	regarding the resid					
	Nurse #2 stated in	an interview on 4/16/15 at				

Facility ID: 923071

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		TE SURVEY		
d plan c	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CO	COMPLETED		
		345315	B. WING			С		
	PROVIDER OR SUPPLIER	343313		REET ADDRESS, CITY, STATE, ZIP C		/16/2015		
		AND REHABILITATION CENTER	1170 LINKHAW ROAD					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 317	Continued From pa	age 6	F 317					
	about a problem wi The OT stated in a 11:13AM that the re to therapy since be on 3/16/15. The OT evaluation done on Therapy Plan of Ca increased flexor to (metacarpophalang result of left extrem per patient report. Fo of motion. Under T Skilled OT is necess in order to maximiz function and allow to mobility with the lease	geal) on the left hand as a hity CVA for the past 3-5 weeks Pain noted with passive range herapy Necessity read: " ssary to normalize muscle tone the UE (upper extremity) the patient to perform bed ast amount of assistance and e. " The treatment diagnosis						
	11:18AM when the not want a splint, th documented this an The DON stated th said to do what the DON stated anyone washcloth in the re nurse who would co Nurse who would re care guide.	an interview on 4/16/15 at resident told Nurse #1 he did he nurse should have nd not done anything further. e resident 's family always resident wanted to do. The e could put a hand rolled sident 's hand and tell the pommunicate this to the MDS evise the care plan and the						
F 318	4/16/15 at 12:57PM made a referral to 1 done for the reside resident was on ho	EASE/PREVENT DECREASE	F 318			4/22/15		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/11/2015 APPROVED 0938-0391	
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (	(X3) DATE SURV COMPLETED C		
		345315	B. WING				04/16/2015	
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•-//		
HIGHLA	ND ACRES NURSING	AND REHABILITATION CENTER			70 LINKHAW ROAD JMBERTON, NC 28358			
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 318	Continued From pa	ge 7	F 3	318				
	Based on the comp resident, the facility with a limited range appropriate treatme	rehensive assessment of a must ensure that a resident of motion receives ent and services to increase d/or to prevent further						
	by: Based on observation interviews the facility prevent a further de- of 1 residents reviee (Resident #11). The Resident #11 was a 5/5/10 and re-admin had a diagnosis of (Stroke) with Left H The most recent Mit Assessment (Quart the resident had so memory loss and w decisions. The MDS required total assist living except for eat range of motion of sides. The MDS rev hospice services. The resident ' s Cat 2/25/15 revealed no contractures or imp resident ' s left hand revealed no information impairment in range A Nursing Admission 3/16/15, under Gen	admitted to the facility on tted on 3/16/15. The resident Cerebrovascular Accident emiplegia (Paralysis). inimum Data Set (MDS) erly) dated 2/23/15 revealed me short and long term vas able to make some S revealed the resident tance for all activities of daily ing and had impairment in the upper extremities on both vealed the resident received re Plan last reviewed on o information regarding aired range of motion for the d. The resident 's care guide ation regarding contractures or			Resident number 11 was assessed Contractures by the Assistant Direct Nursing on 4-16-15. A referral was a to therapy for resident #11 by the Dir of Nursing on 4-16-15. Resident #11 stated he wanted therapy. Hospice was ca and Resident number 11 was discontinue from hospice services on 4-17-15. Reside #11 was referred to and placed on therapy or 4-16-15. A 100 % audit for contractures was completed on 4-16-15 by the hall nurses on all res using a skin assessment tool and turned in Director of Nursing. From the 100% on 4-16-15 any identified resident was referred to therapy on 4-17-15. All no admissions will be assessed by the nurse using a skin assessment tool 48 hours of their admission and will turned into the Director of Nursing d The Director of Nursing, The Assista	idents nto the be audit ew wound within be aily.		

Facility ID: 923071

						0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED	
			A. DOILDIN	·	(	С	
		345315	B. WING			16/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C			
HIGHLA	ND ACRES NURSING	AND REHABILITATION CENTER		1170 LINKHAW ROAD LUMBERTON, NC 28358			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIESID(EACH DEFICIENCY MUST BE PRECEDED BY FULLPREFIXREGULATORY OR LSC IDENTIFYING INFORMATION)TAG		PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIC DATE		
F 318	Continued From pa	ae 8	F 31	8			
F 310	was electronically s Review of the progr 4/15/15 revealed no limited range of mo resident ' s left hand On 4/15/15 at 3:25F observed in bed. Th and thumb were ob resident using the f bed covers. The left were observed to b hand. There was no hand. There was no hand. The resident fingers even with the resident was obser- motion of the right F On 4/15/15 at 3:27F conducted with NA was assigned to the shift. The NA stated resident ' s hand he stated they did not and the resident did hand. The Director of Nu interview on 4/16/15 contracture for the would be requested did not have a hand On 4/16/15 at 9:58 observed lying in be bed. The Occupatio observed to evalual contracture. The O' hand was contracted	igned by Nurse #1. ress notes from 3/16/15 to o documentation regarding tion or of a contracture of the d. PM Resident #11 was he resident 's left index finger served to be extended and the inger and thumb to adjust the t middle, ring and little fingers e curved into the palm of the ot a hand roll in the resident 's was not able to straighten the re use of the right hand. The wed to have good range of hand. PM an interview was (nursing assistant) #1 who e resident on the 3PM-11PM d when she tried to open the e would say that it hurt. The NA do range of motion to the hand d not have a splint for the rsing (DON) stated in an 5 at 9:47AM this was a new resident and a therapy referral d. The DON stated the resident d splint or a hand roll. AM, Resident #11 was ed with 1/4 side rails up on the onal Therapist (OT) was te the resident 's left hand T stated the resident 's left ad and was observed to off middle, ring and little	F 31	Director of Nursing, and the Facilitator completed a 100 <sup>o</sup> serviceon 4-22-15 on contra of motion, communication of during the assessment to ensure impleinterventions, and on ensuring that all interimplemented with all Nurses included hospice employee facilitator completed a 100 <sup>o</sup> on 4-22-15 with all c.n.a.l s motion and on communicatic contractures to their hall nurcompleted an in I service of the RN Hospice Nurse with aides of the facility on range and on communicating on their hall nurse. The staff fa service all new c.n.a.'s on ra and on communicating abort to their hall nurse during or staff facilitator will in-servic nurses on contractures, ran communicating what is four assessment to ensure that a interventions are implement orientation. The MDS nurse all residents during the resid assessment process for new using a QI tool and will turn Director of Nursing or the Ad daily for 4 weeks, weekly fo monthly for 3 months. The M the Director of Nursing will resident for any area of con hall Nurses will assess resident assess will assess resident and on communicating what is four and and process for new using a QI tool and will turn Director of Nursing or the Ad daily for 4 weeks, weekly for monthly for 3 months. The M the Director of Nursing will resident and the process for new using a QI tool and will turn Director of Nursing will assess resident process for new using a QI tool and will turn Director of Nursing will resident to the process for new using a QI tool and will turn Director of Nursing will assess resident process for new using a QI tool and will turn Director of Nursing will resident to the process for new using a QI tool and will turn Director of Nursing will resident to the process for new using a QI tool and will turn Director of Nursing will resident to the process for new using a QI tool and will turn Director of Nursing will resident to the process for new using a QI tool and will turn Director of Nursing will resident to the process for new using a QI tool and will turn Director of Nur	% in I actures, range of what is found ementation of erventions are s, which 's. The staff % in I service on range of ing on rse. Hospice e of motion contractures to cilitator will in- ange of motion ut contractures entation. The e all new ge of motion, nd during the all ted during e will assess dent w contractures it into the dministrator r 4 weeks, and ADS Nurse or make a referral oncern. The		

Facility ID: 923071

If continuation sheet Page 9 of 11

TATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	· · /	E SURVEY PLETED	
		345315				C 04/16/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
HIGHLA	ND ACRES NURSING	AND REHABILITATION CENTER		1170 LINKHAW ROAD LUMBERTON, NC 28358			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 318	Continued From pa	ge 9	F 31	8			
	like this for about 5 the resident if he wa improve the mobility stated: "Yes." The recommend a doub come back and me On 4/16/15 at 10:25 conducted with the the resident. The H with the resident for during the week to g Hospice Aide stated s left hand contract first saw this but ha months. The Hospic had a conversation worsening hand cor On 4/16/15 at 10:34 interview the NAs p they observe a prot should tell the hall m make a referral to the physician. Nurse #1 stated in a 11:02AM she did th on 3/16/15 when the from the hospital. T resident 's left hand resident was still ab his hand. The Nurse the resident had a converse vanted a splint and The Nurse stated s	e therapist his hand had been weeks. The Therapist asked anted to work with therapy to y in the hand and the Resident he OT stated he would be hand roll and would need to asure the resident for a splint. 5AM an interview was hospice aide that worked with ospice Aide stated she was r about an hour in the morning give the resident a bath. The d she had noted the resident ' ing but did not know when she d been weeks and not ce Aide stated she had not with the staff regarding the ntracture. 4AM the DON stated in an rovide care every day and if olem with range of motion they hurse and the nurse would herapy and notify the an interview on 4/16/15 at e re-admission assessment e resident was re-admitted he Nurse stated she noted the d was curled in a little but the ole to pick up items and use e stated she was not aware contracture of the left hand d about the contracture on stated she looked at the d and asked the resident if he the resident stated: " No. " he looked around the room plint. The Nurse stated she did		referred to therapy. The asso will be turned into The Direct or the Administrator daily for weekly for 4 weeks, and mon months. The Director of Nur the Administrator will review at the weekly QI meeting for monthly for 3 months for are concern. All identified areas will be addressed as they are The Executive Quality Impro Committee will review the re Meeting minutes for the cont and frequency of monitoring Executive Committee meetir months.	or of Nursing 4 weeks, thly for 3 rsing and / or the QI tools 8 weeks and as of of concern e identified. vement sults of the QI inued need at the		

If continuation sheet Page 10 of 11

		AND HUMAN SERVICES					FORM	05/11/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED C	
		345315	B. WING					_ 16/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZI	IP CODE		
HIGHLAN	HIGHLAND ACRES NURSING AND REHABILITATION CENTER				70 LINKHAW ROAD			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF	CORRECTION	N	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPE		COMPLÉTION DATE
F 318	Continued From pa	ige 10	F 3	18				
		s not getting any kind of						
	therapy. The Occupational T on 4/16/15 at 11:13 received a referral t resident was re-adr The DON stated in 11:18AM that anyor washcloth in the res nurse who would co Nurse who would re care guide. The Administrator s 4/16/15 at 12:57PM	Therapist stated in an interview AM that therapy had not for Resident #11 since the mitted on 3/16/15. an interview on 4/16/15 at ne could put a hand rolled sident ' s hand and tell the communicate this with the MDS evise the care plan and the stated in an interview on 1 that a referral to therapy done to see what could be						

Facility ID: 923071

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