

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345472	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/01/2024
NAME OF PROVIDER OR SUPPLIER  Southwood Nursing and Retirement		STREET ADDRESS, CITY, STATE, ZIP CODE  180 Southwood Drive Clinton, NC 28328	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50404</p> <p>Based on record reviews, Physician, staff and Resident interviews, the facility failed to provide a safe transfer when Nurse Aide (NA) #7 failed to utilize a mechanical lift when transferring Resident #2. She was transferred to hospital and diagnosed with a fractured femur. Resident #2 expressed the knee felt like it had been bashed and it was painful. This was for 1 of 3 residents reviewed for falls (Resident #2).</p> <p>The findings included:</p> <p>Resident #2 was admitted to the facility on [DATE] with diagnoses which included coronary artery disease, heart failure, end-stage renal disease and osteoporosis.</p> <p>A review of the care plan that was revised on 9/20/23 revealed Resident #2 required full mechanical lift equipped with the green sling for all transfers with 2 staff during transfers.</p> <p>A review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #2 was cognitively intact and was dependent with transfers from bed to the chair.</p> <p>Review of an incident report initiated dated 5/27/24 revealed Resident #2 was transferred with Nurse Aide #7 when Resident # 2 expressed discomfort in her left leg at the knee area and was lowered to the floor, by the Nurse Aide #7. Nurse #3 was notified, and Resident #2 was transported to hospital by Emergency Services.</p> <p>Review of the hospital Emergency Department Physician note dated 5/26/24 revealed left knee pain after a fall that morning. The results of the X-ray revealed total knee joint replacement with intact hardware. No evidence of acute fracture or dislocation.</p> <p>Record review of the medication order and administration record (MAR) for May 2024 revealed Resident #2 received Tramadol 50 MG (milligrams) by mouth every 6 hours for pain. On 5/27/2024 she received a dose at 6:00AM for a pain level of seven with effective relief. A dose of 50MG was administered at 12:00 PM and 6:00 PM with a pain level of zero. On 5/28/27 at 12:00PM and 6:00AM doses were administered, for a pain level of zero. Resident #2 was out of the facility on 5/28/24 at 12:00PM. She returned to the facility, and she had a pain level of seven and was administered a dose of Tramadol 50 MG by mouth at 6:00PM, which was effective.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of hospital history and physical dated 5/29/24 revealed a CT scan (computed tomography scan was diagnostic imagining that used an x-ray and computers to view cross sections of the anatomy to identify injury) identified a fracture in the distal lateral left femoral metaphysis (a weight-bearing part of the lower end of the femur, or the thighbone, that forms the top of the knee joint). Resident #2 was not a candidate for surgery and was discharged back to the facility with a brace on her knee.</p> <p>An interview via telephone on 6/19/24 at 2:29 PM Agency Nurse Aide #7 (NA) revealed this was the first time she had worked in this facility. She had finished Resident #2's morning bath, Resident #2 then asked to sit in the recliner. NA #7 stated she wanted to get help, but she felt pressured to move Resident #2 to the chair. Resident #2 stated that she could stand. She had Resident # 2 put her arms around her neck and stood her up. Resident #2 complained of knee pain and stated to sit her on the floor. Another NA came into the room and was asked by NA #7 to assist with moving Resident #2. The NA expressed that she would go get the nurse and did not assist with moving the resident. Resident #2 was sent to the hospital. NA #7 stated afterwards NA# 5 told her that Resident #7 used a mechanical lift for transfer. She indicated that being rushed was why she did not use a mechanical lift or ask for help.</p> <p>An interview was conducted on 6/20/24 at 10:24 AM with Resident #2. She stated that NA #7 had finished her bath and she wanted to sit in the recliner. She told NA #7 to get help. NA #7 stated she didn't see anyone in the hall. Resident #2 stated she again told NA #7 to get the nurse to help. NA #7 looked out the door and stated she didn't see anyone. NA #7 moved the recliner from the bathroom to beside the bed and stood her up. When she stood up her knee hurt like someone had 'bashed' it. NA #7 put her on the floor and her knee 'hit' the floor and the pain was terrible. The nurse came into the room and called 911.</p> <p>Interview with Nurse #3 on 6/20/24 at 11:38 AM revealed when she walked into Resident #2's room Resident #2 was sitting on the floor next to the bed, she stated that she knew Nurse Aide #7 was new and she told her she needed the mechanical lift and told her to get the nurse. NA #7 stated she did not have help. Nurse #3 stated NA #7 did not say why she did not use the mechanical lift.</p> <p>An interview with Nurse Aide #5 on 6/20/24 at 11:42 AM revealed Nurse Aide #7 came out into the hall and asked for assistance, and when she entered the room, Resident #2 was on the floor. Nurse Aide #7 asked for help to get Resident #7 up off the floor. Nurse Aide #5 returned with Nurse #3, who called Emergency Services.</p> <p>An interview with the facility Physician on 6/20/24 at 3:37 PM revealed after Resident #2 fell on [DATE] the hospital documentation revealed no injury to the knee. The pain was addressed with medication. Resident #2 continued to complain of knee pain the evening of 5/27/24 during a visit. Another x-ray with a mobile x-ray provider was ordered. The morning of 5/28/24 Resident #2 went to a scheduled appointment. Resident #2 returned to the facility with complaints of knee pain and was sent to a different hospital before the mobile x-ray was obtained. The CT scan identified a fracture. Resident #2 was not a surgical candidate, and a knee brace was continued. The Physician indicated that the facility provided appropriate care. The physician did state the fracture was a result of the fall on 5/26/24.</p> <p>The facility provided the following Corrective Action Plan with a completion date of 6/3/24.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The facility identified concerns regarding Resident #2's fall caused by the lack of orientation education of Nurse Aide #7 that was required of all new agency staff.</p> <p>1. Corrective action for resident(s) affected by the alleged deficient practice:</p> <p>On 5/26/24 Resident #2 was immediately assessed by Nurse #3. The Medical Director and Patient Representative was notified, and orders were obtained to send Resident #2 to hospital for further evaluation. After hospital discharge 6/3/24 Resident #2 returned to the facility and remained in a knee brace and continued with pain medication ordered as needed.</p> <p>2. Corrective action for residents with the potential to be affected by the alleged deficient practice.</p> <p>On 5/28/24 the Director of Nursing and Administrator identified residents that were potentially impacted by this practice by completing interviews with resident with BIMS of 13 or greater to identify any concerns of unreported falls or concerns with method used for transferring. This was completed on 5/28/2024. The results included: No identified concerns.</p> <p>The Unit Manager completed body audits for residents with BIMS 12 or less to identify any concerns of post fall injuries and indications of any further falls or incidents that did not have a corresponding incident report. This was completed on 5/28/24. The results included: No identified concerns.</p> <p>On 5/28/24 all residents were assessed for falls by the Director of Nursing, Assistant Director of Nursing or the MDS Coordinator. Then care plans were reviewed to ensure accuracy, task initiated and Kardex accuracy. This was completed on 5/29/2024. The results included: 15/70 residents noted with additional required interventions. On 5/28/2024 the facility Interdisciplinary team implemented corrective action for those residents which includes updated care plan and Kardex.</p> <p>On 5/28/24 the Director of Nursing reviewed incident reports for the last 14 days to ensure that no other adverse events occurred due to inaccurate transfer status and that the MD and family were notified. This was completed on 5/28/2024. The results included: 0/9 residents were identified as having no concerns.</p> <p>On 5/28/2024 the Director of Nursing and Staff Development Coordinator assessed all residents who sustained a fall in the past 14 days for adequate pain control and potential injuries. This was completed on 5/28/2024. The results included there were no identified concerns.</p> <p>On 5/28/24 the Director of Nursing and Staff Development Coordinator reviewed resident progress notes for the past 14 days to ensure that incident reports were completed for fall events. This was completed on 5/28/2024. The results included: There were no identified concerns. On 5/28/24 the Director of Nursing and Interdisciplinary team determined no implemented corrective action were needed for those residents which includes completion of incident report, notification to Medical Director/Patient Representative and assessment for any change in condition.</p> <p>3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/28/24, the Staff development Coordinator began in servicing all full time, part time and prn Registered Nurses, Licensed practical Nurse, Nurse Aides and medication aide staff (including agency) on Transfer safety and Fall prevention and post fall process. This training will include all current staff including the agency. This training included:</p> <ul style="list-style-type: none"> <li>- Importance of checking Kardex prior to any Resident Transfer</li> <li>- How to check the Kardex</li> <li>- Importance of following Kardex to ensure resident safety.</li> <li>- Reporting adverse events</li> <li>- What are the common causes of falls?</li> <li>-Identifying Falls Risk</li> <li>- General Falls Prevention Strategies</li> <li>- What should I do if I see a resident fall or see a resident on the floor?</li> <li>- Nursing immediate actions</li> <li>- Post Fall Documentation and Ongoing Assessment</li> <li>- Completing the incident report</li> </ul> <p>On 5/30/2024 Education was added for:</p> <ul style="list-style-type: none"> <li>- Handling resident behaviors</li> <li>- The Director of Nursing will ensure that any of the above-mentioned staff who does not complete the in-service training by 5/30/2024 will not be allowed to work until the training is completed.</li> </ul> <p>Monitoring Procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.</p> <p>4. Monitoring Procedure to ensure that the plan of correction is effective, and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements.</p> <p>The Director of Nursing will monitor by observation audits the transfer safety, and audits of fall prevention and Agency Orientation process weekly for 2 weeks and monthly for 3 or until resolved. Reports will be presented to the weekly Quality Assurance committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored, and an ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum data set Coordinator, Therapy, Health Information management, and the Dietary Manager.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>All items listed on this self-imposed action plan were complete and implemented on 5/28/24 with ongoing monitoring to ensure compliance. This includes the action plan and any potential citation associated with this action plan should be considered past noncompliance as of 6/3/24.</p> <p>The corrective action plan was validated on 6/20/24 and concluded the facility implemented an acceptable corrective action plan. Interviews conducted with staff revealed the facility provided education and training on patient transfers and the utilization of lifts. The ongoing monitoring audits were validated as completed on 6/3/24.</p> <p>The facility's corrective action plan's completion date was verified as 6/3/24.</p>		

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<p>F 0726</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>50404</p> <p>Based on Physician, staff, resident interviews and record review the facility failed to ensure 1 of 4 agency Nurse Aides (NAs) interviewed were oriented on the first day of assignment to the facility kiosk system, Kardex and residents' transfer method. NA #7 did not use a mechanical lift with assistance to transfer Resident #2 to her recliner. Resident #2 was transferred to the hospital and diagnosed with a fractured femur. This was for 1 of 3 residents reviewed for falls (Resident #2).</p> <p>Findings included:</p> <p>This tag was cross referenced to</p> <p>F 689: Based on record reviews, Physician, staff and Resident interviews, the facility failed to provide a safe transfer when Nurse Aide (NA) #7 failed to utilize a mechanical lift when transferring Resident #2. She was transferred to hospital and diagnosed with a fractured femur. Resident #2 expressed the knee felt like it had been bashed and it was painful. This was for 1 of 3 residents reviewed for falls (Resident #2).</p> <p>An interview via telephone on 6/19/24 at 2:29 PM Agency Nurse Aide (NA) #7 revealed 5/26/24 was the first time she had worked in this facility. NA #7 stated afterwards another NA# 5 told her that Resident #7 used a mechanical lift for transfer. She indicated she had no competency training prior to starting her assignment.</p> <p>An interview with the Scheduler on 6/20/24 at 9:15 AM revealed she did not have an orientation competency packet for NA #7. The Scheduler stated she had not prepared an orientation competency packet for the nursing staff to provide orientation training to NA #7 because she came in to replace another agency staff that called out. When an agency staff worked for the first time on a weekend or after hours, the charge nurse signed off with the agency staff on the orientation packets. The Scheduler confirmed Agency Nurse #3 was the charge nurse on 5/26/24.</p> <p>Interview with Agency Nurse #3 on 6/20/24 at 11:38 AM revealed she was the charge nurse on 5/26/24. On the weekends, a new agency staff had a packet at the nursing station, and she helped agency staff members to complete the orientation packet. The orientation packet included instructions on how to use the kiosk system (used to provide patient care information and view transfer information). NA #7 did not have an orientation packet as she was called in to cover a shift.</p> <p>During an interview on 6/20/24 at 4:44 PM the Assisamt Director of Nursing (ADON) indicated she had not come into the facility to complete an orientation packet with NA #7. The charge nurse in the facility was tasked with orientation. The ADON indicated NA #7 contacted the IT (information technology) department to get access to the medical record and time clock.</p> <p>(continued on next page)</p>		

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<p>F 0726</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview on 6/20/24 at 8:45 AM with the Director of Nursing revealed when staff reported to work for the first time an orientation packet was reviewed and signed off by the agency staff and the Scheduler prior to the staff member working the floor. On weekends the charge nurse reviewed the packets with the agency staff before they began work. There was no orientation packet available for NA #7 on 5/26/24.</p> <p>An interview with the Administrator on 6/19/24 at 3:00 PM revealed all agency staff were trained with an orientation packet before work. The facility identified that Nurse Aide #7 did not get the orientation packet and was not trained by the Scheduler or the nursing staff. The Administrator explained there was no orientation packet available for NA #7 on 5/26/24, and it was a weekend. The procedure for training agency staff was put into place after this accident.</p>