PRINTED: 06/20/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
345472		B. WING		C 03/21/2017		
	ROVIDER OR SUPPLIER	TREME		STREET ADDRESS, CITY, STATE, ZIP CODE 180 SOUTHWOOD DRIVE BOX 708 CLINTON, NC 28328	33/21/2317	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 157 SS=D	(INJURY/DECLINE/R A facility must immed consult with the residu known, notify the resion an interested family accident involving the injury and has the polintervention; a signific physical, mental, or p deterioration in health status in either life throlinical complications significantly (i.e., a ne existing form of treatmonsequences, or to treatment); or a decision the resident from the §483.12(a). The facility must also and, if known, the resion interested family more change in room or roc specified in §483.15(resident rights under regulations as specificating section. The facility must recontend the address and phore legal representative of the section of pain were made after the section of the pain were made after the resident regulation of the address and phore legal representative of the pain were made after the resident regulation of the address and phore legal representative of the pain were made after the resident regulation of the properties of the resident rights under regulations as specifications.	iately inform the resident; ent's physician; and if dent's legal representative y member when there is an eresident which results in tential for requiring physician cant change in the resident's sychosocial status (i.e., a an mental, or psychosocial reatening conditions or a need to alter treatment due to adverse commence a new form of ion to transfer or discharge facility as specified in	F 15	The statements made on this plan of correction are not an admission to and not constitute an agreement with the	do (X6) DATE	

Electronically Signed Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 04/10/2017

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBED:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345472	B. WING			C 2/24/2047	
NAME OF PE	ROVIDER OR SUPPLIER	0.02	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		3/21/2017	
TVAINE OF T	TOVIDER OR OUT FEILER						
SOUTHWO	OOD NURSING AND RE	TIREME		180 SOUTHWOOD DRIVE BOX 708			
				CLINTON, NC 28328			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE	
F 157	Continued From pag	e 1	F 15	57			
				alleged deficiencies. To remain compliance with all federal and regulations the facility has take take the actions set forth in this correction. The plan of correct	d state en or will s plan of tion		
	on 11/29/16, with dia Alzheimer's Disease Weakness, Difficulty fracture of base of ne subsequent encounter routine healing. According to an Adm (MDS) dated 12/6/16 moderately cognitive	ginally admitted to the facility gnoses including, Dementia, with late onset, Muscle Walking and Displaced eck of right femur, and er for closed fracture with ission Minimum Data Set Resident #1 was ly impaired. In the area of asfers, he required extensive		constitutes the facility \subseteq sallegate compliance such that all alleged deficiencies cited have been of corrected by the date or dates. F 157 A corrective action for affected For resident # 1, on 12/28/2011 resident was assessed by the to have pain in the right hip and resident was medicated with P medication and the on-call MD	ed r will be indicated. resident: 6 when the hall nurse d leg, the PRN pain		
	the area of dressing, hygiene, Resident #1 Resident #1's care pladdressed increased deconditioning (loss function) with actual included to monitor a hours post fall follow bruising, change in mithe physician.	required total assistance. lan dated 12/12/16 risk for falls related to of muscle tone or loss of fall. The interventions and document for pain x 72 up and to report pain, nental status or agitation to on 3/19/17 at 3:05 AM, the		notified. The MD gave an orde 12/28/2016 to complete a pelv hip x-ray. X-ray results were reback on 12/29/2016 positive for impacted sub capital fracture of femur neck. The MD was notifificature on 12/29/16. The residuent to the hospital ER on 12/2 admitted. On 12/30/16, MD was that the investigation into the investigat	is and right eceived or an acute of the right ied of dent was 29/2016 and as notified injury		
	another hall Christma back toward the nurs medication cart. She Assistant told her Re outside his door. She on at the time. The T stated she assessed exhibit any signs of p	pervisor revealed she was on as morning and she came be's station toward the erevealed a Nursing sident #1 was on the floor estated there was a lot going whird Shift Nurse Supervisor Resident #1 and he did not be bein. She recalled the did there was no grimacing.		All current residents experience have the potential to be affected alleged deficient practice. Beginning on 04/07/2017 all curresidents were assessed for in pain or injury by the hall nurses direction of the Director of Nursewere completed on 4/10/17. The assessment included interview	ed by the urrent idications of s under the sing. These he pain		

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	` ´COM	(X3) DATE SURVEY COMPLETED	
		345472	B. WING		l	C / 21/2017	
NAME OF PI	ROVIDER OR SUPPLIER		'	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	,21,2011	
				180 SOUTHWOOD DRIVE BOX 708			
SOUTHWOOD NURSING AND RETIREME				CLINTON, NC 28328			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC		(X5)	
PREFIX TAG				(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)		COMPLETION DATE	
F 157	Continued From page		F 15	57			
		ot see anything to keep from		current interviewable patients to a	ask if		
	moving him. The Thir	d Shift Nurse Supervisor		they are currently experiencing pa	ain. If		
		t Resident #1 to the front of		they are in pain then an assessm			
	_	a special chair to watch him		completed that included the locat			
	•	ated she forgot to write up		pain, severity of the pain, charact			
		ing, to report the fall to the		of the pain, range of motion for ex	•		
		tact the family and doctor.		pain and whether or not it is chroi			
		nt home at the end of her		acute. For cognitively impaired re			
	shift and forgot about			the PAIN AD pain scale was com			
		Supervisor continued by		This pain scale numerically ranks			
	_	complained of pain two or		signs and symptoms such as brea			
	-	she found out later there was		negative vocalizations, facial exp			
		Il fracture. The Third Shift		body language, and consolability determine a 1-10 pain scale for the			
	-	called prior to Resident #1's edication when he became		patient. If pain was identified, the			
		when she came back to		assessment was completed that i			
	_	(16) or Tuesday (12/27/16)		the location of the pain, severity of			
		started complaining of pain.		pain, characteristics of the pain, r			
	_	Supervisor did not explain		motion for extremity pain and whe			
		the doctor when Resident #1		not it is chronic (based on history			
	_	of pain on 12/26/16 or		acute.	,		
	12/27/16 after the res			For chronic pain, as needed pain			
		g the fall to the doctor, the		medications were administered b	y the		
		pervisor stated if there were		nurse. A follow up 30-45 minutes	after		
	no injuries after a fall	, she would fax the doctor		administration was completed to	ensure		
	and if there was an ir	njury she would get an order		pain was resolved. If not resolved	d then		
	to send the resident of	out to the emergency room.		additional pain medications were			
	She stated she did no	ot fax the doctor the night of		administered according to orders			
		cause it slipped her mind.		additional pain medications were			
	The Third Shift Nurse Supervisor said a lot was			ordered by the physician, they we			
		ot of people needing care at		contacted immediately for additio	nal pain		
	one time.			management orders.			
	_	on 3/19/17 at 2:47 PM, Staff		For acute pain, the Director of Nu	rsing		
		ne worked on first shift with		was notified and as needed pain	_		
		ay during the week and he		medications were administered (i			
		12/28/16. She stated the		ordered). If the patient did not ha			
	_	s doing her rounds on		order for pain medications the MI			
	12/28/16 and told her			contacted immediately to get pair			
	complaining of pain.	She stated Resident #1 did		medication and other pain related	l orders.		

CENTER	3 FOR WEDICARE &	WEDICAID SERVICES				OIVID INC	<u>7. 0936-039 i</u>
, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
						,	c I
	345472						21/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	·	
				18	30 SOUTHWOOD DRIVE BOX 708		
SOUTHW	OOD NURSING AND RE	IIREME		С	LINTON, NC 28328		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 157	Continued From page	e 3	F	157			
		ch time she picked up his			Once pain medications were administe	red	
		I her hand as if he was			a follow up 30-45 minutes after	.00	
		he turned him over and he			administration was completed to ensur	е	
		e. She revealed his family			that the pain was resolved. If not		
		him when he indicated he			resolved, the MD was notified immedia	tely	
	was hurting. Staff Nu	rse #1 revealed she gave			for additional orders and interventions.	If	
	Resident #1 Tylenol t	for pain and called the doctor			the acute pain involved an extremity, the	ie	
	on call at 4:29 PM. S			MD was immediately notified of the			
	know Resident #1 ha			findings.			
	looked for information						
	not see anything abo			Systemic changes made were:			
	During an interview of						
	Director of Nursing (I			In-service education began on 04/07/2			
	_	y was not done when the fall			by the Staff Development Coordinator		
	happened because the				all RNs, LPNs, Med Aides, and NA□s I	-1,	
	l .	ne. The DON revealed the pervisor was careless in not			PT, and PRN. The in-service topics included: assessment and notification of	of	
		family and not doing an			the physician of new or unresolved pair		
		DON revealed she could not			The Director of Nursing will ensure that		
		ritten on 12/25/16 regarding			any employee who has not received th		
		ot see an incident report or a			training by 04/10/2017 will not be allow		
fax to the doctor or a pemphasized for a fall v		phone call to the family. She			to work until the training is completed.	-	
		with an injury, the procedure			(See Education Attachment)		
		Administrator, family and			,		
	doctor and for a fall v	vithout injury, make			The RN on call is the Director of Nursir	ıg if	
	notifications and put	something in place to			the staffing on-call is a LPN. The facili	y	
	prevent the fall from	happening again such as			specific in-service was sent to Hospice		
		side the bed or bringing the			Providers and Agency Staff whose		
	I -	rse's station. The DON			employees give residents care in the		
		' an X-ray was done and on			facility to provide training for staff prior	to	
		mined Resident #1 had a			returning to the facility to provide care.		
	I .	had surgery, due to the			Any in-house staff member who did no		
fracture for right hip repair on					receive in-service training by 04/10/20		
	revealed after it was				will not be allowed to work until training	l	
	interviews that Resid				has been completed.		
	I .	d the doctor and Resident			This information has been integrated in	ıto.	
	AM.	fied on 12/30/16 at 10:25			This information has been integrated in the standard orientation training and in		
	I .	on 3/21/17 at 12:00 PM, the			required in-service refresher courses for		
	During an interview t	/// U/ = // // at 12.00 W, the	1		required in-service refresher coulses it	/1	1

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED	
		345472	B. WING		C 03/21/2017		
NAME OF PROVIDER OR SUPPLIER SOUTHWOOD NURSING AND RETIREME				STREET ADDRESS, CITY, STATE, ZIP CODE 180 SOUTHWOOD DRIVE BOX 708 CLINTON, NC 28328	<u> </u>	03/21/2017	
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 157			F1	all employees and will be reviewed be Quality Assurance Process to verify the change has been sustained. The facility plans to monitor its performance by: The Director of Nursing, Staff Development Coordinator, or designed will monitor this issue using the Clinic Quality Assurance Survey Tool Incider Review and MD Notification Tool (see attachment). The monitoring will inclus observing five resident so for indicated pain after a fall, pain management, a timely MD notification. The tool will be completed weekly for 4 weeks then monthly times 2 months. Reports will presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing the ensure corrective action initiated as appropriate. Compliance will be monitand ongoing auditing program review the weekly QA Meeting. The weekly Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Management and considered to the program of the weekly QA Month of the program of the weekly QA Meeting. The weekly of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Management and considered to the program of the progra		e al nt de rs of ad ed at QA	
F 514 SS=D		TE/ACCURATE/ACCESSIB	F 5	and the Administrator.		4/10/17	
	resident in accordance standards and practice	ntain clinical records on each se with accepted professional ses that are complete; ed; readily accessible; and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED		
		345472	B. WING			C 03/21/2017		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		03/21/2017		
SOUTHWOOD NURSING AND RETIREME				180 SOUTHWOOD DRIVE BOX 708 CLINTON, NC 28328				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 514	information to identify resident's assessme services provided; the preadmission screen and progress notes. This REQUIREMENT by: Based on record reversacility failed to docur and also failed to resident and occurred, for Resident #1. An x-ray revealed the resident fracture. The findings included Resident #1 was origon 11/29/16, with dia Alzheimer's Disease Weakness, Difficulty fracture of base of resubsequent encounter routine healing.	ust contain sufficient by the resident; a record of the ints; the plan of care and e results of any ing conducted by the State; It is not met as evidenced friew and staff interviews, the ment an assessment of a fall cument resident's complaints on given for pain relief after a 1 of 3 sampled residents, ay completed after the fall thad sustained a right hip d: ginally admitted to the facility gnoses including, Dementia, with late onset, Muscle Walking and Displaced eck of right femur, and er for closed fracture with	F 5 ⁻²	F 514 A corrective action for affected For resident # 1, on 12/28/201 resident was assessed by the to have pain in the right hip an resident was medicated with P medication and the on-call MD notified. The MD gave an orde 12/28/2016 to complete a pelv hip x-ray. X-ray results were reback on 12/29/2016 positive for impacted sub capital fracture of femur neck. The MD was notified fracture and orders on 12/29/1 resident was sent to the hospit 12/29/2016 and admitted. On the MD was notified that the in into the origin of injury revealed.	6 when the hall nurse d leg, the RN pain was r on is and right eceived or an acute of the right ed of 6. The tall ER on 12/30/16, vestigation			
	Third Shift Nurse Sul another hall Christma back toward the nurs medication cart. She Assistant told her Re outside his door. The Supervisor stated sh	sident #1 was on the floor		unreported fall. All current residents who have have the potential to be affecte alleged deficient practice. Beginning on 04/07/2017 all curesidents were interviewed or a based on their cognitive status	ed by the urrent assessed			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
					С			
		345472	B. WING_				03/21/2017	
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	S1	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	72172017	
				18	80 SOUTHWOOD DRIVE BOX 708			
SOUTHW	OOD NURSING AND F	RETIREME			LINTON, NC 28328			
(V4) ID	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL				PROVIDER'S PLAN OF CORRECTION		(X5)	
(X4) ID PREFIX TAG				×	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 514	Continued From page	age 6	 F	514				
	the resident was a	lert and there was no			history or indicators that a fall may have	'e		
		ited she did not see anything to			occurred. The Social Worker interview			
		him. She stated she forgot to			all alert and oriented residents for any	falls		
		that morning, to report the fall			that may have occurred over the past			
	to the next shift, ar	nd to contact the family and			days. If falls were reported by the			
	doctor. She reveal	ed she went home at the end			resident, it was then compared to the			
	of her shift and for	_			resident□s medical records to ensure	a		
		rse Supervisor continued by			falls assessment was completed along	ı		
	_	1 complained of pain two or			with MD and responsible party			
	three days later and she found out later there was				notifications.			
		mall fracture. The Third Shift			For cognitively impaired residents, the			
	Nurse Supervisor recalled prior to Resident #1's fall, she gave him medication when he became				nurses under the direction of the Direc	tor		
	_				of Nursing completed a head to toe assessment for injuries of unknown ori	ain		
	_	ed when she came back to 26/16) or Tuesday (12/27/16)			If injuries were noted, an investigation	-		
	1	he started complaining of pain.			initiated. In addition to this, various	as		
		v on 3/19/17 at 2:47 PM, Staff			nursing staff across all three shifts wer	e		
	_	she worked on first shift with			interviewed to identify any unreported			
	Resident #1 every	day during the week and he			over the past 30 days. This was			
		to 12/28/16. She stated the			accomplished by printing a list of falls to	or		
	Nursing Assistant	was doing her rounds on			the last 30 days. The Director of Nursi			
	12/28/16 and told I	her Resident #1 was			reviewed the list of falls with staff for			
	complaining of pair	n. She stated Resident #1 did			identification of any possible unreporte	d		
		each time she picked up his			falls that they may be aware of. If any			
		ed her hand as if he was			were identified as unreported, the resid			
	_	d she turned him over and he			was immediately assessed for injury, the			
		ide. She revealed his family			MD and responsible party notified, and			
		ith him when he indicated he			incident report completed. This proces	S		
	_	Nurse #1 revealed she gave			was completed on 04/10/2017.			
	_	ol for pain and called the doctor . She revealed she did not			Systemic changes made were:			
					Cysternic changes made were.			
know Resident #1 had fallen. She si		tion regarding a fall and she did			In-service education began on 04/07/2	017		
		bout him having a fall.			by the Staff Development Coordinator			
		v on 3/20/17 at 2:13 PM, the			all RNs, LPNs, Med Aides, and NA s			
	_	(DON) revealed an			PT, and PRN. The in-service topics	- ,		
		ably was not done when the fall			included: Incident reporting and require	ed		
		e the Third Shift Nurse			notifications, completion of an incident			
	1	ome. The DON revealed the			report, falls assessment, ongoing			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345472	B. WING				21/2017
NAME OF PROVIDER OR SUPPLIER SOUTHWOOD NURSING AND RETIREME			1	18	TREET ADDRESS, CITY, STATE, ZIP CODE 80 SOUTHWOOD DRIVE BOX 708 :LINTON, NC 28328	1 0011	21/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 514	calling Resident #1's incident report. The E find a nurse's note with fall and she did not fax to the doctor or a emphasized for a fall was to call the DON, doctor and for a fall with notifications and put sprevent the fall from a putting a mattress be resident up to the nurrevealed on 12/28/17 12/29/16 it was deter fracture. Resident #1 fracture for right hip revealed after it was a interviews that Reside fracture, she revealed #1's family were notified. During another interviewed Administrator revealed.	pervisor was careless in not family and not doing an DON revealed she could not ritten on 12/25/16 regarding of see an incident report or a phone call to the family. She with an injury, the procedure Administrator, family and without injury, make something in place to mappening again such as side the bed or bringing the rise's station. The DON an X-ray was done and on mined Resident #1 had a had surgery, due to the epair on 12/30/16. The DON discovered through ent #1 had a fall and the doctor and Resident ied on 12/30/16 at 10:25 iew on 3/21/17 at 1:03 PM, ealed her expectation would omplete fall report and notify	F	514	monitoring, pain assessment and documentation of interventions includin administering PRN medications. The Director of Nursing will ensure that any employee who has not received this training by 04/10/2017 will not be allow to work until the training is completed. (See Education attachment). The facility specific in-service was sent Hospice Providers and Agency Staff whose employees give residents care i the facility to provide training for staff pto returning to the facility to provide car Any in-house staff member who did not receive in-service training by 04/10/201 will not be allowed to work until training has been completed. This information has been integrated in the standard orientation training and in required in-service refresher courses for all employees and will be reviewed by the Quality Assurance Process to verify that the change has been sustained. The facility plans to monitor its performance by: The Director of Nursing, Staff Development Coordinator, or designee will monitor this issue using the Clinical Quality Assurance Survey Tool Incident Review and MD Notification Tool (see attachment). The monitoring will includ observing five resident □s for falls assessment, indicators of pain after a fapain management, documentation of Pain medications and timely MD	red to n rior re. t 17 d the or the at	

NAME OF PROVIDER OR SUPPLIER SOUTHWOOD DIVERSING AND RETIREME SULMANY SIAPLEST OF DESCRIPTIONS (EACH DESCRIPTION NUMBER DESCRIPTION OF DESCRIPTION NUMBER DIVERSED BY YOUR DIVERSED BY YOUR SEGULATORY OR LSC IDENTIFYING INFORMATION) F 514 Continued From page 8 F 514 Continued From page 8 F 514 F 514 F 514 Continued From page 8 Continued From page 8 F 514 Continued From page 8 F 51	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER SOUTHWOOD NURSING AND RETIREME (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE DEFICIENCY) F 514 Continued From page 8 F 514 Continued From page 8 F 514 REGULATORY OR LSC IDENTIFYING INFORMATION) F 514 F 514 Continued From page 8 F 514 REGULATORY OR LSC IDENTIFYING INFORMATION) F 514 Continued From page 8 F 514 Notification. The tool will be completed weekly for 4 weeks then monthly times 2 months. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager			345472	B. WING			l		
SOUTHWOOD NURSING AND RETIREME (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 514 Continued From page 8 F 514 REGULATORY OR LSC IDENTIFYING INFORMATION) F 514 Continued From page 8 F 514 REGULATORY OR LSC IDENTIFYING INFORMATION) F 514 Continued From page 8 F 514 Continued From page 8 F 514 REGULATORY OR LSC IDENTIFYING INFORMATION) F 514 Continued From page 8 F 514 Continued From page 8 F 514 Notification. The tool will be completed weekly for 4 weeks then monthly times 2 months. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager	NAME OF D	DOVIDED OD CUDDUED	545472		СТ	EDEET ADDRESS CITY STATE ZID CODE	03/	21/2017	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 514 Continued From page 8 F 514 Continued	NAME OF PI	ROVIDER OR SUPPLIER							
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 514 Continued From page 8 F 514 Continued From page 8 F 514 Continued From page 8 F 514 F 514 REGULATORY OR LSC IDENTIFYING INFORMATION) F 514 F 514 Continued From page 8 F 514 Continued From page 8 F 514 Reports will be completed weekly for 4 weeks then monthly times 2 months. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager	SOUTHWOOD NURSING AND RETIREME								
PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 514 Continued From page 8 F 514 Continued From page 8 F 514 Continued From page 8 F 514 F 514 F 514 Continued From page 8 F 514 F 514 F 514 Continued From page 8 F 514 F 514 F 514 F 514 Continued From page 8 F 514 F 51	(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
notification. The tool will be completed weekly for 4 weeks then monthly times 2 months. Reports will be presented to the weekly Quality Assurance (QA) committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX			X	CROSS-REFERENCED TO THE APPROPRIA			
					514	notification. The tool will be completed weekly for 4 weeks then monthly times months. Reports will be presented to the weekly Quality Assurance (QA) commit by the Administrator or Director of Nurseto ensure corrective action initiated as appropriate. Compliance will be monited and ongoing auditing program reviewed the weekly QA Meeting. The weekly QA Meeting is attended by the Director of Nursing, MDS Coordinator, Support Nurse, Therapy, HIM, Dietary Manager	2 lee itee iing red d at		