PRINTED: 07/22/2011 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTITUTION 8 2011	(X3) DATE SU COMPLE		
		345241	B. WING		17/4 07//	98/2011	
	ROVIDER OR SUPPLIER	B/EDEN		TREET ADDRESS, CITY, STATE, ZIP CO 226 N OAKLAND AVENUE EDEN, NC 27288		30/2011	
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
SS=J	(INJURY/DECLINE/R A facility must immedit consult with the reside known, notify the reside or an interested family accident involving the injury and has the potential physical, mental, or post deterioration in health, status in either life three clinical complications) significantly (i.e., a necessiting form of treatment); or a decising the resident from the fallow or interested family must also pand, if known, the resident rights under Fregulations as specified in §483.15(e) resident rights under Fregulations as specified this section. The facility must record the address and phone legal representative or This REQUIREMENT by: Based on record review	ately inform the resident; ent's physician; and if ident's legal representative or member when there is an resident which results in resident which results in ential for requiring physician ant change in the resident's expension conditions or a mental, or psychosocial eatening conditions or a need to alter treatment ed to discontinue an ent due to adverse commence a new form of on to transfer or discharge acility as specified in promptly notify the resident dent's legal representative ember when there is a mmate assignment as (2); or a change in ederal or State law or d in paragraph (b)(1) of and periodically update and periodically update and periodically update and periodically update and periodically member.	F 157		ed to be affected ent practice. ferred to Morehed of on December related to acute nical status. This itted to Morehead diagnosis with uction with as placed on and released based based before the fact of the facts esident's discharation of this plan does not consider the provider of the truth of the tru	ead 8, d a ck re, be	
		PPLIER REPRESENTATIVE'S SIGNATURE		The plan of correction is pre- required by the provisions of	pared and/or executed beca f Federal and State law.	use it is	

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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 9HKL11

Facility ID: 922997

		THE OLIVIOLO				OMBIN	<i>J.</i> 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLET	
		345241	B. WIN	IG		07/0	08/2011
NAME OF PR	ROVIDER OR SUPPLIER		4	STR	REET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	ENTER HEALTH & REHA	B/EDEN		22	26 N OAKLAND AVENUE EDEN, NC 27288		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	1	PROVIDER'S PLAN OF CORRE	CTION	
PRÉFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE PROPRIATE	(X5) COMPLETION DATE
					details regarding the di	scharge of	
F 157	Continued From page	1	F	157	Resident #1 on Decem	ber 8, 2010).
	of a change in conditi	on for one (1) of two (2)				,	
	sampled residents (R	esident #1) when Resident	İ	İ	Director of Nursing an	d Staff	
		ominal pain, exhibited			Development Coordina		ad
		and was noted to have no examined by nursing staff.				-	!
	power sounds when a	xanimed by nursing stail.			one-to-one education in	_	}
	 Immediate jeopardy b	egan on 12/04/2010 and			communicating with su		
	was identified on 07/0				regarding notification of	_	ր
		was removed on 07/07/2011			condition, including in		
	at 6:39 P.M., when the	e facility provided a credible		ļ	constipation, nausea, a	nd vomitin	g,
	allegation of complian	ice. The facility will remain a scope and severity level D			and completion of char	nge of	
	(no actual harm with r	potential for more than		İ	condition forms, InterA	Act II. when	h to
	minimal harm that is r	not immediate jeopardy) to			report to the MD/PA/N	•	
	ensure monitoring of s completion of employe	systems put in place and			following the chain of		
	included:				On July 7 2011 the St	toff	
	Resident #1 was adm	itted to the facility on			On July 7, 2011, the St		1
		t #1 had a hospitalization			Development Coordina		a
		0 with diagnoses of right			education for all licens		
	lower lobe pneumonia	, fracture of the right femur.			regarding notification	_	h l
	Hospital discharge sur	mmary dated 11/30/2010			condition and assessme		
	stated Resident #1 de (obstruction of the boy				resident specifically re	lated to	
		ly secondary to pneumonia.			constipation, nausea, a	nd vomitin	g,
	He was treated with la				and assessments in rela	ation to cha	nge
		mproved and his bowels		ĺ	of condition and report	ing and wi	11
		on discharge from the			be completed by July 1		
	hospital.				include those staff on v		
	Physician orders were	reviewed and revealed a			work only weekends.		
	physician order dated	11/30/2010 for Vicodin			2011, all available Cer		ino
		et po.(by mouth) every for			Assistants were educat		b
	(4) hours for pain. Lex	ki-Comp's Geriatric Dosage					htituto
	Handbook 12th edition indicated that constipation was a side effect of the medication.				Preparation and/or execution of this admission or agreement by the provalleged or conclusions set forth in the plan of correction is prepared a required by the provisions of Redor	rider of the truth of he statement of def ind/or executed bed	the facts iciencies.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345241	B. WING		07/08/2011
	OVIDER OR SUPPLIER	B/EDEN	2	REET ADDRESS, CITY, STATE, ZIP CODE 226 N OAKLAND AVENUE EDEN, NC 27288	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLETION
F 157	#1 had a potential for with episodes of cons medication. Approach fluids, observe for box adequate bowel elimin physician as indicated. A review of the Bladdo for 11/26/2010 throug Resident #1 had a do on 12/1/2010 and 12/2 Complete Blood \cour 12/2/2010 indicated a On 12/04/2010 at 06:0 stated Resident #1 was chronic constipation. 01:00 AM. with no resindicated Resident #1 food three times and s Resident #1 warm prucould not keep it down temperature- 97.4, pu blood pressure 168/87 On 12/04/2010 at 1:30 indicated Resident #1 bathroom for three dailquid one time. He was medium soft stool was given. The document #1's abdomen was dis with complaints of paint touched. No bowel so areas of the stomach.	28/2010 indicated Resident alteration in bowel function tipation related to hes included: encourage wel pattern to ensure nation and notification of it. er and Bowel report sheet h 12/8/2010 revealed cumented bowel movement 4/2010. at (CBC) results obtained on white cell count of 13.8 DO AM., nursing notes as experiencing some An enema was given at ults. The nurse's note had vomited undigested staff attempted to give me juice, but Resident #1 h. Vital signs were lse-72, respirations-20 and 7.	F 157	communicating with s regarding change in concluding incidents of and completion of Charcondition forms and wompleted by July 12, include those staff on work weekends only. An impromptu meeting Quality Assessment and including the Nursing Administrator, Director Staff Development Concrete Resident Care Manage and Medical Director at the Brian Center of 7, 2011 at 12:50pm to plan of action regarding deficient practice. Staff Dayly 11, 2011 the farm Assessment and Assur Committee will meet period of three weeks actions associated with of change in residents forward, the Quality Assurance Committee Interdisciplinary Team Preparation and/or execution of this admission or agreement by the providing of Feder required by the provisions of Feder required by the provisions of Feder required by the provisions of Feder	constipation ange of vill be 2011 to vacation and ag of the nd Assurance Home or of Nursing, cordinator, ement Director, was conducted Eden on July implement a ng the alleged arting the week acility Quality rance weekly for a to review h notification status. Going Assessment and c, to include the n (including the splan does not constitute vider of the truth of the facts he statement of deficiencies. and/or executed because it is
ORM CMS-256	7(02-99) Previous Versions Obse	plete Event ID:9HKL11	Fa	cility ID: 922997	If continuation sheet Page 3 of 36

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	j	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		i e			**************************************			
		345241	B. WING			07/0	8/2011	
BRIAN CE	ROVIDER OR SUPPLIER ENTER HEALTH & REH	AB/EDEN		226 N	ADDRESS, CITY, STATE, ZIP CODE OAKLAND AVENUE I, NC 27288			
(X4) ID PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE OPRIATE	(X5) COMPLETION DATE	
F 157	On 12/05/2010 at 12 stated Resident #1 frothy brown sputum breakfast. He comp stomach pain. His afirm to touch and hy noted in all areas of were temperature-9 and blood pressure Resident #1 had na signs were temperat respirations-24 and On Monday, 12/6/20 notes stated "Reside some hydration prothad decreased and nausea/vomiting ove abdomen is somewh 12/5 he experienced Enemas given x 2 at taking Lasix 80 mg. 300 mg. His urine is foul odor. 12/5/10 h temp. (temperature) Tylenol and ice chips of the stated "Resident #1" to dysphagia, he's of does not like. The last had episodes of nau severe constipation. (effective). 12/5 tem	blood pressure 121/70. 2:30 PM., nursing noted was coughing, spitting up and only took liquids for blained of nausea and abdomen was distended and poactive bowel sounds were the stomach. Vital signs 7.1, pulse-68, respirations-16 140/72. At 4:00 PM., usea and vomiting. Vital ture-99.1 axillary, pulse-67, blood pressure 132/64. 210 at 05:45 AM., nursing ent #1 appears to be having blems. His PO (oral) intake he's had episodes of at 48 (forty-eight) hours. His nat distended. On 12/4 and a severe constipation. Indeffective. Currently he's BID (twice daily) and Avapro a dark/amber tome without the experienced an elevated which was treated with	F 15		Director of Nursing, Ad Social Services Director Director, Therapy Progr Dietary Manager, Unit of Resident Care Managem and MDS Coordinator) monthly or as needed. Residents with the potential affected by the alleged of practice. Residents who changes in condition recinitervention, such as conhave the potential to be the alleged deficient pradictly July 7, 2011, the Director began a review of the curesidents who have had change in condition required in condition of Nursing and corresponding document medical records of these determine that a nursing was done and intervention medical records of these determine that a nursing was done and intervention implemented, and commit the appropriate parties. residents were noted with and the interventions were noted with a plan of correction is prepared and/or required by the provisions of Federal and the plan of correction is prepared and/or required by the provisions of Federal and the plan of correction is prepared and/or required by the provisions of Federal and the plan of correction is prepared and/or required by the provisions of Federal and the plan of correction is prepared and/or required by the provisions of Federal and the plan of correction is prepared and/or required by the provisions of Federal and the plan of correction is prepared and/or required by the provisions of Federal and the plan of correction is prepared and/or required by the provisions of Federal and the plan of correction is prepared and/or required by the provisions of Federal and the plan of correction is prepared and/or required by the provisions of Federal and the plan of correction is prepared and/or required by the provisions of Federal and the plan of correction is prepared and/or required by the provisions of Federal and the plan of correction is prepared and/or required by the provisions of Federal and the plan of correction is prepared and/or required by the provisions of Federal and the plan of correction is prepared and/or required by the provisions of Federal and the plan of correc	c, Activities am Manas Coordinate ient Direct will meet it all to be deficient exhibit acquiring affected bectice. On or of Nursurrent an acute airing 2011, the ited the tation in the residents assessment and acute it and acute it and acute it and acute it and acute it as a constant of the truth of the skin teatement of deficient executed because it acute it acute it acute it acute it as a constant of the truth of the reacuted because it acute it ac	es ger, pr, pr, tor, tor, tor, tor, tor, tor, to to to to to to to to to to to to to	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SUI COMPLET	
		345241	B. WIN	.G		07/0	8/2011
	OVIDER OR SUPPLIER	B/EDEN		STREET ADDRESS, CITY, STATE, ZIP CODE 226 N OAKLAND AVENUE EDEN, NC 27288			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE PROPRIATE	(X5) COMPLETION DATE
F 157	(daily)." Resident #1 complete blood count a complete metabolic 12/6/2010, CBC resul count of 19.1 (normal increased from the reearlier. On 12/6/2010 stated Resident #1 cowas given Phenergar (IM). Vital signs were pulse-65, respirations 115.62. On 12/7/2010 at 1:30 temperature 97.1, pul blood pressure 156/1 to spit up frothy sputubad and refused breawas noted. At 8:45 Pyellowish liquid and wfurther vomiting noted and refused day to decent #1 experienthat affected day to deconstipation was not assessment. On 12/8/2010 at 06:00 Resident #1 vomited appearance. Vital sig pulse-71, respirations 95/51. At 11:00 AM., temperature-97.4, pul	dD, Avapro 300 mg. qd 's physician ordered a (CBC) with differential and panel (CMET). On its indicated a white cell 4.0-10.5). This was sult received four days of at 9:40 PM., nursing notes complained of nausea and of 25 mg. intramuscularly of temperature-97.9, -24 and blood pressure PM., vital signs were se-72, respirations-20 and of 3. Resident #1 continued of m, complained of feeling kfast. No bowel movement M., Resident #1 vomited ras given Phenergan with no l. Data Set assessment dated Resident #1 received pain of the assessment stated ced occasional mild pain ay activities and sleep. indicated on the D AM., nursing notes stated iquid that was phlegm in ns were temperature 99.5, -28 and blood pressure	F	157	follows: treatment ini RP notification, ident underlying cause with Appropriate notificati treatments initiated ar for both residents. 3. Systemic Measures On July 7, 2011, facil reinforcement of the fi practice for the Interd Team (including the I Nursing, Administrate Services Director, Ac Director, Therapy Pro Dietary Manager, Res Management Director Coordinator) to review basis, Monday throug residents who have ex changes in condition assessments or observ symptoms are docum interventions were ini attending physician w appropriate by review reports, change of cor Bowel records, and te Adjustments to the pl Preparation and/or execution of the admission or agreement by the pro alleged or conclusions set forth in The plan of correction is prepared required by the proprisions of Pede	ification of to correction. on and and completed ity initiated facility's isciplinary Director of or, Social tivities ogram Mana sident Care; and MDS w on a daily the Friday, the chibited acut to assure that yations of ented, tiated, and to assure that yation form the statement of definition form the statement of definition form an of care at a plan does not consider of the truth of the statement of definant/or executed becauted because of the statement of definant/or executed because of the statement of definition form the statement of definition of care and of c	he ger, bse e t he l as our s, ers. id little l

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUil		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345241	B. WIN	IG		07/08/2011
NAME OF P	ROVIDER OR SUPPLIER			1	EET ADDRESS, CITY, STATE, ZIP CODE	
BRIAN C	ENTER HEALTH & REHA	B/EDEN		226 N OAKLAND AVENUE EDEN, NC 27288		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE COMPLETION
F 157	that morning and had breakfast. Morning in Resident #1 was mod distended and very had 10:00 AM. Resider hospital on 12/8/2010 grade small bowel of The Hospital dischard 12/15/2010 included high-grade small bow perforation present of X-rays done on admissmall bowel obstruct air consistent with perforation present of X-rays done on admissmall bowel obstruct air consistent with perforation present of X-rays done on admissmall bowel obstruct air consistent with perforation present of X-rays done on admissmall bowel obstruct air consistent with perforation present of X-rays done on admissmall bowel obstruction air consistent with performing the with performing the standing of the performing the standing orders for constipation was the mind and Resident # standing orders for constipation of the performing the did not notify the	been unable to eat medications were vomited, aning. His abdomen was ard. Resident #1's physician was sent to (name) hospital int #1 was admitted to (name) o with a diagnosis of high instruction with perforation. ge summary dated a discharge diagnosis of wel obstruction with in admission (12/08/2010), ssion revealed a high-grade fon with free intraperitoneal inforation. ht shift (11:00 PM07:00 are for Resident #1 on 12/4, 2010. On 07/6/2011 at 3:15 is not abnormal for Resident mach pain and/or become ain medication. Nurse #3 o at 01:00 AM., Resident istended and hard. She men and noted very little could not press on Resident ise he complained of pain She said she checked the	F	157	Care Assignment Sheet made based on these reinput of medical profes July 7, 2011, the facility mechanism to account review of the 24-hour rincidents and changes i by the manager on duty charge nurse. The Director Nursing or Administrate called to discuss finding further action as appropreduality Assessment and Committee will monito daily Monday thru Frid period of 4 weeks, then period of 4 weeks, then deemed necessary by the Assessment and Assura Committee. On July 7, 2011, the Receipt Coordinator conducted all scheduled licensed regarding what constitutes assessment, post-change Preparation and/or execution of this padmission or agreement by the providence of the post-change of correction is prepared and all scheduled licensed in the plan of correction is prepared and all schedules or conclusions set forth in the The plan of correction is prepared and all schedules are provided and the provided and schedules are set forth in the prepared and the provided and schedules are set forth in the prepared and the provided and schedules are set forth in the prepared and the provided and schedules are set forth in the prepared and the provided and schedules are set forth in the prepared and the provided and schedules are set forth in the prepared and t	views and the sionals. On y initiated a for weekend eport, an condition and/or etor of or will be gs and initiate oriate. The d Assurance or the process ay for a weekly for a randomly as a equality ence egional circctor of Development training with nurses at a nursing e of condition of the facts statement of deficiencies. Hor executed because it is

CENTERS FOR MEDICARE & I STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
WAN LEWA OL	Colonia		A. BUILDING B. WING		0210010044
		345241			07/08/2011
	OVIDER OR SUPPLIER NTER HEALTH & REHA	AB/EDEN	22	EET ADDRESS, CITY, STATE, ZIP CODE 6 N OAKLAND AVENUE DEN, NC 27288	
DIGITAL GA			 	PROVIDER'S PLAN OF COF	RRECTION (X5)
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSG IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 157	Continued From page one time and the star monitor for twenty-for hours before faxing/hours before faxing/hours before faxing/hours before faxing/hours before faxing/hours before faxing/hours #2 worked ev PM.) and provided of 12/5 and 12/6/2010. She stated Resident pain nausea and von hospital on 11/30/20 physician would be nausea and vomitin day. Nurse #2 state physician regarding because Resident # shift. Nurse #4 worked do and provided care for 12/8/2010. On 07/6 she notified the phy Resident #1 vomite given him and the form Resident #1's conditional could not remembe physician about Reabdomen, complain absence of bowels #4 stated she was diagnosis of ileus for hospitalization in N staff monitored von stools, abdominal cevery shift. This we nursing notes or or sheets. Nurse #4 signs of increased	ge 6 Indard protocol was to our (24) to seventy-two (72) calling the physician. ening shift (3:00 PM11:00 care for Resident #1 on 12/4, On 07/6/2011 at 3:35 PM., #1 had complaints of leg mitting on his return from the 10.0. Nurse #2 stated the notified by telephone or fax if g continued for more than one d she did not notify the the nausea and vomiting the the nausea and vomiting the was not vomiting every ay shift (07:00 AM3:00 PM.) or Resident #1 on 12/6 and 63/2011 at 4:35 PM., she stated was amily was concerned about ition. Nurse #4 stated she ar if she also notified the sident #1's distended the of abdominal pain or the sounds on 12/4/2010. Nurse aware that Resident #1 had a rom his previous ovember 2010 and nursing niting, constipation, loose distention and bowel sounds ould be documented in the in the daily skilled nursing stated Resident #1 displayed pain on 12/8/2010. She stated	F 157	assessment, use of In guidelines for assessment including calling 911 assessment indicates threatening event and involvement for identification of charges in resident communication of the continuity of care. The Nursing, Resident Caronauring staff education allowed to work. The be included in the factorientation. Beginning scheduled Certified In Assistants were educated to constipation, including to constipation, including to constipation, including to constipation, naus vomiting. Certified In Assistant's will be preducation via the Director vi	ment ely intervention if initial a life d physician tified acute ondition. The d for the age in condition, ose changes and he Director of are Management vide all licensed on prior to being his education will cility's new hire ag July 7, 2011, Nursing cated regarding hare when a a change in but not limited ea, and Nursing rovided this rector of are Management this plan does not constitute provider of the truth of the facts
	Resident #1 was n	noaning loudly and began		The plan of correction is prepar	ed and/or executed because it is ederal and State law.
FORM CMS-2	2567(02-99) Previous Versions	Obsolete Event ID: 9HK	L11 F	Facility ID: 922997	If continuation sheet Page 7 of

		MILDIO GENVICES				OWR M	<u>). 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345241	B. WIN	IG		07/0	8/2011
NAME OF PR	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	ENTER HEALTH & REHA	B/EDEN		226 N OAKLAND AVENUE EDEN, NC 27288			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT	TION	
PREFIX TAG	(EACH DEFICIENC)	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IX.	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COPRIATE	(X5) COMPLETION DATE
F 157	Continued From page vomiting. She notified and Resident #1 was On 07/6/2011 at 5:30 Nursing stated any che would be documented sheet. The report she been shredded but she information that had be sheet to be document. The interim Director of staff followed a flip che in certain situations. See from the nurse's desk, "constipation" section nursing staff on what the and/or who to notify in regarding the nursing at 1:30 PM., the interiminated, she would expendify the administrative available at all times for assessment. She state constipation and no be expect the physician to the Nurse #1 worked day and provided care for and 12/7/2010. On 07 #1 stated Resident #1' and no bowel sounds we examined him on 12/4.	If the physician at that time transferred to the hospital. PM., the interim Director of ange in resident condition on the 24 hour report ets for December 2010 had e would expect any een on the 24 hour report ed in the resident's chart. If Nursing stated nursing art to determine what to do she obtained the flip chart referred to the and stated it informed o document and not when any situation. When asked notes written on 12/4/2010 in Director of Nursing ect the nursing staff to en urse on call who was or further help in ed, with nausea, vomiting, well sounds, she would to be notified at that time. Shift (07:00 AM3:00 PM.) Resident #1 on 12/4, 12/5 If/2011 at 8:55 AM., Nurse is abdomen was distended	F	157	Director, or Staff Develor Coordinator prior to bein work. In addition, on July 7, 20 facility's grand rounds provided includes Director of Resident Care Management and/or Staff Development Coordinator, increased the of the grand rounds to at times per week for the new weeks to include observed discussion with four rand chosen licensed nurses residents with the potential acute changes in condition residents with acute changes in condition, physician involution, physician involut	pment g allowed 11 the cocess, of Nursingent Director the frequency least three ext four stions, lomly egarding tal to have on, identifinges in olvement a tions bein the ector of inical I rounds o were	or ed s
		distended and tender to			reviewed to assess for ad	ditional	1
		or him to have diminished			needs and interventions.	The	
	or no bowel sounds."	Nurse #1 stated the een aware that Resident	**		Preparation and/or execution of this plan admission or agreement by the provider o alleged or conclusions set forth in the stat The plan of correction is prepared and/or required by the provisions of Federal and	does not constitu f the truth of the ement of deficie executed because	acts cies.

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	345241	B. WING _		07/08/2011	
NAME OF PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CENTER HEALTH & REHAB/ED	DEN		226 N OAKLAND AVENUE EDEN, NC 27288		
PREFIX (EACH DEFICIENCY MUS	IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 157 Continued From page 8 would have notified the ple medication if Resident #1 profusely vomiting, had are was in severe pain and/or indicated as long as Resident vomiting, she had no complete be notified if the pain, potential for blockage material in the vomitus, te abdomen and absence or sounds. Resident #1's phe complete bowel obstruction lot different that an ileus a that Resident #1 survived. If he had been called on 1 information noted in the number of abdominal phe would have told the fact resident to the hospital for the Administrator was not Jeopardy on 07/07/2011 and The facility presented a crecompliance on 07/07/2011 included: Address how the corrective accomplished for those resident #1 transferred to Resident #1 transferred to	had continued in elevated temperature, inot voiding. She dent #1 was voiding and concerns. "Resident #1's inormal for Resident #1 men, abdominal pain or inds. He said he would re was any question of e, vomiting, fecal inder or distended hyperactive bowel ysician stated that a in and perforation was a ind it was miraculous. The physician stated, 2/4/2010 and told the cursing notes (nausea stended and firm, in pain, no bowel sounds), sility to transfer the evaluation. Indicate the indicate in the indicate	F 157	Director of Nursing and F Clinical Director also revide documentation in the med records of these residents identification of acute characteristic condition and notification physician. Necessary follocompleted and there are noutstanding concerns. Admeasures put into place to alleged deficient practice recur include: The Interd Team (IDT) will review for reports on a daily basis M through Friday during the meeting to ensure any characteristic condition is identified. A interventions and notificate be made based on these reading to the provision of Nursing, and/or Staff Development Coordinator will review for reports daily, Monday the Friday, to identify any characteristic condition. Add the licensed nurses will be annually on nursing asset post-change of condition use of Interact II tools as Preparation and/or execution of this plan deadnission or agreement by the provider of alleged or conclusions is forth in the stafe or required by the provisions of Federal and Stafe or required by the provisions of Federal a	iewed the lical to ensure anges of of ow-up was so ditional or ensure the does not disciplinary powel fonday of IDT ange in appropriate ations will eviews. RCMD, to the company of the co	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		345241	B. WIN	G		07/0	8/2011
	ROVIDER OR SUPPLIER	B/EDEN	STREET ADDRESS, CITY, STATE, ZIP CODE 226 N OAKLAND AVENUE EDEN, NC 27288				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 157	December 8, 2010 at changes in his clinical admitted to the hospit small bowel obstruction placed on comfort me to Brian Center of Edewith a continuation of further corrective action. On July 6, 2011 the factor with the continuation of the corrective action.	10:00am related to acute status. This resident was all with a diagnosis of a on with perforation and was asures and released backen on December 15, 2010 his orders; therefore, no on could be accomplished. Incility's interim Director of estigation into the facts ent's discharge on	F	157	for assessment componentimely intervention includes 911 if initial assessment in life threatening event and involvement for identified changes in resident conditensure continued compliant. 4. Quality Assessment and A	ling callir ndicates a physician I acute tion to nce.	
	until July 7, 2011. This details regarding the condition and assessing condition and assessing condition and assessing condition and assessing condition and assessing condition and assessing condition and assessing condition and report	one-to-one education in a sting with supervisors of change in condition, constipation, nausea, and ion of change of condition rentions to reduce acute to report to the MD/PA/NP, of command.			On July 7, 2011, the Qual Assessment and Assurance Committee, including the Administrator, Human Recoordinator, Director of Manageme MDS Coordinator, Mainted Director, Social Worker, Administrator, Director, Therapy Program Medical Records Coordinator Dietary Manager to discussepisode experienced by Recond December 4, 2011. The Committee also has review acute episode with the fact Medical Director.	facility sources Nursing, nt Directe enance Activities n Manage ator, and ss the acu esident #	er,
	and work only weeken available Certified Nur	ds. On July 7, 2011, all			Preparation and/or execution of this plan do admission or agreement by the provider of alleged or conclusions set forth in the state The plan of correction is prepared and/or exrequired by the provisions of Federal and St	he truth of the facient nent of deficient ecuted because	ects vies

	OF DEFICIENCIES CORRECTION				(X3) DATE SURVEY COMPLETED		
		345241	B, WIN	G		07/0	8/2011
	(EACH DEFICIENC)	B/EDEN ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	22 EI X	EET ADDRESS, CITY, STATE, ZIP CODE 26 N OAKLAND AVENUE DEN, NC 27288 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETION DATE
F 157	of constipation and condition forms and vaccondition for the vac	ondition including incidents impletion of Change of vill be completed by July 12, staff on vacation and work g of the Quality Assessment ing the Nursing Home rof Nursing, Staff ator, Resident Care, and Medical Director was a Center of Eden on July 7, aplement a plan of action deficient practice. Starting 011 the facility Quality trance Committee will meet three weeks to review h notification of change in forward, the Quality trance Committee, to linary Team (including the diministrator, Social wities Director, Therapy etary Manager, Unit Care Management ordinator) will meet monthly will be accomplished for a potential to be affected by ctice: acute changes in condition such as constipation, have	F	157	On July 7, 2011, the Correviewed the education is provided to the licensed regarding identification condition, nursing assess initiation of intervention assessment findings. The Administrator and/of Nursing will review data during reviews and repopatterns/trends to the QAC Committee weekly for fand monthly thereafter. Committee will evaluate effectiveness of the above will add additional interbased on negative outcomidentified to ensure conticompliance.	materials nursing s of change sment, an s based o or Directo a obtained rt A&A our weeks The QA& o the ve plan, an ventions mes	taff in d n r of
	deficient practice. On	July 7, 2011, the Director of w of the current residents			Preparation and/or execution of this ple admission or agreement by the provide alleged or conclusions set forth in the s The plan of correction is prepared and/	r of the truth of tatement of defi or executed bec	the facts ciencies.

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345241	B. WI	IG		07/0	8/2011
	ROVIDER OR SUPPLIER	B/EDEN		STREET ADDRESS, CITY, STATE, ZIP CODE 226 N OAKLAND AVENUE EDEN, NC 27288			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO BE	(X5) COMPLETION DATE
F 157	documentation in the residents to determine was done and interve and communicated to Two residents were n interventions were as MD and RP notification underlying cause with notification and treatm completed for both residents what measure systemic changes madeficient practice will be facility's practice for (including the Director Social Services Director Therapy Program Markesident Care Manage Coordinator) to review through Friday, those exhibited acute change that assessments or care documented, interthe attending physicial appropriate by review change of condition for telephone orders. Adjust and Care Assignment on these reviews and professionals. On July inlitated a mechanism review of the 24-hour	On July 7, 2011, the udited the corresponding medical records of these at that a nursing assessment ntions were implemented, the appropriate parties. oted with skin tears and the follows: treatment initiated, on, identification of the a correction. Appropriate nents initiated and sidents. The will be put into place or de to ensure that the not occur: The initiated reinforcement of or the Interdisciplinary Team of Nursing, Administrator, for, Activities Director, anager, plement Director, and MDS or on a daily basis, Monday residents who have less in condition to assure observations of symptoms eventions were initiated, and in was contacted as ing the 24 hour reports, orms, Bowel records, and ustments to the plan of care. Sheets will be made based the input of medical of 7, 2011, the facility to account for weekend.	F	157	Preparation and/or execution of this pheadmission or agreement by the provide alleged or conclusions set forth in the street plan of correction is prepared and required by the provisions of Federal and the street of the plan of correction is prepared and the plan of correction is prepared and the plan of correction is prepared and the plan of correction is prepared and the plan of prederation is prepared and the plan of correction is prepared and the plan of prederation is prepared and the plan of the pla	er of the truth of statement of def for executed bec	the facts ciencies.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345241	B. WIN	B. WING		07/08/2011	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHAB/EDEN				226	ET ADDRESS, CITY, STATE, ZIP CODE IN OAKLAND AVENUE EN, NC 27288		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 157	and/or charge nurse. Administrator will be of and initiate further action Quality Assessment at will monitor the proces for a period of 4 weeks of 4 weeks, then rand by the Quality Assess Committee.	The Director of Nursing or called to discuss findings tion as appropriate. The and Assurance Committee as daily Monday thru Friday as, then weekly for a period omly as deemed necessary ament and Assurance	F	157			
	Development Coordinall scheduled licensed constitutes a nursing a condition assessment guidelines for assessment imply intervention incassessment indicates physician involvement changes in resident condition, communica continuity of care. The Resident Care Manag Development Coordin nursing staff education work. This education facility's new hire orien	ator conducted training with a nurses regarding what assessment, post-change of a use of Interact II tools as ment components, and luding calling 911 if initial a life threatening event and a for identified acute condition. The Interact II tool cation of change in tion of those changes and a Director of Nursing, ement Director, or Staff ator will provide all licensed in prior to being allowed to will be included in the intation. Beginning July 7,					
	2011, scheduled Certi were educated regard when a resident exper condition, including bu nausea, and vomiting. Assistants will be prov Director of Nursing, Re	fied Nursing Assistants ing notification of the Nurse iences a change in it not limited to constipation,			Preparation and/or execution of this pla admission or agreement by the provide alleged or conclusions set forth in the s The plan of correction is prepared and/	r of the truth of tatement of def or executed bed	the facts ciencies.

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345241	B. WING			07/08/2011	
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHAB/EDEN				226	ET ADDRESS, CITY, STATE, ZIP CODE S N OAKLAND AVENUE EN, NC 27288		
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F 157	rounds process, which Nursing, Resident Ca and/or Staff Developm the frequency of the g three times per week include observations, randomly chosen licer residents with the potendanges in condition, acute changes in condition, acute changes in condition, acute changes in condition involvement as approbeing implemented to need. The Director of Clinical Director conditional Director conditional needs and of Nursing and Region reviewed the document records of these resid of acute changes of cophysician. Necessary and there are no outsimeasures put into plandeficient practice does interdisciplinary Team reports on a daily basiduring the IDT meeting condition is identified, and notifications will be reviews. The Director Staff Development Co 24-hour reports daily,	2011 the facility's grand includes Director of re Management Director ment Coordinator, increased trand rounds to at least for the next four weeks to discussion with four insed nurses regarding ential to have acute identified residents with edition, physician priate, and interventions address the resident's Nursing and Regional fucted grand rounds on July ere reviewed to assess for interventions. The Director interventions. The Director intervention in the medical ents to ensure identification of follow-up was completed anding concerns. Additional ce to ensure the alleged and recur include: The (IDT) will review bowel is Monday through Friday grown or these of Nursing, RCMD, and/or ordinator will review Monday through Friday, to	F	157		nu does not cons	filute
		resident's condition. ed nurses will be educated sessment, post-change of			Preparation and/or execution of this pla admission or agreement by the provide alleged or conclusions set forth in the s The plan of correction is prepared and/ required by the provisions of Federal and	r of the truth of tatement of defi or executed bec	the facts ciencies.

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		345241	B. WING		07/0		
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHAB/EDEN				REET ADDRESS, CITY, STATE, ZIP COE 226 N OAKLAND AVENUE EDEN, NC 27288	Œ		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 157	guidelines for assess timely intervention inco assessment indicates physician involvement changes in resident of compliance. Indicate how the facility performance to make sustained. The facility ensuring that corrective actions of effectiveness. The Populity assurance systems of the corrective action of effectiveness. The Populity assurance systems of the committee facility Administrator, Coordinator, Director Management Director Coordinator, Maintens Worker, Activities Director Manager, Medical Reducation Manager, Medical Reducation Manager, Medical Reducation materials pursing staff regarding condition, nursing assinterventions based of the Administrator and the Administ	t, use of Interact II tools as ment components, and cluding calling 911 if initial is a life threatening event and it for identified acute condition to ensure continued ity plans to monitor its esure solutions are y must develop a plan for on is achieved and must be implemented and evaluated for its OC is integrated into the stem of the facility: Quality Assessment and e (QA&A), including the Human Resources of Nursing, Resident Care r, MDS(Minimum Data Set)	F 15	Preparation and/or execution admission or agreement by the alleged or conclusions set for the plan of correction is pre	he provider of the truth of rth in the statement of defi	the facts	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345241	B. WING		07/08/2011	
	OVIDER OR SUPPLIER	B/EDEN	2	REET ADDRESS, CITY, STATE, ZIP CODE 126 N OAKLAND AVENUE EDEN, NC 27288		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 157 F 309 SS=J	for four weeks and m Committee will evaluabove plan, and will a based on negative of continued compliance Immediate Jeopardy at 6:39 PM. Interview confirmed they had remarked	e QA&A Committee weekly conthly thereafter. The QA&A ate the effectiveness of the add additional interventions atcomes identified to ensure e. was removed on 07/07/2011 we with licensed nursing staff eccived in-servicing on use of InterAct II tools as ment and when/ whom to ges in resident condition. Provided by the facility that in 07/07/2011 and copies tools that would be used as sment. ARE/SERVICES FOR ING	F 157			
	mental, and psychos accordance with the and plan of care. This REQUIREMENT by: Based on medical rephysician interviews, to assess and monito pain with associated distended abdoment sounds for one (1) of	est practicable physical, ocial well-being, in comprehensive assessment F is not met as evidenced ecord review, staff and the facility failed to continue or new onset of abdominal nausea and vomiting, and absence of bowel two (2) sampled residents resulted in hospitalization for		Preparation and/or execution of this admission or agreement by the provice alleged or conclusions set forth in the The plan of correction is prepared an required by the provisions of Federal	der of the truth of the e statement of defici id/or executed becau	ne facts iencies.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED			
		345241	B. WIN	B. WNG		07/08/2011			
	ROVIDER OR SUPPLIER ENTER HEALTH & REHAI	B/EDEN	I	STREET ADDRESS, CITY, STATE, ZIP CODE 226 N OAKLAND AVENUE EDEN, NC 27288					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT CEACH CORRECTIVE ACTION SHOLE CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION			
F 309	Continued From page 16 small bowel obstruction with perforation. Immediate jeopardy began on 12/04/2010 and was identified on 07/07/2011 at 11:20 AM. Immediate Jeopardy was removed on 07/07/2011 at 6:39 PM. when the facility provided a credible allegation of compliance. The facility will remain out of compliance at a scope and severity level D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring of systems put in place and completion of employee training. Findings included: Resident #1 was admitted to the facility on 05/14/2004. Resident #1 had a hospitalization 11/23/2010-11/30/2010 with diagnoses of right lower lobe pneumonia, fracture of the right femur. Hospital discharge summary dated 11/30/2010 stated Resident #1 developed an ileus (obstruction of the bowel) during his		F		24				
	were moving regularly hospital. Physician orders were physician order dated 5-500 tab one (1) table (4) hours for pain. Lex Handbook 12th editior was a side effect of the A care plan dated 09/2 #1 had a potential for with episodes of const	28/2010 indicated Resident alteration in bowel function	a or age tion				On July 6, 2011 the facility's interim Director of Nursing began an investigation into the facts surrounding the resident's discharge on December 8, 2010. The investigation continued until July 7, 2011. This investigation included details regarding the discharge of Resident #1 on December 8, 2010. Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed because it is		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345241	B. WING			07/08/2011	
NAME OF PRO	VIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	07700	7/2011
BRIAN CENTER HEALTH & REHAB/EDEN				2:	26 N OAKLAND AVENUE DEN, NC 27288		5
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	A review of the Bladder for 11/26/2010 through Resident #1 had a door 12/1/2010 and 12/4/2010 at 06:0 stated Resident #1 was chronic constipation. Of:00 AM. with no resident with the stated resident #1 with the stated resident #1 with the stated resident #1 with the stated resident #1 with the stated resident #1 with the stated resident #1 with the stated resident #1 said he had for three days. Resident #1 said he had the stated resident #1's abdomes to touch with complaine stomach was fouched the resident #1's abdomes to touch with complaine stomach was fouched the resident #1's abdomes to touch with complaine stomach was fouched the resident #1's abdomes to touch with complaine stomach was fouched the resident #1's abdomes to touch with complaine stomach was fouched the resident #1's abdomes to touch with complaine stomach was fouched the resident #1's abdomes to touch with complaine stomach was fouched the resident #1 was cought the stomach. His a	wel pattern to ensure nation and notification of d. er and Bowel report sheet th 12/8/2010 revealed cumented bowel movement 4/2010. O AM., nursing notes as experiencing some An enema was given at rults. Resident #1 had not three times. Nursing a Resident #1 warm prune could not keep it down. erature- 97.4, pulse-72, ood pressure 168/87. O PM., nursing notes stated and not used the bathroom ent #1 vomited liquid one in enema and a medium soft the enema was given.	F	309	Director of Nursing and S Development Coordinator one-to-one education in re- resident assessment and communicating with super regarding change in cond- including incidents of cor- nausea, and vomiting, and completion of change of of forms, InterAct II, when the MD/PA/NP, and follochain of command. On July 7, 2011, the Staff Development Coordinator education for all licensed regarding assessment of a specifically related to com- nausea, and vomiting, and assessments in relation to condition and reporting as- completed by July 12, 20 include those staff on vac- work only weekends. On 2011, all available Certification Assistants were educated communicating with super regarding change in cond Preparation and/or execution of this pla- admission or agreement by the provide alleged or conclusions set forth in the ad- required by the provisions of Federal a required by the provisions of Federal a	r provided egards to egards to ervisors ition, astipation do report towing the rinitiated nurses a resident estipation do change of the following the lation and July 7, and Nursir on ervisors ition an does not constitute of statement of deffor executed beginning to the following the truth of the truth of the following the truth of the following the truth of the following the truth of the following the truth of the following the truth of the following the truth of the following the truth of the following the truth of the following the truth of the truth of the following the truth of the following the truth of the following the truth of the following the truth of the following the truth of the following the truth of the following the truth of the following the truth of the following the truth of the truth of the following the truth of the following the truth of the following the truth of the truth of the truth of the truth of	fitute the facts ciencies.

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHAB/EDEN A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 226 N OAKLAND AVENUE	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 228 N OAKLAND AVENUE	
226 N OAKLAND AVENUE	3/2011
EDEN, NC 27288	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CORRE	(X5) COMPLETION DATE
including incidents of constipation and completion of Change of Condition forms and will be completed by July 12, 2011 to include those staff on vacation and work weekends only. On 12/6/2010 at 4:00 PM., nursing notes stated Resident #1 had nausea and vomiting one time. Phenergan 25 mg. suppository and Tylenol suppository was given. Vital signs were temperature-99.1 axiliany, pulse-67, respirations-24 and blood pressure 132/64. On 12/6/2010 at 05:45 AM., nursing notes stated 'Resident #1 appears to be having some hydration problems. His PO (oral) intake had decreased and he's had episodes of nausea/vomiting over 48 (forty-eight) hours. His abdomen is somewhat distended. On 12/4 and 12/5 he experienced severe constipation. Enemas given x 2 and effective. Currently he's taking Lasix 80 mg. BID (twice daily) and Avapro 300 mg. His urine is a dark/amber tome without foul odor. 12/6/10 he experienced an elevated temp. (temporature) which was treated with Tylenol and ice chips." On 12/6/2010 at 9:40 PM., nursing notes stated Resident #1 complained of nausea and Phenergan 28 mg. intramuscularly (IM) was given and noted to be effective. Vital signs were temperature-97.9, pulse-65, respirations-20 and blood pressure 156/103. Resident #1 comitinued to spit up frothy sputum and complained of feeling bad. No bowel movement was noted. Breakfast	r, d d e e ne itute he facts ciencies.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345241	B. WIN	B. WING		07/08/2011	
	ROVIDER OR SUPPLIER	B/EDEN	STREET ADDRESS, CITY, STATE, ZIP CODE 226 N OAKLAND AVENUE EDEN, NC 27288				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
F 309	On 12/7/2010 at 8:45 Resident #1 vomited y twenty-five (25) per ce consumed. Phenerga further vomiting noted temperature-97.4, pul- blood pressure 134/56 A Quarterly Minimum 12/07/201 indicated R medication as needed Resident #1 experience that affected day to de Constipation was not i assessment. On 12/8/2010 at 06:00 Resident #1 vomited li appearance. Vital sign pulse-71, respirations- 95/51. On 12/8/2010 at 11:00 vital signs were temper respirations-26 and ble Resident #1 had vomit had been unable to ea medications were vom moaning. Abdomen w hard. Resident #1's pl Resident #1 was sent AM. Resident #1 was on 12/8/2010 with a di bowel obstruction with	PM., nursing notes stated vellowish liquid. Only ent of the meal was in 25 mg. was given with no . Vital signs were se-76, respirations-26 and 6. Data Set assessment dated esident #1 received pain lated ecocasional mild pain and activities and sleep. Indicated on the liquid that was phlegm in this were temperature-99.5, 28 and blood pressure led twice that morning and at breakfast. Morning lited. Resident #1 was ras distended and very thysician was notified and to (name) hospital agnosis of high grade small	F	309	Director, Therapy Programatical Preparation and Mos Coordinator) of monthly or as needed. 2. Residents with the potential affected by the alleged depractice. Residents who changes in condition requintervention, such as conhave the potential to be at the alleged deficient practice and a review of the curresidents who have had a change in condition requintification. On July 7, 2011, the Director of Nursing audicorresponding document medical records of these determine that a nursing was done and intervention implemented, and command the appropriate parties. The residents were noted with and the interventions were noted with and the interventions were noted with and the interventions of this padmission or agreement by the provide alleged or conclusions set prepared and required by the provisions of Frederal required by the provi	coordinator, nent Director, will meet Intial to be deficient exhibit acute quiring astipation, affected by ctice. On or of Nursing arrent an acute airing 2011, the ited the tation in the existents to assessment ons were nunicated to Two th skin tears are as ted, MD and cation of the lan does not constitute lear of the truth of the facts statement of deficiencies. If or executed because it is	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Ι' ΄	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345241	B. WING			07/08/2011		
	ROVIDER OR SUPPLIER	B/EDEN	STREET ADDRESS, CITY, STATE, ZIP CODE 226 N OAKLAND AVENUE EDEN, NC 27288					
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F 309	small bowel obstruction admission (12/08/admission revealed a obstruction with free is with perforation. Nurse #3 worked night AM.) and provided cate 12/6, 12/7 and 12/8/2 PM., she stated it was #1 to complain of store constipated due to passid she received reproduction constipated and naus stated, on 12/04/2010 #1's abdomen was distened to his abdome bowel sounds. She of #1's abdomen because and that was "different" for him. Some time and felt a solic Constipation was the mind and Resident # standing orders for constipation was the mind and Resident # standing orders for constipation was the mind and Resident # standing orders for constipation was the mind and provided cate 12/5 and 12/6/2010. She stated Resident pain nausea and vome time and the standing pain nausea and vome time and t	diagnosis of high-grade on with perforation present 2010). X-rays done on high-grade small bowel ntraperitoneal air consistent of the shift (11:00 PM07:00 re for Resident #1 on 12/4, 010. On 07/6/2011 at 3:15 is not abnormal for Resident mach pain and/or become ain medication. Nurse #3 forts of Resident #1 being fee and vomiting. Nurse #3 of at 01:00 AM., Resident stended and hard. She en and noted very little fould not press on Resident is the complained of pain the said she checked the diagram and mass of stool. First thing that came to her awas given an enema per constipation. Nurse #3 stated physician on 12/4/2010 at the sident #1 had vomited only and ard protocol was to ur (24) to seventy-two (72)	F	309	underlying cause with cor Appropriate notification a treatments initiated and cor for both residents. 3. Systemic Measures On July 7, 2011, facility is reinforcement of the facility practice for the Interdiscip Team (including the Director, Team (including the Director, Activity Director, Therapy Program Dietary Manager, Resident Management Director, and Coordinator) to review on basis, Monday through Fresidents who have exhibit changes in condition to as assessments or observation symptoms are documente interventions were initiated attending physician was cappropriate by reviewing reports, change of conditions and the plan of Care Assignment Sheets of the plan of Care Assignment Sheets of the plan of correction is prepared and/or required by the provisions of Federal and	nitiated ity's plinary ctor of social ies m Manage at Care d MDS a daily riday, those ited acute essure that was of d, ed, and the ontacted of the 24 ho on forms, none order f care and will be ews and the of the truth of the attenent of defice or executed becare	e as ur s. e tute te facts iencies.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345241	B. WING			07/08/2011	
NAME OF PR	OVIDER OR SUPPLIER	010211		STREE	ET ADDRESS, CITY, STATE, ZIP CODE	1 07100	5/2011
BRIAN CENTER HEALTH & REHAB/EDEN				226	N OAKLAND AVENUE		
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F 309	physician would be not nausea and vomiting day. Nurse #2 stated physician regarding the because Resident #1 shift. Nurse #4 worked day and provided care for 12/8/2010. On 07/6/2 she notified the physician and the fam Resident #1 vomited given him and the fam Resident #1's condition could not remember it physician about Resident #1's condition to the physician about Resident #1's condition abdomen, complaints absence of bowel sout #4 stated she was awaliagnosis of ileus from hospitalization in Nov staff monitored vomits stools, abdominal distevery shift. This would nursing noted or on the sheets. Nurse #4 state signs of increased paresident #1 was most vomiting. She notified and Resident #1 was. On 07/6/2011 at 5:30 Nursing stated any chewould be documented sheet. The report sheets.	otified by telephone or fax if continued for more than one she did not notify the ne nausea and vomiting was not vomiting every shift (07:00 AM3:00 PM.) Resident #1 on 12/6 and to 12/6/2010 that almost everything that was nily was concerned about on. Nurse #4 stated she if she also notified the dent #1's distended of abdominal pain or the that Resident #1 had a notified the dent #1's distended of abdominal pain or the that Resident #1 had a notified the dent #1's distended of abdominal pain or the that Resident #1 had a notified the dent #1's distended of abdominal pain or the that Resident #1 had a notified the dent #1's distended of abdominal pain or the that Resident #1 had a notified the dent #1's distended on 12/4/2010. Nurse that Resident #1 had a notified the documented in the network that the dent #1 displayed in on 12/8/2010. She stated that time that time transferred to the hospital. PM., the interim Director of the physician at that time transferred to the hospital.	F3	309	input of medical profession July 7, 2011, the facility is mechanism to account for review of the 24-hour reprincidents and changes in the by the manager on duty as charge nurse. The Director Nursing or Administrator called to discuss findings further action as appropriately Assessment and Committee will monitor the daily Monday thru Friday period of 4 weeks, then we period of 4 weeks, then we period of 4 weeks, then redeemed necessary by the Assessment and Assurance Committee. On July 7, 2011, the Region Coordinator conducted the all scheduled licensed nurgarding what constitute assessment, post-change assessment, use of Interactive and Assurance of this plant of this plant of the pla	nitiated a r weekend ort, condition nd/or or of will be and initiate. The Assurance he proces r for a reekly for andomly a Quality ce ional ector of evelopment aining wi rses es a nursir of conditi ct II tools	ate s a as as as
		peen on the 24 hour report led in the resident's chart.			admission or agreement by the provide alleged or conclusions set forth in the s The plan of correction is prepared and/ required by the provisions of Federal a	r of the truth of tatement of defi or executed bec	the facts ciencies.

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345241 B. WING			07/08/2011			
NAME OF PROVIDER OR SUPPLIER BRIAN CENTER HEALTH & REHAB/EDEN		•	STREET ADDRESS, CITY, STATE, ZIP CODE 226 N OAKLAND AVENUE EDEN, NC 27288				
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F 309	staff followed a flip chin certain situations. from the nurse's desk "constipation" section nursing staff on what and/or who to notify in regarding the nursing at 1:30 PM., the interistated, she would expnotify the administrati available at all times if assessment. She state constipation and no be expect the physician in the expect the physician in the expect that the expect the physician in the expect that the expect the physician in the expect that the expect the physician in the expect that the expect the physician in the expect that the expect the physician in the expect that the	of Nursing stated nursing art to determine what to do She obtained the flip chart, referred to the and stated it informed to document and not when any situation. When asked notes written on 12/4/2010 m Director of Nursing sect the nursing staff to eve nurse on call who was for further help in ted, with nausea, vomiting, owel sounds, she would to be notified at that time. shift (07:00 AM3:00 PM.) Resident #1 on 12/4, 12/5 7/7/2011 at 8:55 AM., Nurse is abdomen was distended were heard when she disconded and tender to for him to have diminished Nurse #1 stated the been aware that Resident stended. She said she te physician for pain that a continued and an elevated temperature, ad/or not voiding. She Resident #1 was voiding and no concerns.	F	309	guidelines for assessme components, and timely including calling 911 if assessment indicates a lathreatening event and prinvolvement for identification of identification of changes in resident communication of those communication of those continuity of care. The Nursing, Resident Care Director, or Staff Devel Coordinator will provide nursing staff education allowed to work. This be included in the facility orientation. Beginning scheduled Certified Nursing staff education of the Nursing target experiences a condition, including but to constipation, nausear, vomiting. Certified Nursing, Resident Care Nursing, Resident Care Director, or Staff Develorector, or	intervention initial ife hysician led acute dition. The or the or the changes and Director of Management lopment le all licensed prior to be ing education will ty's new hire July 7, 2011, rsing led regarding le when a change in t not limited and rsing led this tor of Management lopment lopment	
	attending physician st	ated Resident #1 required ating, bowel movements			admission or agreement by the prov alleged or conclusions set forth in th The plan of coπection is prepared a required by the provisions of Federa	e statement of deficiencies. nd/or executed because it is	

	OF DEFICIENCIES CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 309	to assess Resident #1 material in vomitus, al distended abdomen a bowel sounds The Administrator was Jeopardy on 07/07/20 The facility presented compliance on 07/07/20 included: Address how the correaccomplished for those been affected by the compliance on affected by the compliance on the compliance on the compliance on the compliance on affected by the compliance of the compliance o	n. He expected nursing staff I routinely for vomiting, fecal adominal tenderness, and absence or hyperactive a notified of the Immediate 11 at 11:20 AM. a credible allegation of 2011 at 6:39 PM. which active action will be a residents found to have deficient practice: ad to the hospital on 10:00am related to acute status. This resident was all diagnosis with a small perforation and was placed and released back to Brian cember 15, 2010 with a ers; therefore, no further I be accomplished. cility's interim Director of astigation into the facts nt's discharge on a investigation continued investigation included ischarge of Resident #1 on	F	309	Coordinator prior to being work. In addition, on July 7, 20 facility's grand rounds purchased to an analysis and rounds to at times per week for the new weeks to include observed discussion with four rand chosen licensed nurses residents with the potential acute changes in condition residents with acute changes in condition, physician involution, ph	of Nursing, ent Director of he frequency least three ext four ations, lomly egarding hal to have on, identified ages in olvement as tions being he ector of inical larounds on were ditional The Regional	
		ne-to-one education in			rreparation and/or execution of this p admission or agreement by the provic alleged or conclusions set forth in the The plan of correction is prepared an required by the provisions of Federal	ler of the truth of the facts statement of deficiencies. Vor executed because it is	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BUILLI	NYCH UCA: TU O MCUA	D/EDEN		22	26 N OAKLAND AVENUE	
DRIAN CE	NTER HEALTH & REHA	BIEDEN		E	DEN, NC 27288	
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F 309	F 309 Continued From page 24 communicating with supervisors regarding change in condition, including incidents of constipation, nausea, and vomiting, and completion of change of condition forms, InterAct II(Interventions to reduce acute care transfers), when to report to the MD/PA/NP, and following the chain of command.		F	309	documentation in the med records of these residents identification of acute cha condition and notification physician. Necessary follo completed and there are n	to ensure anges of a of ow-up was
	On July 7, 2011, the Coordinator initiated nurses regarding ass specifically related to vomiting, and assess of condition and repo by July 12, 2011 to in and work only weeke available Certified Nueducated on communication of constipation and condition forms and				outstanding concerns. Ad measures put into place to alleged deficient practice recur include: The Interd Team (IDT) will review be reports on a daily basis M through Friday during the meeting to ensure any characteristic and notifica be made based on these retained to the The Director of Nursing, and/or Staff Development Coordinator will review 2	o ensure the does not isciplinary powel fonday IDT ange in ppropriate tions will eviews.
	and Assurance include Administrator, Director Development Coording Management Director conducted at the Brid 2011 at 12:50pm to it regarding the alleged the week of July 11, Assessment and Assure weekly for a period of actions associated were sident status. Goin				reports daily, Monday the Friday, to identify any charesident's condition. Add the licensed nurses will be annually on nursing assess post-change of condition a use of Interact II tools as a for assessment component Preparation and/or execution of this plandmission or agreement by the provide alleged or conclusions set forth in the so The plan of correction is prepared and/required by the provisions of Federal a	ough ange in itionally, e educated sment, assessment, guidelines ts, and an does not constitute or of the truth of the facts statement of deficiencies. for executed because it is

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 309	Director of Nursing, A Services Director, Ad Program Manager, D Coordinator, Resider	plinary Team (including the	F	309	timely intervention inc 911 if initial assessment life threatening event a involvement for identi changes in resident con ensure continued comp	nt indicates and physici fied acute adition to	a	
	those residents having the same deficient particles and efficient particles. Or the potential to be aff deficient practice. Or Nursing began a review of the potential to be aff deficient practice. Or Nursing began a review of the potential of t	it acute changes in condition a, such as constipation, have fected by the alleged and July 7, 2011, the Director of the current residents at the change in condition. On July 7, 2011, the udited the corresponding emedical records of these that a nursing assessment entions were implemented, to the appropriate parties. In the appropriate parties and the sollows: treatment initiated, on, identification of the the correction. Appropriate ments initiated and esidents.			On July 7, 2011, the Q Assessment and Assur Committee, including Administrator, Human Coordinator, Director Resident Care Manage MDS Coordinator, Ma Director, Social Works Director, Therapy Prog Medical Records Coor Dietary Manager to disepisode experienced by on December 4, 2011. Committee also has reacute episode with the Medical Director.	uality ance the facility Resources of Nursing, ment Direct intenance er, Activitic gram Mana dinator, and scuss the act y Resident The viewed this	etor, es ger, d cute #1	
	systemic changes m deficient practice will On July 7, 2011, faci the facility's practice	ures will be put into place or ade to ensure that the not occur: lity initiated reinforcement of for the Interdisciplinary Team or of Nursing, Administrator,			On July 7, 2011, the C reviewed the education Preparation and/or execution of this admission or agreement by the provi alleged or conclusions set forth in th The plan of correction is prepared ar required by the provisions of Federa	n materials plan does not const der of the truth of t e statement of defic d/or executed beca	itute ue facts iencies.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SUI COMPLET	
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F 309	Therapy Program Mai Resident Care Manage Coordinator) to review through Friday, those exhibited acute change that assessments or care documented, intel the attending physicial appropriate by review change of condition for telephone orders. Adjund Care Assignment on these reviews and professionals. On July initiated a mechanism review of the 24-hour changes in condition is and/or charge nurse. Administrator will be cand and initiate further act Quality Assessment a will monitor the process for a period of 4 week	tor, Activities Director, mager, Dietary Manager, mement Director, and MDS of on a daily basis, Monday residents who have mes in condition to assure observations of symptoms rentions were initiated, and mass contacted as ing the 24 hour reports, mas, Bowel records, and mustments to the plan of care Sheets will be made based the input of medical material to account for weekend report, incidents and months to the plan of care sheets will be made based the input of medical material to account for weekend report, incidents and months to the plan of care sheets will be made based the input of medical material to account for weekend report, incidents and months to the plan of care sheets will be made based the input of medical material to account for weekend report, incidents and months to the plan of care sheets will be made based the input of medical material to account for the facility to account for weekend report, incidents and months to account for the facility to account for the facility to account for the facility for a period material the facility	F	Nu rev QA and Co the int	provided to the licensed regarding identification of condition, nursing assess initiation of intervention assessment findings. e Administrator and/or Direct rsing will review data obtained items and report patterns/trenews and report patterns/trenews. A Committee weekly for fill monthly thereafter. The QA mmittee will evaluate the effect above plan, and will add add erventions based on negative entified to ensure continued continued to	of change sment, an s based of tor of ed during ds to the our week &A ectivenes litional outcome	s in d n s s of
	the Director of Nursing Development Coordin all scheduled licensed constitutes a nursing a condition assessment guidelines for assessr timely intervention inc	ator conducted training with nurses regarding what assessment, post-change of use of Interact II tools as nent components, and luding calling 911 if initial a life threatening event and		- 1	Resident identified to be affect eged deficient practice. Preparation and/or execution of this pla admission or agreement by the provider alleged or conclusions set forth in the state of the plan of correction is prepared and/or required by the provisions of Federal and the plan of corrections of Federal and the provisions of Federal	n does not cons of the truth of latement of defi or executed bec	titule the facts ciencies.

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F 309	is used for the identific condition, communicate continuity of care. The Resident Care Manage Development Coordinursing staff education work. This education work. This education facility's new hire orie 2011, scheduled Cert were educated regard when a resident expecondition, including by the nausea, and vomiting Assistants will be provided to being allowed to we in addition, on July 7, rounds process, which Nursing, Resident Ca and/or Staff Development of the general work of the general frequency of the general three times per week include observations, randomly chosen licer residents with the potential condition, acute changes in conditi	condition. The Interact II tool cation of change in ation of those changes and expirector of Nursing, gement Director, or Staff nator will provide all licensed in prior to being allowed to will be included in the intation. Beginning July 7, iffed Nursing Assistants thing notification of the Nurse riences a change in put not limited to constipation, and continued to constipation, and the resident Care Management elopment Coordinator prior book. 2011 the facility's grand in includes Director of the Management Director ment Coordinator, increased for the next four weeks to discussion with four insed nurses regarding ential to have acute identified residents with dition, physician priate, and interventions address the resident's Nursing and Regional functed grand rounds on July ere reviewed to assess for interventions. The Director and Clinical Director also	F3	Preparation and/or execut admission or agreement to alleged or conclusions set The plan of correction is	tion of this plan does not con by the provider of the truth of torth in the statement of det prepared and/or executed be s of Federal and State law.	fthe facts jiciencies.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SU COMPLE	
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F 309	records of these reside of acute changes of complysician. Necessary and there are no outs measures put into pla deficient practice doe Interdisciplinary Team reports on a daily based during the IDT meeting condition is identified, and notifications will be reviews. The Director Staff Development Condition and the IDT meeting condition as the IDT meeting and notifications will be reviews. The Director Staff Development Condition along the IDT meeting condition ally, the license annually on nursing a condition assessment guidelines for assessment guidelines for assessment indicates physician involvement changes in resident compliance. Indicate how the facility ensuring that corrective sustained. The plan in the corrective action endification of the plan in the corrective action endified assurance committee facility Administrator, Idad Startance Committee faci	lents to ensure identification ondition and notification of follow-up was completed tanding concerns. Additional ce to ensure the alleged is not recur include: The in (IDT) will review bowel is Monday through Friday is Monday through Friday is to ensure any change in Appropriate interventions are made based on these of Nursing, RCMD, and/or coordinator will review in Monday through Friday, to resident's condition. It is ed nurses will be educated in the educ	F3	Preparation and/or executio admission or agreement by alleged or conclusions set for The plan of correction is prequired by the provisions.	the provider of the truth o orth in the statement of de epared and/or executed be	the facts ficiencies.

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
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F 309	Management Director Coordinator, Maintena Worker, Activities Director Manager, Medical Red Dietary Manager to diexperienced by Resid 2011. The Committee acute episode with the On July 7, 2011, the Ceducation materials properly to the Administrator and review data obtained of patterns/trends to the for four weeks and more Committee will evalua above plan, and will as based on negative out continued compliance.	r, MDS(Minimum Data Set) ance Director, Social actor, Therapy Program cords Coordinator, and scuss the acute episode ent #1 on December 4, a also has reviewed this a facility's Medical Director. Committee has reviewed the rovided to the licensed g identification of change in essment, and initiation of an assessment findings. Wor Director of Nursing will during reviews and report QA&A Committee weekly bothly thereafter. The QA&A te the effectiveness of the dd additional interventions tecomes identified to ensure was removed on 07/07/2011	F	309			
	confirmed they had re- nursing assessment, u guideline for assessment notify for acute change Documentation was pr in-servicing began on	use of InterAct II tools as ent and when/ whom to es in resident condition. rovided by the facility that 07/07/2011 and copies pols that would be used as					
	IN RANGE OF MOTIC	SE/PREVENT DECREASE DN nensive assessment of a	F 3	318	Preparation and/or execution of this pla admission or agreement by the provider alleged or conclusions set forth in the si The plan of correction is prepared and/o required by the provisions of Federal ar	r of the truth of tatement of def or executed bed	the facts iciencies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	MULTIPLE CONSTRUCTION		RVEY ED
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F 318	resident, the facilit with a limited rang appropriate treatm	y must ensure that a resident e of motion receives ent and services to increase nd/or to prevent further	F 31190 Re	Resident identified to be a ged deficient practice. sident #10 began treatments on 6/7/	nts in the	9-27-1
	by: Based on observatinterviews, the fact restorative service strengthening exerchabilitation deparesidents reviewed. Findings included: 1. Resident #10 w	vas admitted to the facility on	An we and the An Res ser	Residents with the potential the alleged deficient practical audit was conducted of received a control of the discharged from the the referred to the Restorative past 3 months and comply residents who were referentiated by the control of the residents who were referred to the appropriate placed in the appropriated grams.	esidents who erapy program for the Program for the eted on 7/25 erred to restorative ened by thera	n or /11.
	mellitus, osteopore ischemic heart dis fractured femur. The review of the (Minimum Data Se Resident #10 had problems with more decision-making sassistance of one transfers; was on wheelchair for mole the resident was of	kills; required extensive person with bed mobility and a toileting program; and, used a bility. The MDS also indicated nly able to maintain her an assistance; but, had no	The write repart of the paper are and Nur	Systemic Measures therapy department is not tten record of when reside estorative, when the RCA cific to that resident and v erwork is received. The r recording when referrals discussing this with the l se Coordinator as referra therapy department is co Preparation and/or execution of the admission or agreement by the pro alleged or conclusions set forth in The plan of correction is prepared required by the provisions of Fede	ents are refer as are trained when the estorative aid are received Restorative ls are received inducting an is plan does not consti- wider of the truth of the the statement of defice and/or executed becar	red les cd. ute to facts tencies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SUF	
			A. BUILDING			
		345241	B. WING		07/0	8/2011
	ROVIDER OR SUPPLIER ENTER HEALTH & REHA	B/EDEN	2	EET ADDRESS, CITY, STATE, ZIP CODE 26 N OAKLAND AVENUE DEN, NC 27288		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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 318	The review of the fact dated 4/8/11 revealer of 10 indicating the refalls. A review of the Care as approaches: Resident Falling Star Program	e 31 ility's Fall Risk Evaluation d Resident #10 had a score esident was at high risk for Plan dated 4/12/11 included dent #10 was on the facility's ; received Physical Therapy; alarm; and was toileted	F 318, are 4. The the	going audit of residents refetorative program to insure the begun in a timely manner. Quality Assessment and Asset therapy manager will include monitor of referrals to restonthly report to the QA&A (anthly for 3 months, then as	nat service surance ude results prative in t	s of heir
	Resident #10 receive from 4/19/11 to 4/25/ difficulty walking. The Weekly PT Prog dated 4/25/11 indicat discharged from ther	nical records revealed Id PT (Physical Therapy) In for muscle weakness and It for muscle weakness and it for muscle weakness and it for muscle weakness and it for muscle weakness and it for muscle weakness and it for muscle weakness and		Anny 101 D Monais, morras		
	referred Resident #11 daily exercise and staresident's strength ar was to receive the reeach week for twelve signed by the PTA (Fand RNA#1 (Restoral indicating RNA#1 recein the functional mains.)	ated 4/25/11 revealed PT 0 to Restorative Nursing for anding to increase the and flexibility. The resident storative nursing six times weeks. The record was Physical Therapy Assistant) tive Nursing Assistant) treived the caregiver's training attenance program.		Preparation and/or execution of this p admission or agreement by the provic alleged or conclusions set forth in the The plan of correction is prepared an required by the provisions of Federal	ler of the truth of statement of defi d/or executed bec	he facts ciencies.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345241	B. WING_		07/0	08/2011	
	ROVIDER OR SUPPLIER ENTER HEALTH & REHA	AB/EDEN	s	TREET ADDRESS, CITY, STATE, ZIP CODE 226 N OAKLAND AVENUE EDEN, NC 27288			
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 318	A review of the clinic #10 had an unobservattempting an unassi Interventions include a voice recorded ala. The Rehabilitation/R Records (June 7, 20 revealed Resident #1 standing knee bends exercises to both low During an observation Resident #10 was obwheelchair with an a was alert and reveals well. During an interview of Acting DON (Directo process for referrals the Rehabilitative De of the written request Record) to the ADON Nursing) and a copy record the date the received at the top of stated that in reference restorative for Reside Transition Form on 6 the date the therapist Physical Thera	al records revealed Resident yed fall on 5/10/11 while isted transfer from her bed. d changing the bed alarm to rm system. estorative Service Delivery 11 through July 6, 2011) 10 received sit to stand; s; and range of motion	F 31	Preparation and/or execution admission or agreement by the alleged or conclusions set for the plan of correction is preprequired by the provisions of	ne provider of the truth o rth in the statement of de pared and/or executed be	the facts ficiencies.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONST IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SUF	
			1	<u> </u>		
		345241	B. WING		07/0	8/2011
	OVIDER OR SUPPLIER	B/EDEN	1	REET ADDRESS, CITY, STATE, ZIP CODE 126 N OAKLAND AVENUE EDEN, NC 27288		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 318	outlined program. The know why the resider until 6/7/11. During an interview o revealed Resident #1 6/7/11 for range of me extremities and stand bends whenever poss not remember receivitraining from the Rehapril 2011; but confirm the "Rehab To Restorindicating she receive RNA#1 revealed she Restorative Transition and that was when shiften top of the form. 483.70(h)(3) CORRID SECURED HANDRA The facility must equipment for a facility must equipment for a facility falled to secure thalls (300 and 400 Hellar review of the facility in review of the facility and the review of the facility in review of the facility in the review of	estorative aide on the e PTA stated that he did not at did not receive restorative on 7/7/11 at 2:20pm, RNA#1 0 began restorative on otion for bilateral lower to sit exercises; also, knee sible. RNA#1 stated she did not the Care Provider abilitative Department in med it was her signature on rative Transition Record did care provider training. The received the "Rehab a Record" from the ADON are wrote the date of 6/7/11 at DORS HAVE FIRMLY ILS procorridors with firmly leach side.	F 318			
	furthest from resident	rooms. The 100 and 300 alls leading to the dining		Preparation and/or execution of this pl admission or agreement by the provide alleged or conclusions set forth in the The plan of correction is prepared and required by the provisions of Federal a	er of the truth of statement of def /or executed bec	the facts ciencies.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		OMB NO. 0938-0391					
AND PLAN O	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	JLTIPLE CONSTRUCTION DING	(X3) DATE SU COMPLE		
		345241	B. WING)			
NAME OF P	ROVIDER OR SUPPLIER	L.,			07/0	08/2011	
	ENTER HEALTH & REHA	3/EDEN	STREET ADDRESS, CITY, STATE, ZIP CODE 226 N OAKLAND AVENUE				
				EDEN, NC 27288			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHIP CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	On 07/05/11 at 10:18 facility, handrails on the outside resident room outside the staff break loose. On 07/05/11 at 11:30 ochairs were observed 100 and 300 Halls to p to the dining room. On 07/06/11 at 1:12 Pichairs were observed 100 and 300 Halls to p from the dining room. On 07/06/11 at 3:19 Pichairs were observed 100 and 300 Halls to p from the dining room. On 07/06/11 at 3:19 Pichairs were observed 100 and 300 Halls to p from the wall in the staff break room 406 was pulled away from the wall in the staff break room was verified away from the wall in the staff break room 305 was and rail had pulled away inches in two areas who bolted to the panel and wall in the 300 Hall betwithe 400 Hall was visibly away from the wall 1/4ticon 07/07/11 at 3:46 PM Acting Director of Nursi Manager (MM), the MM hall outside resident roof ixed well to the wall. The tails in the 300 Hall outside resident roof ixed well to the wall.	AM, while on tour of the le wall in the 400 Hall 406 and in the 300 Hall room were observed to be AM, residents in wheel using the handrails in the ull themselves on their way AM, residents in wheel using the handrails in the ull themselves on their way AM, the 400 Hall rail outside visibly loose and could be all 1/4th inches. The he 300 Hall outside the sibly loose and could be all 1/4th inches. The he 300 Hall outside loose and the wall panel y from the wall 1/4th ere the rail had been wall. The handrail on the veen the beauty shop and loose and could be pulled in inches. It, while on tour with the mg and the Maintenance stated the hand rail in the wall 406 was loose and not be MM stated the hand side resident room 305,		1 Areas identified to be affered leged deficient practice. The handrail outside room 40 outside the break room, the room 305, and the rail on 300 between the beauty shop and have been attached to the watthey can not be pulled away wall. 2 Residents with the potential affected by the alleged deficipractice. Handrails throughout the 5 control the building have been reattact necessary. 3. Systemic Measures Handrail security has been accommantenance department previous maintenance department previous maintenance program. Handrail checked monthly for 3 month indicated. 4. Quality Assessment and A Preparation and/or execution of this plan admission or agreement by the provider	of, the rail ail outside of hall 400 hall ll so that from the al to be ent corridors of and any hed as lded to the ventive ails will be as, then as	c facts	
	near the beauty shop ar	nd the break rooms were		alleged or conclusions set forth in the sta The plan of correction is prepared and/o required by the provisions of Federal and	r executed because		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 07/22/2011 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING_ 345241 07/08/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 226 N OAKLAND AVENUE **BRIAN CENTER HEALTH & REHAB/EDEN** EDEN, NC 27288 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 468 Continued From page 35 F 46The maintenance supervisor will report loose and not fixed well to the wall. The MM to the Safety Committee monthly for 3 stated the 300 Hall was a high traffic hall for months, then as indicated. residents.

Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by the provisions of Federal and State law.