NOV 2 6 2012

PRINTED: 11/13/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345436	B. WING		10/31/2012
NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	10.01.2012
WELLINGTON REHABILITATION AND	HEALTHCARE		1000 TANDALL PLACE	
The state of the s			KNIGHTDALE, NC 27545	
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID. PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 156 483.10(b)(5) - (10), 483.7 RIGHTS, RULES, SERV The facility must inform to and in writing in a langual understands of his or her regulations governing responsibilities during the facility must also provide notice (if any) of the State §1919(e)(6) of the Act. So made prior to or upon ad resident's stay. Receipt any amendments to it, moviting. The facility must inform elentitled to Medicaid benefor admission to the nursing resident becomes eligible items and services under the which the resident may nother items and services and for which the resident when the items and services spondorm each resident when the items and services and for which the resident may not the resident when the items and services and for which the resident may not the resident when the items and services and for which the resident may not the resident when the items and services and for which the resident may not the resident when the items and services and for which the resident when the items and services and resident when the items and services and resident when the items and services and resident services	the resident both orally age that the resident rights and all rules and sident conduct and e stay in the facility. The the resident with the e developed under Such notification must be amission and during the of such information, and must be acknowledged in the efor Medicaid of the are included in nursing a State plan and for not be charged; those that the facility offers and the facility offers and the changes are made to pecified in paragraphs (5) ion. The each resident before, or and periodically during rvices available in the reservices, or services not covered a facility's per diem rate.	F 15	Preparation and/or execution of this correction does not constitute admit agreement by the provider with the of deficiencies. The plan of correct prepared and/or executed because required by provision of Federal arregulations. F-156 1. Residents #40 and #112 reparties were contacted on 11/14/2012 to confirm the received the Advanced Be Notice mailed by the facil Director of Social Services both confirmed that they be received the notification a confirmation of such was documented in their recorsocial Services tab. 2. Residents receiving Medit benefits who have been deficate from receiving those benefits who have been deficate to confirm acknowledgement of received by the Director Services to confirm acknowledgement of received back in the facility of confirmed receipt was from the notices that had received back in the facility policy and proced regarding Advanced Benefits and received Benefits policy and proced regarding Advanced Benefits policy.	ession or estatement tion is it is ind State esponsible at they had eneficiary ity es. They nad and d under the care iscontinued offits from been of Social ipt of the otice uing mentation obtained not been ty. ducated by the ure

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

program participation.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		345436	B, WIN	െ		10/:	31/2012
	ROVIDER OR SUPPLIER TON REHABILITATION A	ND HEALTHCARE		10	REET ADDRESS, CITY, STATE, ZIP CODE 000 TANDALL PLACE (NIGHTDALE, NC 27545		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 156	A description of the methods, under paragraph of the restablishing eligibited the right to request and 1924(c) which determined to maintaining procedures an equitable second to be considered toward the cost of the medical care in his or down to Medicaid eliging of names, and another such as the Stagency, the State lice ombudsman program, advocacy network, and unit; and a statement complaint with the Stagency concerning restablity, and non-complaint with the Stagency concerning restablity, and non-complaint with the Stagency concerning restablity, and non-complaint with the Stagency concerning restablity and non-complaint with the Stagency concerning restablity and non-complaint with the Stagency concerning the related to maintaining procedures regarding requirements include provide written information concerning the right to or surgical treatment as	anner of protecting personal of (c) of this section; quirements and procedures lity for Medicaid, including passessment under section ines the extent of a couple's at the time of a attributes to the community thare of resources which available for payment institutionalized spouse's her process of spending ibility levels. ddresses, and telephone and State client advocacy at survey and certification insure office, the State the protection and dithe Medicaid fraud control that the resident may file a te survey and certification is ident abuse, neglect, and is ident property in the liance with the advance is. by with the requirements of part 489 of this chapter written policies and advance directives. These provisions to inform and ation to all adult residents accept or refuse medical and, at the individual's divance directive. This		156	3. The Executive Director Office Manager will con Improvement (QI) monit notification to the responsand/or resident of acknown receipt of the Medicare in coverage notice 5 x week weeks, then 3 x weekly for 4 we then 1 x monthly for 9 m Medicare non coverage in be sent via registered/retirequested mail in the event to obtain signature within Medicare A discontinuat 4. The Executive Director/I will report results of QI in to the Performance Improvement Committee monthly x 12 continued compliance an revision. 5. Date of completion 11/28	duct Quality oring of sible party yledged on- ly for 4 or 4 weeks, eks, and onths. The otice will or receipt on of failure 5 days of on. designee nonitoring overnent months for d/or	11 [28]12

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345436	B. WIN	G		10/31/2012	
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F 156	applicable State law. The facility must information, specialty, and physician responsible The facility must promoveritten information, ar applicants for admissinformation about how Medicare and Medica	advance directives and m each resident of the way of contacting the for his or her care. ninently display in the facility and provide to residents and on oral and written	F	156			
	by: Based on documenta facility to acquire a ac Medicare provider nor sampled residents' (The Non coverage no s right to appeal the d of physical, speech or under Medicare. The Medicare must be pro resident/responsible p The non-coverage not appeal decision for se occupational therapy, effective date indicate have to pay for any the received after the date right to appeal decisio that the responsible pe						

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	IULTIP	PLE CONSTRUCTION	(X3) DATE SU COMPLET	
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F 156	end on the effective dand that they may approntacting the QIO(Q) Organization). The QI reviewer authorized be decision to end the set of the tereatment team word plan and the SW woulfollow-up with resident #40 had been once the date had been that billing could be merores. She indicated when the notices were file for Resident #40 in process. She indicated may approve the test of the mental team word plan and the SW woulfollow-up with resident that billing could be merores. She indicated when the notices were file for Resident #40 in process. She indicated when the notices were file for Resident #40 in process.	date indicated on the notice peal the decision by suality Improvement IO is the independent by Medicare to review the services. admitted to the facility on ses included difficulty walking, abnormal posture. The DS) dated 9/12/12, indicated dosome short and long term making problems. Resident tional and therapy services. verage notice identified the as 7/23/12 and the letter 2. There was no signature a responsible person or the notified that the coverage of on the effective date and that they may appeal cting the QIO(quality ation). In 10/31/12 at 11:47AM, the ger indicated that the as responsible for sending a letters. She indicated that the could discuss the discharge ould discuss the discharge of disend the letters and attractional tractions and the sending the appeal do that she was unaware of the sent and the dates on BO	II.	156			

STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING				
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F 156	6/18/12. The non-coverviewed and reveals what was on the fination she did not know who		F 156				
	During an interview on 10/31/12 at 12:35PM, the SW indicated that non-coverage letters was sent for Resident #112 on 6/11/12(end of coverage (6/16/12), he did not have a signed copy of the letter nor was he sure the family/ resident received the letter. He indicated that he did not have a system in place to follow-up to ensure the letter was received or a signature obtained. Resident #40 end date 7/23/12 sent 7/17/12 there was no signature on document and SW indicated that he had not follow-up on whether the residents received the document. There was no response on the process to correlate the discharge dates with the BOM for billing purposes.						
	discharged on 6/18/ difficulty walking, ge rehabilitation service (MDS) dated 5/29/1: #112 had no short o	as admitted on 5/29/12 and 12. Her diagnoses included neral muscle weakness and es. The Minimum Data Set 2, indicated that Resident r long term memory or Resident #112 received lysical therapy.					
	end coverage date a	overage notice identified the as 6/16/12 and the letter was There was no signature that sponsible person or Resident				: : : :	

CLITTEIN	OT OR MEDIONINE C	T	- 1				
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 156	services would end o on the notice and that decision by contacting improvement organiz. During an interview or business office mana SW(social worker) was out the non-coverage once the date had be the treatment team with plan and the SW would follow-up with resider that billing could be more that billing could be more services would be 10 6/18/12. The non-cover reviewed and revealed what was on the finance improved the services would be 10 6/18/12 and	and that the coverage of an the effective date indicated at they may appeal the graph of the QIO (quality ation). In 10/31/12 at 11:47AM, the ger indicated that the as responsible for sending a letters. She indicated that the notes of the discharge ould discuss the discharge ould discuss the discharge ould send the letters and ant/family and inform BOM so nonitored during the appeal and that she was unaware of the sent and the dates on BO andicated that end of /18/12 and Resident #112		156			
	SW indicated that nor for Resident #112 on (6/16/12), he did not letter nor was he sure received the letter. He have a system in place letter was received or Resident #40 end date.	e indicated that he did not be to follow-up to ensure the a signature obtained. to 7/23/12 sent 7/17/12 there document and SW indicated		mila de desir de la companio de la c			ANALONINA SINCERNA CANADA CANA

CENTER	S FOR MEDICARE & I	MEDICAID SERVICES				1	. 0000 0001	
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 156	Continued From page residents received the response on the proc discharge dates with purposes.	e document. There was no ess to correlate the	F	156				
F 241 SS=E	administrator indicates SW would send their certified and SW expethe resident/family rephone call. Review the Social woresidents neither residents neither residents neither resident/RP received 483.15(a) DIGNITY AINDIVIDUALITY The facility must promanner and in an emenhances each resident recognition of his This REQUIREMENT by: Based on observation facility failed to maintain there are no signs possible where oth can see confidential information for 24 of (Resident #15, #74, #74, #74, #74, #74, #74, #74, #74	note care for residents in a vironment that maintains or ent's dignity and respect in or her individuality. It is not met as evidenced an and staff interview the ain an environment in which ested in residents' rooms that er residents and/or visitors clinical or personal 52 sampled residents. #89, #43, #51, #37, #104, #18, #38, #19, #22, #80, #41,	I.	241	F-241 1. The signage was ren resident #15's room Consents were obtain 15, 74, 89, 43, 51, 33, 57, 29, 18, 38, 19, 22, 71, 21, 72, 20, and 8 falling star used as a facility's fall risk prowere also obtained for 89, 43, 51, and 15 to hummingbird icon us identifier in the facility of their dietary restricts.	on 10/31/2012. ned for residents 7, 104, 85, 53, 2, 80, 41, 62, 58, 8 to have a part of the gram. Consents or residents 74, have a ed as an ty to alert staff		

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F 241	observed on the wal #15. The sign identificad: "float heels where Hose To Right Foot stated above on 10% 10/30/12 at 10:00am. An interview with nutersident #15's bed who was a falling staresident rooms. Resident rooms. Re	2:59:49 AM a sign was I over the bed of resident ied the resident by name that en in bed. No shoes or Ted The sign was observed as 29/12 at 3:00PM and on in. The sign was observed as 29/12 at 3:00PM and on in. The sign on the wall over was placed there by the facility 10/28/12 at 9:30am a far was observed next to 21 fitted next to the entrance to fitted next to the entrance to fitted next to their names. The fitted next to their names observed on 10/29/12, fitted next to resident names fitted names are to their rooms. The fitted names are to their names fitted names are to the to	F	241	2. An audit of current residence completed by the MDS Cand Dietary Manager to a consents were obtained for needing a care identifier. The Interdisciplinary Tereducated by the Executive on the facility policy and regarding Resident Care and need for consent to at the time of implement identifiers. The education provided to newly hired the orientation process. 3. The DCS or Unit Manages conduct Quality Improvement identifier 5 x weekly for then 3 x weekly for then 3 x weekly for 4 weeks, and monthly for 9 months. 4. The DCS or Unit Manages report results of QI mon Performance Improvement Committee monthly x 12 continued compliance and revision. 5. Date of completion 11/2	Coordinator ensure for residents 10/30/2012. In was we Director I procedure Identifiers be obtained ation of care in will be staff during ger will ement (QI) identifiers to en obtained fing the 4 weeks, eeks, then I and then 1 x ger will itoring to the ent 2 months for ind/or	11/28/12

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	PENTR JOHNOUTHORNELL	A. BUILDING			
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F 309 SS=D	An interview with the 11:00am that signag resident safe and so for resident. A pictur the resident was on 483.25 PROVIDE C. HIGHEST WELL. BE Each resident must provide the necessal or maintain the high mental, and psychologaccordance with the and plan of care. This REQUIREMENT by: Based on observation interview, the facility for a resident in a was sampled residents. Findings included: Resident #28 was a 10/3/11. Active diag Parkinson, hyperter A review of the ann 8/28/12 revealed resident	their names beside the ms. ADON on 10/28/12 at e was used for keeping new staff knew how to care e of a hummingbird indicated nectar thick liquids. ARE/SERVICES FOR ING receive and the facility must ry care and services to attain est practicable physical, social well-being, in comprehensive assessment IT is not met as evidenced on, record review and staff railed to provide positioning heel chair for one of 3	F 241	F-309 1. Resident #28 is position wheelchair utilizing a p prevent leaning to the lewhen out of bed. 2. An audit of current residents are positioning concerns have referred to therapy for so All nursing personnel we educated by the DCS or Manager and/or Therapy on proper wheelchair positioning on 11/20/12. facility department manabeen educated on proper wheelchair positioning of 11/16/2012. This educated be presented to newly his during the orientation proper.	illow to off daily dents was and Unit to sitioned selchair. air we been creening. ere Unit Director sitioning of proper The agers have n ion will red staff	

F 309 Continued From page 9 identified. Bed mobility was with extensive assist with one person. Activities of daily living require extensive assist with 1 person. A review of the current care plan dated 9/10/12 identified a problem of fragile skin prone to skin tears. The interventions included reposition every round and as necessary and use pillows or other supportive/protective devices to assist with positioning. A review of the kardex used by the nursing aides providing care for Resident #28 identified she was to be repositioned every 1 to 2 hours. On 10/29/12 at 10:23am Resident #28 was observed sitting in a wheel chair leaning to the left side of chair, a family member placed a pillow in the wheel chair to straighten resident up. He stated that she is always leaning and the staff do TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) The department managers will monitor wheelchair positioning during daily monitoring rounds. The Customer Care Liaison will monitor wheelchair positioning on weekends. 3. The DCS or Unit Manager will conduct Quality Improvement (QI) monitoring of proper wheelchair positioning 5 x weekly for 4 weeks, then 1 x weekly for 4 weeks, then 1 x wonthly for 9 months. 4. The DCS/Designee will report results of QI monitoring to the Performance Improvement Committee monthly x 12 months for continued compliance and/or revision.	CENTERS FOR MEDICARE & MEDICAID SERVICES					T OIVID	10. 0530-0351	
NAME OF PROVIDER OR SUPPLIER WELLINGTON REHABILITATION AND HEALTHCARE WELLINGTON REHABILITATION AND HEALTHCARE WELLINGTON REHABILITATION AND HEALTHCARE C(4) ID SUMMARY STATEMENT OF DESICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FOR PROPRIES PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY? TAG PROPRIES PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY? THE department managers will monitor wheelchair positioning during daily monitoring rounds. The Customer Care Liaison will monitor wheelchair positioning on weekends. The DCS or Unit Manager will conduct Quality improvement (Q1) monitoring of proper wheelchair positioning. A review of the kardex used by the nursing aides providing care for Resident #28 identified she was to be repositioned every 1 to 2 hours. On 10/29/12 at 10:23am Resident #28 was observed sitting next to her bed in a broda wheelchair. She was learning toward the loft side of the chair; there was no positioning device in place. On 10/31/12 at 11:20am Resident #28 was observed sitting in a broda wheelchair resident was observed observed stiting in a broda wheelchair with her head resting against the side of the chair; there was no positioning device in place. On 10/31/12 at 11:20am Resident #28 was observed stiting in a broda wheelchair rest to the								
WELLINGTON REHABILITATION AND HEALTHCARE 1000 TANDALL PLACE KNIGHTDALE, NC 27545 100 TANDAL PLACE KNIGHTDALE, NC 27545 100 TANDALD PLACE KNIGHTDALE, NC 27545 100 TANDAL PLACE KNIGHTDALE, NC 27545 100 TANDALE PLACE KNIGHTDALE, NC 27545 100 TANDAL PLACE KNIGHTDALE, NC 27545		•	345436	B. WIN	IG		10/31/2012	
F 309 Continued From page 9 identified. Bed mobility was with extensive assist with one person. Activities of daily living require extensive assist with 1 person. A review of the current care plan dated 9/10/12 identified a problem of fragile skin prone to skin tears. The interventions included reposition every round and as necessary and use pillows or other supportive/protective devices to assist with positioning. A review of the kardex used by the nursing aides providing care for Resident #28 was observed sitting in a wheel chair learning to the left stated that she is always learning toward the left side of their, a family member placed a pillow in the was no positioning device in place. On 10/31/12 at 11:20am Resident #28 was observed sitting in a broda wheelchair, she was learning toward the left side of the chair with her head resting against the side of the chair with her head resting against the side of the chair was no positioning device in place. On 10/31/12 at 11:20am Resident #28 was observed sitting in a broda wheelchair next to the			ND HEALTHCARE		10	000 TANDALL PLACE		
Continued From page 9 identified. Bed mobility was with extensive assist with one person. Activities of daily living require extensive assist with 1 person. A review of the current care plan dated 9/10/12 identified a problem of fragile skin prone to skin tears. The interventions included reposition every round and as necessary and use pillows or other supportive/protective devices to assist with positioning. A review of the kardex used by the nursing aides providing care for Resident #28 identified she was to be repositioned every 1 to 2 hours. On 10/29/12 at 10:23am Resident #28 was observed sitting in a wheel chair leaning to the left stated that she is always leaning and the staff do not always put the pillow in place. On 10/3012 at 9:45Am resident was observed sitting next to her bed in a broda wheelchair. She was leaning toward the left side of the chair; there was no positioning during daily monitoring rounds. The Customer Care Liaison will monitor wheelchair positioning during daily monitoring rounds. The Customer Care Liaison will monitor wheelchair positioning on weekends. 3. The DCS or Unit Manager will conduct Quality Improvement (QI) monitoring of proper wheelchair positioning 5 x weekly for 4 weeks, then 1 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. 4. The DCS/Designee will report results of QI monitoring to the Performance Improvement Committee monthly x 12 months for continued compliance and/or revision. 5. Date of completion 11/28/2012	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	HOULD BE	COMPLETION
of chair; no positioning device was in place. A review of the physician orders revealed a order listed on the October 2012 monthly pre-printed order sheet with an original date of 12/19/11 that read may use neck collar for head positioning. An interview with the nurses aide (NA) #1 on 10/31/12 at 10:31am revealed that she provided care daily for Resident #28. NA#1 indicated that	F 309	identified. Bed mobility with one person. Active extensive assist with A review of the currer identified a problem of tears. The intervention round and as necessal supportive/protective positioning. A review of the karded providing care for Research was to be repositione. On 10/29/12 at 10:23 observed sitting in a vide of chair, a family the wheel chair to strastated that she is always not always put the pill On 10-3012 at 9:45A sitting next to her bed was leaning toward the head resting again there was no position on 10/31/12 at 11:20 observed sitting in a bed leaning to left with of chair; no positioning A review of the physical listed on the October order sheet with an or read may use neck continuous and interview with the situation of the continuous with the situation of the physical listed on the October order sheet with an or read may use neck continuous and the physical listed on the October order sheet with an or read may use neck continuous and the physical listed on the October order sheet with an or read may use neck continuous and the physical listed on the October order sheet with an or read may use neck continuous and the physical listed on the October order sheet with an or read may use neck continuous and the physical listed on the October order sheet with an or read may use neck continuous and the physical listed on the October order sheet with an or read may use neck continuous and the physical listed on the October order sheet with an order of the physical listed on the October order sheet with an order of the physical listed on the October order sheet with an order of the physical listed on the October of the physica	y was with extensive assist vities of daily living require 1 person. In care plan dated 9/10/12 of fragile skin prone to skin mis included reposition every ary and use pillows or other devices to assist with It used by the nursing aides sident #28 identified she devery 1 to 2 hours. It am Resident #28 was wheel chair leaning to the left member placed a pillow in aighten resident up. He ays leaning and the staff do low in place. In resident was observed in a broda wheelchair. She is left side of the chair with mist the side of the chair; ling device in place. It am Resident #28 was broda wheelchair next to the the her head resting on side godevice was in place. It is a date of 12/19/11 that ollar for head positioning. In the revealed that she provided		309	monitor wheelchair posi during daily monitoring The Customer Care Liai monitor wheelchair posi weekends. 3. The DCS or Unit Manage conduct Quality Improve (QI) monitoring of proper wheelchair positioning 5 for 4 weeks, then 3 x we weeks, then 1 x weekly the weeks, and then 1 x mon months. 4. The DCS/Designee will results of QI monitoring Performance Improvement Committee monthly x 12 for continued compliance revision.	cioning rounds. con will cioning on ger will coment or x weekly for 4 for 4 for 4 for 9 for to the int months and/or	11/28/12

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPE	E CONSTRUCTION	(X3) DATE SUR\		
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETE		
		345436	B. WNG		10/31	/2012	
	OVIDER OR SUPPLIER	AND HEALTHCARE	10	EET ADDRESS, CITY, STATE, ZIP CODE 100 TANDALL PLACE NIGHTDALE, NC 27545			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 315	discussion revealed on her side and she position her in the will on when she is active and stand up. I only sleeping." 483.25(d) NO CATH RESTORE BLADDE Based on the reside assessment, the fact resident who enters indwelling catheter is resident's clinical concatheterization was who is incontinent of treatment and service infections and to resident's clinical concatheterization was who is incontinent of treatment and service infections and to resident's clinical concatheter in the service infection as possible. This REQUIREMENT by: Based on medical restate for one of the catheter for one of the catheter for one of the catheters (Resident was admitted and 3/9/1 included: Diabetes Chronic pain syndromancer. Diagnoses indwelling urinary contains and the will be catheters of the	ent every 2 hours. Further that a pillow was used to put had a neck brace to help heelchair. "I do not put them e, she will use them to try put them in when she is ETER, PREVENT UTI, ER It's comprehensive ility must ensure that a the facility without an s not catheterized unless the indition demonstrates that necessary; and a resident of bladder receives appropriate testore as much normal bladder exister as much normal bladder IT is not met as evidenced record review, resident and acility failed to provide a for the use of a urinary wo residents with urinary #39). Findings include: Itted to the facility 1/13/12 and 2. Cumulative diagnoses Mellitus, Hypertension, ome and history of prostate also included the use of an atheter (suprapubic catheter).	F 315	F-315 1. A diagnosis of Urinar was received for residents wit catheters have been resure there is a diag supporting continued and an order for use Current licensed nurseducated on the acce condition to utilize a catheter and need for order to care for the catheter. 3. The DCS or Unit Maconduct Quality Impart (QI) monitoring suppedocumentation and ocaring for the urinary weekly for 4 weeks, the weekly for 4 weeks, the weekly for 4 weeks, a monthly for 9 months admission charts and orders will be review identify any new order urinary catheters.	tent #39 on th urinary eviewed to nosis I catheter use in place. ses were ptable clinical urinary physician urinary anager will rovement porting rders for catheter 5 x then 3 x then 1 x and then 1 x s. New telephone ed daily to		
	A Significant Chang	je Minimum Data Set (MDS)			• •	1	

CENTERS FOR MEDICARE & MEDICARD SERVICES		OVER THE PERSON OF THE PERSON			(X3) DATE SURVEY		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		345436	B. WIN	IG		10/3	1/2012
	OVIDER OR SUPPLIER	ND HEALTHCARE		10	EET ADDRESS, CITY, STATE, ZIP CODE 100 TANDALL PLACE NIGHTDALE, NC 27545		
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F 315	mild cognitive impairindwelling urinary cat MDS. A Quarterly MDS dat #39 had an indwelling. A Care plan dated 3/9/17/12 indicated Reindwelling urinary cat ongoing assessment character of urine; or symptoms of urinary catheter and tubing to thigh to prevent pushift; encourage fluickinks or twists in tubic On 7/30/12, a physic Resident #39 had ble blood clots in the uring change indwelling cathematuria (blood in trauma with movement A review of Resident revealed there was reindwelling urinary cathematuria as pecific did the indwelling urinary cathematuris were noted. On 10/29/12 at 10:50	red Resident #39 displayed ment. The use of an inter was noted on the red 9/5/12 indicated Resident gurinary catheter. 28/2012 and last reviewed sident #39 used an theter. Approaches included: of color, clarity and regoing assessment for tract infection; change every 4 weeks; secure tubing ulling, catheter care every lintake; monitor tubing for ing. sian's progress note indicated cod tinged urine and small mary drainage bag. Urology: atheter, irrigate bladder, urine) secondary to catheter	F	315	Education will be provide newly hired licensed nurse the orientation process. 4. The DCS/Designee will reresults of QI monitoring to Risk Management/Quality Improvement (RM/QI) Comonthly x 12 months for continued compliance and revision. 5. Date of completion 11/28/	eport to the minittee	11/28/12
		a catheter in his bladder.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	JLTIPL	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.	A. BUIL	DING					
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	ROVIDER OR SUPPLIER	AND HEALTHCARE							
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F 315	F 315 Continued From page 12 On 10/31/12at 9:59 AM., Resident #39's primary physician stated Resident #39 had chronic hematuria (blood in urine) and problems with		F	315					
F 329 SS=D	obstruction due to prefurther indicated he will indicated he will indicated he will indicated he was unaware there was unaware there was unaware there will indicate of the indicated as needed. On 10/31/12 at 5:15 stated there should will use of the indicated will be university. 483.25(I) DRUG RE UNNECESSARY DRUG UNNECESSARY DRUG Unnecessary drugs.	rostate cancer history. He would recommend the se changed on an "as sident #39's physician said he was not a physician's order theter or for the catheter to be by the nursing staff. PM., the Director of Nursing be a physician's order for the catheter (suprapubic) GIMEN IS FREE FROM RUGS g regimen must be free from An unnecessary drug is any excessive dose (including)	L.	329	F-329 1. Resident # 15 and antipsychotic medidiscontinued by the 2. Current residents reantipsychotic mediantipsychotic	cation has been e physician. eceiving			
	without adequate mindications for its us adverse consequent should be reduced a combinations of the Based on a compresident, the facility who have not used given these drugs utherapy is necessar as diagnosed and drecord; and resident drugs receive gradu	drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically			been reviewed by the Clinical Services and Manager. An audith to ensure there was supported for continued use of an interest of the medication without reduction. Three graductions and eighth were initiated by the 11/16/2012. Current licensed medicated on the reduction in the reducated on the reduction of the reducated on the r	the Director of and Unit was completed a diagnosis inued use of the ed for risk ement for an antipsychotic ta dose radual dose at eliminations are physician on urses were			

STATEMENT OF DEFICION STATEMENT OF DEPLOYERS (CP) PRODUCES PROPERLY (CROSS-METERS) (CP) PROVIDER OR SUPPLIED (CACH DEFICIENCY MUST BE PRECEDED BY FULL PERCY (CROSS-METERS)	CENTER	S FUR WEDICARE &	VILDICAID SERVICES	(X3) MULTIPLE CONSTRUCTION (X3) DAT		DVALDATE CLIDVEY			
STREET ADDRESS, CITY, STATE, 2IP CODE 1000 TANDALL PLACE WELLINGTON REHABILITATION AND HEALTHCARE ### WINDTHCARE ### WELLINGTON REHABILITATION AND HEALTHCARE ### WINDTHCARE ### WINDTHCARE	STATEMENT OF DEPOSITION IN IDENTIFICATION NUMBER:			1''		(X3) DATE SURVEY COMPLETED			
### PRESENCE TO THE PROPERTY OF THE PROPERTY O		345436				10/31/2012			
F 329 Continued From page 13 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to have documentation which included the benefits versus the risk for continued dust of 10 sampled residents. (Resident #15 & rad) The facility on 8/10/12. Diagnoses included but not limited to hypertonsion, cardiovascular accident, contracture right hand, dysphagia, histal hernia, anemia, abnormal posture, depression and anxiety. A review of the physician orders for the month of October 2012 revealed an order for Resperidal 0.25mg take 1 tab daily. The original date of order was 1/30/12. A review of Resident #15's medical record had no documentation of a diagnoses for the use of a flagnoses for the use of allocation was 1/30/12. A review of Resident #15's medical record had no documentation of a diagnoses for the use of				1000 TANDALL PLACE					
contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to have a diagnoses for the use of antipsychotic medications (Respiredal) and Seroquel) for 2 of 10 residents. (Resident #15 & #74) Findings include: Resident #15 was admitted to the facility on 8/10/12. Diagnoses included but not limited to hypertension, carciflowscular accident, contracture right hand, dysphagia, histal hernia, anemia, abnormal posture, depression and anxiety. A review of the physician orders for the month of October 2012 revealed an order for Resperidal 0.25mg take 1 tab daily. The original date of order was 1/30/12. A review of Resident #15's medical record had no documentation of a diagnoses for the use of	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI	OULD BE COMPLETION			
Respirdal.	F 329	contraindicated, in an drugs. This REQUIREMENT by: Based on observation interview, the facility for the use of antipsy (Respirdal) and Seron (Resident #15 & 74) have documentation versus the risk for contipsychotic medical reduction for 1 of 10 of (Resident #15 & #74). Findings include: Resident #15 was ad 8/10/12. Diagnoses in hypertension, cardious contracture right han anemia, abnormal polanxiety. A review of the physical October 2012 revealed 0.25mg take 1 tab day was 1/30/12. A review of Resident documentation of a contracture of the physical contracture right han anemia, abnormal polanxiety.	is not met as evidenced in, record review and staff failed to have a diagnoses chotic medication quel) for 2 of 10 residents. The facility also failed to which included the benefits intinued use of an tion with out a dose sampled residents. Imitted to the facility on included but not limited to vascular accident, d, dysphagia, hiatal hernia, insture, depression and cian orders for the month of ed an order for Resperidal ally. The original date of order #15's medical record had no	F 329	appropriate diagnosis with behavior monitor on 11/20 3. The DCS or Unit Manage conduct Quality Improver (QI) for new orders for antipsychotic medications received 5 x weekly for 4 then 3 x weekly for 4 weeks, at 1 x monthly for 9 months. consultant Pharmacist will diagnosis and gradual dos reductions of residents recantipsychotic medications monthly and report discreto the attending physician. 4. The DCS or Unit Manage report results of QI monitor Performance Improvement Committee monthly x 12 for continued compliance revision. The consultant Pharmacist will report to to committee quarterly on compliance to diagnosis at gradual dose reduction.	or will nent weeks, ks, then nd then The l review e eiving pancies r will oring to t months and/or he			
		Respirdal.							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		345436	B. WNG		10/31/2012			
	NAME OF PROVIDER OR SUPPLIER WELLINGTON REHABILITATION AND HEALTHCARE			REET ADDRESS, CITY, STATE, ZIP CODE 000 TANDALL PLACE (NIGHTDALE, NC 27545)E			
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F 329	10/31/12 at 1:00pm r a diagnoses or media residents chart for the Resident #74 was ad 3/8/12. The active dia hypertension, demendant of October 20 Seroquel 25mg eventariant was admitted as a review of the media resident was admitted as a review of the media resident was no document the use of Seroquel. An interview with the on 10/31/12 at 3:15p diagnoses for the use director of nursing in reviewed the resident was diagnoses available. 2. Resident #15 was 8/10/12. Diagnoses in hypertension, cardio contracture right han anemia, abnormal polanxiety. A review of the media revealed a pharmacy 8/11/12 that recommends.	director of nursing on evealed that she did not see cal justification in the e use of Respirdal. Imitted to the facility on agnoses were listed as atia and depression. In physician orders for the 11 revealed an order for y hours of sleep (hs). cal record revealed the d to the facility on Seroquel. medical record revealed entation of a diagnoses for assistant director of nursing m confirmed there was no e of Seroquel. The assistant dicated that she had ats medical record and there able. admitted to the facility on included but not limited to vascular accident, id, dysphagia, hiatal hernia, osture, depression and cal record for Resident #15 y consultation report dated ended a dose reduction for hysicians' response was that	F 329					

OLIVILIA	STON MEDICANE &	WEDICAID SERVICES				1	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED 10/31/2012	
		345436 B. WING					
NAME OF PROVIDER OR SUPPLIER WELLINGTON REHABILITATION AND HEALTHCARE				10	EET ADDRESS, CITY, STATE, ZIP CODE 00 TANDALL PLACE NIGHTDALE, NC 27545		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	refused any further remedication. The resp discussion was done Further review of the there was no docume weighted the risks in available. An interview with the 10/31/12 at 1:00pm of find any documentation indicating the benefits weighted the risks as medication. 483.30(e) POSTED NINFORMATION The facility must post a daily basis: o Facility name. o The current date. o The total number at by the following category unlicensed nursing stresident care per shift Registered nurse a conception of Resident census. The facility must post specified above on a of each shift. Data me	angers in medication and she eduction in dosing of onse also stated this via a phone call. Imedical record revealed entation of the benefits out the use of Respirdal was director of nursing on evealed that she could not on in Resident #15's chart is of the use of Respirdal out sociated with the NURSE STAFFING If the following information on the entation of licensed and faff directly responsible for it: es. cal nurses or licensed adding the entated and		329	F-356 1. Daily staffing with accurate information is posted daily. 2. No residents were identified 3. The Director of Clinical Servential Manager, was educated requirements of posting accurate complete staffing information include census on a daily base the Nursing Home Administ. The Weekend Supervisor and licensed nurses were educated regarding posting of daily stable by the Director of Clinical Services and/or Unit Manage. 4. A quality improvement tool be completed by the Nursing Home Administrator or designally 5x/week x 2 weeks, the	vices, to the arate, n to sis by rator. d affing er will g gnee	
·	o Clear and readable o In a prominent plac	format. e readily accessible to			3x/week x 2 weeks, then we		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED			
		345436	B. WIN	B. WING		10/31/2012	
	NAME OF PROVIDER OR SUPPLIER WELLINGTON REHABILITATION AND HEALTHCARE			10	EET ADDRESS, CITY, STATE, ZIP CODE 000 TANDALL PLACE NIGHTDALE, NC 27545		
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F 356	make nurse staffing of for review at a cost no standard. The facility must main staffing data for a min required by State law. This REQUIREMENT by: Based on observation facility failed to have to posted in the facility for Findings include: On 10/28/12 during the daily staffing hours we the facility. On 10/29/morning of 10/31/12 reposerved posted within On 10/28/12 at 11:500 Nursing brought in a conference room. An interview with the 10/30/12 at 2:00pm restaffing hours were us stated that the staffing in the facility stand up have not had a standing the staffing hours were us stated that the staffing in the facility stand up have not had a standing the staffing hours were us staffing the facility stand up have not had a standing the staffing hours were us staffing the facility stand up have not had a standing the staffing hours were us staffing the facility stand up have not had a standing the staffing hours were us staffing the facility stand up have not had a standing the staffing hours were us staffing the facility stand up have not had a standing the staffing the staffing the facility stand up have not had a standing the staffing the s	n oral or written request, lata available to the public of to exceed the community of the exceed the community of the exceed the community of the posted daily nurse simum of 18 months, or as whichever is greater. is not met as evidenced of an and staff interview the sine daily staffing hours or 1 of 1 required posting. The initial tour of the facility note encountries of the facility. The initial tour of the facility note of the facility. The initial tour of the facility note of the facility. The initial tour of the facility note of the facility and the facility. The initial tour of the facility note of the facility hours were in the facility. The initial tour of the facility note of the facility hours were in the facility. The initial tour of the facility note of the facility hours were in the facility. The initial tour of the facility note of the facility hours were in the facility. The initial tour of the facility note of the facility hours were in the facility.	it.	356	4weeks and then one time monthly for 9 months to ensur daily staffing posting is accurant complete. 5. The Nursing Home Administrator or designee will report the results of the Qualit Improvement tool to the Performance Improvement committee monthly x 3 month identify trends and need for further education and/or monitoring. Date of completice 11/28/2012	ate II ty ns to	1/28/12

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S COMPL	
		345436	B, WNG)	10/31/2012	
	OVIDER OR SUPPLIER	AND HEALTHCARE		STREET ADDRESS, CITY, STATE, ZIP COD 1000 TANDALL PLACE KNIGHTDALE, NC 27545	E	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENCE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE		LE CONSTRUCTION (X3) DATE COMP		
		345436	B. WING			11/2	27/2012
	SUMMARY STA	ON AND HEALTHCARE TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	1000 TAND	RESS, CITY, STATE, ZIP COD DALL PLACE DALE, NC 27545 PROVIDER'S PLAN OF CORP EACH CORRECTIVE ACTION S DSS-REFERENCED TO THE A	RECTION SHOULD BE	(X5) COMPLETION DATE
K 012 SS=D	Building construction	FETY CODE STANDARD on type and height meets one .1.6.2, 19.1.6.3, 19.1.6.4,	K 01	correcti agreem of defic prepare required regulati	ation and/or execution of the state of the provider with the provider with the provider with the stand of correct and/or executed becaused by provision of Federal tons.	mission or the statement rection is te it is	
K 018 SS=D	A. Based on obserwere holes around thesprinkler riser roheater room. 42 CFR 342.80 (a) NFPA 101 LIFE SA Doors protecting corequired enclosures hazardous areas anthose constructed owood, or capable of minutes. Doors in sequired to resist the no impediment to that are provided with a the door closed. Duare permitted.	s not met as evidenced by: vation on 1/27/2012 there pipes penatrating the ceiling in om and the kitchen water FETY CODE STANDARD rridor openings in other than s of vertical openings, exits, or e substantial doors, such as if 1% inch solid-bonded core resisting fire for at least 20 sprinklered buildings are only e passage of smoke. There is e closing of the doors. Doors means suitable for keeping atch doors meeting 19.3.6.3.6 3.6.3 rohibited by CMS regulations ellities.	K 01	8 2.	The Maintenance Dire fire caulking and dry with pipes in the sprinkly and the kitchen water lon 12/18/2012. An audit was complete Maintenance Director all areas around the homeaters were sealed to K012. The Maintenance Director conduct Quality Impro (QI) monitoring of this weekly for 4 weeks, the weekly for 4 weeks, an monthly for 9 months. The Maintenance Director report results of QI months for the Risk Management/Improvement (RM/QI) monthly x 12 months for compliance and/or revidence of completion 12/2	yall around ler riser room heater room hea	12/31/12
				K018	The Maintenance Directhe latch on the MDS of so it will latch in according to the MDS of	ctor enlarged	12/18/12
ABORATORY	OBECTOR'S OR PROVIDE	ER/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE	1	TITLE	•••	(X6) DATE

Any deficiency schement 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.

If continuation sheet Page 1 of 2

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE COMI A. BUILDING 01 - MAIN BUILDING 01				E SURVEY PLETED	
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WELLINGTON REHABILITATION AND HEALTHCARE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	OOO TANI	RESS, CITY, STATE, ZIP CODE DALL PLACE DALE, NC 27545 PROVIDER'S PLAN OF CORRECTACH CORRECTIVE ACTION SHO	ULD BE	(X6) COMPLETION DATE		
K 018	Continued From particles STANDARD is A. Based on observator the MDS office far 42 CFR 483.70 (a) NFPA 101 LIFE SAR Required automatic continuously maintal condition and are in periodically. 19.7. 25, 9.7.5	s not met as evidenced by: vation on 11/27/2012 the door illed to latch. FETY CODE STANDARD sprinkler systems are ined in reliable operating spected and tested 6, 4.6.12, NFPA 13, NFPA a not met as evidenced by: vation on 11/27/2012 the	K 018	2. 3 4 5 K062 1. 2	An audit was completed by Maintenance Director to en accordance with K018. The Maintenance Director conduct Quality Improvement of the Risk Management/Qualimprovement (RM/QI) Composition of the Completion 12/31/20 A 5 Year Obstruction Test is scheduled for 12/20/2012. An audit was completed by Maintenance director to ens All other tests required to the sprinkler system had been scheduled. The Maintenance Director conduct Quality Improvement of the Risk Management/Qualimprovement of the Risk Management/Qualimprovement of completion 12/31/20 A 5 Year Obstruction Test is scheduled for 12/20/2012. An audit was completed by Maintenance director to ens All other tests required to the sprinkler system had been scheduled. The Maintenance Director wonduct Quality Improvement of this standard weekly for 4 weeks, and the monthly for 9 months. The Maintenance Director report results of QI monitor the Risk Management/Qual Improvement (RM/QI) Composition of compliance and/or revision Date of completion 12/31/20	y the nsure will nent (QI) I x nen I x will ring to lity mmittee ontinued to 012. is the sure ne will ent (QI) 2 x en I x will ring to lity mmittee ontinued	12/31/12		