| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| THE REHAB AND HC CTR AT VILLAGE GR | 1601 PURDUE DRIVE FAYETTEVILLE, NC 28304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 244 SS=D | 483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION | F 244 | | |

When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

This REQUIREMENT is not met as evidenced by:
Based on record review, resident interview and staff interviews, facility failed to respond on Resident Council grievance of food being served cold regularly.

The findings include:

During the interview with the Resident Council representative on 12/19/2012 at 1:21 PM, he stated that the food was always served cold at the facility. He added the worst time was in the morning as the breakfast was always served cold

Review of the Resident Council minutes for the month of July 2012 revealed coffee was always served cold. Further review of the Resident Council minutes revealed the facility did not follow up with the residents ' grievance of coffee being cold.

Review of the Resident Council minutes for the month of October 2012 revealed breakfast, lunch and dinner were " reliably " served cold. Further review of the Resident Council minutes revealed the facility did not follow up with the residents '

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For those residents that have received cold food and coffee, the Dietary Manager explained to them that coffee will be placed in a thermos, and poured per request for coffee as each tray is delivered to the residents. For those residents that received cold food, the dietary manager ordered new cups, bowls, and bases to ensure they items hold heat more efficiently. 1/16/13

For those residents having the potential to be affected, the Dietary manager or designated person will check food temps of all 4 tray carts daily for one week, then weekly for three weeks. The dietary manager ordered new bowls, cups, and bases to ensure the items will hold temperature more efficiently. 12/20/12

The Dietary Manager addressed the concerns of cold food and beverages with the Resident Council Representative. 12/20/12

A Resident Council Meeting was held to enable the dietary manager to follow up with the Resident Council regarding the concerns of cold food and coffee. The dietary manager explained the steps he was taking to ensure food and coffee was no longer cold. 12/20/12

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| [signature] | LNHA | 1/16/13 |

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.

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| F 244 | Continued From page 1<br>grievance of the food being served cold.<br><br>Review of the Resident Council minutes for the month of November 2012 documented under dietary " food still coming cold at times. " Further review of the Resident Council minutes revealed the facility did not follow up with the residents grievance related to this concern.<br><br>During the interview on 12/19/2012 at 1:00 PM, the Dietary manager reported he did not follow up with the residents ' council grievance of the food being cold for the months of July 2012, October 2012 and November 2012. The dietary manager further reported that next time he would make sure he follows up with residents' concerns of the food being served cold.<br><br>During interview with Administrator on 12/19/2012 at 1: 15 PM, she reported that her expectation was for the Dietary manager to have followed up with residents ' council grievances of food being served cold for the months of July 2012, October 2012 and November 2012. The Administrator further stated she will make sure next time all the grievances concerning food being cold from the Resident Council will be brought up to her attention and followed up with promptly. | F 244 | The Activity Director received inservice training on following up on all concerns brought up in Resident Council Meetings and to document what was done in the meeting minutes.<br><br>The Meeting Minutes for Resident Council have been revised to include a section for follow-up on any previous concerns. The Administrator will review the monthly meeting minutes to ensure all concerns have been followed up on.<br><br>The Plan of Correction for this alleged deficient practice will be reviewed monthly for three months, then quarterly for two quarters in the Quality Assurance Committee meeting. | 12/20/12<br><br>12/20/12<br><br>1/24/13 On-going |
| F 281 SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality.<br><br>This REQUIREMENT is not met as evidenced by. | F 281 | | |

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| F 281 | Continued From page 2<br>Based on medical record review, observation and staff interviews, the facility failed to provide a nutritional supplement prescribed by a physician for 1 of 4 sampled residents with nutritional supplements. (Resident #41)<br><br>The findings include:<br><br>Resident #41 was readmitted to the facility on 10/17/12 with diagnoses of CHF (Congestive Heart Failure), History of chronic debility, Altered mental status, Dysphagia, Depression, Hypertension, Parkinson Disease, Depression, CVA (Cardio Vascular Accident), Hypokalemia and Dementia. Resident # 41 ' s quarterly MDS (Minimum Data Set) dated 10/30/2012 documented the resident had long and short term memory problems with moderately impaired cognitive skills for decision making. The MDS also indicated the resident needed extensive assistance with eating and was on a therapeutic diet.<br><br>A medical record review of admission orders dated 10/17/12 noted an order for 1 can of nutritional supplement to be provided daily as a diet supplement.<br><br>A review of the November 2012 and December 2012 printed Medication Administration Record (MAR) indicated (nutritional supplement) one can every day written directly after the prescribed diet order. Time of day the (nutritional supplement) was to be provided to Resident #41 was not indicated on the MAR. There was no documentation that (nutritional supplement) had been given | F 281 | STANDARD DISCLAIMER:<br>This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).<br><br>Resident #41 received the ordered Ensure immediately after identifying that it was not given. The order was changed to reflect a specific time each day the supplement is to be given.<br><br>All licensed nursing staff have been provided inservice training on providing and documenting any supplement ordered by a physician.<br><br>All MARS have been audited to ensure residents with orders for supplements have a time assigned to each supplement.<br><br>Monthly supplement audits will be conducted monthly by a nurse supervisor for three months. The Director of Nursing and Medical Records Coordinator will monitor for compliance.<br><br>The plan of correction for this alleged deficient practice shall be incorporated into the minutes of the facility's most recent Quality Assurance Committee meeting minutes. | 12/18/12<br><br>1/20/13<br><br>1/8/13<br><br>1/12/13<br>On-going<br><br>On-going |

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| F 281 | Continued From page 3 | F 281 | | |

An interview was conducted with Nurse # 3 on 12/18/12 at 11:00 AM. Nurse #1 indicated she was not aware of Resident #41 receiving a nutritional supplement. Diet prescription with physician order for nutritional supplement was reviewed with Nurse #1. Nurse #1 then called Dietary Department to see if nutritional supplement was being sent on the resident ' s meal trays and reported Dietary Department indicated it was not. Nurse #1 stated the procedure for an order written for nutritional once daily would be for nursing staff to provide the nutritional supplement and document it on the MAR. Review of MAR (November 2012 and December 2012) with Nurse #1 revealed no notations had been made to indicate nutritional supplement had been given to Resident #41 in November 2012 or December 2012.

An interview with the Dietary Supervisor was conducted on 12/18/12 at 11:20 PM. Dietary Supervisor indicated nutritional supplement had not been provided for Resident #41 through the Dietary Department. Dietary Supervisor indicated when an order for a nutritional supplement is written in terms such as qd (every day or daily), BID (twice daily), or QID (four times a day), then that nutritional supplement is provided by nursing. Dietary supervisor further stated that if an order for a nutritional supplement is written as " with meals " , then that nutritional supplement would be sent on the resident ' s meal tray from the Dietary Department.

During an observation on 12/18/2012 at 12:50 PM, NA (Nurse Assistant) # 3 retrieved Resident # 41 ' s tray from 300 Hall trays and set up tray

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| F 281 | Continued From page 4<br>for the resident. NA # 3 took dishes off of tray, cut up meat. NA # 3 was asked if Resident # 41 gets a supplement. " No, I don't think so", she replied. The observation of Resident # 41 ' s tray revealed no supplement on noon tray.<br><br>An interview with the Dietary Manager was conducted on 12/18/12 at 3:04 PM. Dietary Manager indicated the procedure for providing nutritional supplements was for the Dietary Department to send the supplements out from the Dietary Department on a meal tray if the supplement was ordered " with meals " or if the order indicated the supplement was to be provided with a specific meal. He further stated that if a nutritional supplement is ordered for any other time of day, that nutritional supplement is provided by the Dietary Department to Nursing for distribution to the resident(s).<br><br>An interview was conducted with the Administrator on 12/19/12 at 11:50 AM. The Administrator indicated her expectation was that the nutritional supplement would have been provided as ordered by the physician and that this would have been documented by nursing on the MAR as given, along with the date/time provided. The Administrator further stated that it was the nursing staff responsibility to provide the nutritional supplements to Resident # 41 but they missed it. She also added that there was no reason for her staff not to have followed the physician order of providing Resident # 41 with nutritional supplements. | F 281 | | |
| F 371 SS=D | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must - | F 371 | | |

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| F 371 | Continued From page 5<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations, staff interviews and record review the facility failed to ensure hood vents and an operating fan in the kitchen was free from grease and dust build-up.<br><br>The findings include:<br><br>1. Observation was made on 12/16/12 at 3:45 PM of the hood vents located above the stove top, tilt grill and deep fat fryer with a heavy grease and dust built-up.<br><br>Interview with the Cook on 12/16/12 at 3:52 PM indicated that she did not know the last time the hood vents had been cleaned and she also stated that they were not on the cleaning schedule.<br><br>Record review of the cleaning schedule revealed that the vents were not on the cleaning schedule.<br><br>An interview with the Certified Dietary Manager (CDM) on 12/17/12 at 9:35 AM indicated that the vents should be cleaned once a week and he would get them put on the cleaning schedule. The CDM stated that the vents were probably cleaned approximately 2 weeks ago. | F 371 | STANDARD DISCLAIMER:<br>This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).<br><br>No individual residents were identified as having been affected by the alleged deficient practice.<br><br>The hood vents were cleaned immediately after identifying they were dirty.<br><br>Dietary staff was inserviced on cleaning the hood vents weekly.<br><br>The fans in the kitchen were removed immediately. Dietary staff provided with inservice training on fans not allowed in kitchen.<br><br>The hood vents were added to the weekly cleaning schedule. The Dietary Manager or designated person will initial off weekly on the weekly cleaning schedule.<br><br>The Plan of Correction for this alleged deficient practice will be included in the minutes of the most recent Quality Assurance Committee meeting. | 12/18/12<br><br>12/18/12<br><br>12/18 /12<br><br>12/18/12 on-going<br><br>12/18/12 Ongoing |

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| F 371 | Continued From page 6 | F 371 | | |

An interview was made with the Kitchen Supervisor on 12/18/12 at 10:20 AM and she stated that she thought the previous cook cleaned the hood vents at the end of August or first of September. The Kitchen Supervisor further stated that she thought that the Maintenance Department was responsible for the cleaning the vents. The vents have now been added to the revised cleaning schedule to be cleaned once a week.

An interview with the Maintenance Manager on 12/19/12 at 10:35 AM revealed that the hood system and vents in the kitchen is serviced every 6 months by an outside contracted company. The Maintenance Manager further stated that the dietary staff should clean the hoods vents once a week.

An interview with the Administrator on 12/19/12 at 2:00 PM revealed that it was her expectation that the hood vents were cleaned weekly.

2. An observation was made on 12/16/12 at 3:50 PM of an operating large fan with moderate amount of dust on the front and back grill of the fan. The fan was observed blowing towards the steam table, stove top, tilt grill and deep fat fryer.

A second observation was made on 12/17/12 at 9:35 AM of an operating large fan with moderate amount of dust on the front and back grill of the fan. The fan was observed blowing towards the steam table, stove top, tilt grill and deep fat fryer.

An interview was made with the Kitchen Supervisor on 12/18/12 at 10:20 AM and she

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| F 371 | Continued From page 7<br>stated that the large fan was removed from the kitchen for cleaning sometime during the week.<br><br>Record review of the cleaning schedule revealed that the fan was not on the cleaning schedule.<br><br>An interview with the Administrator on 12/19/12 at 2:00 PM revealed that it was her expectation that the fan not to be used in the kitchen area. | F 371 | | |
| F 441 SS=B | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their | F 441 | | |

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| F 441 | Continued From page 8<br>hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations and staff interviews, the facility failed to ensure ice was stored and passed in a sanitary manner in 4 of 4 ice chests.<br><br>The findings include:<br><br>1. On 12/17/12 at 4:10 pm on the 100 hall, the ice chest was observed sitting in the hallway with the lid closed. Upon inspection the ice chest was noted to be half-full of standing water with a small amount of ice noted floating in the water. The ice scoop container lid was broken off and resting inside the container with the ice scooper.<br><br>On 12/18/12 at 11:51 am on the 100 hall, the ice chest was observed in the nourishment room with the lid closed. The ice scooper was inside the container with the broken lid resting inside the container with the scoop. Nurse #2 stated that the staff went to get fresh ice because there was only water inside. Nurse #2 stated the coolers were washed by the dietary department on 3-11 shift and the 11-7 nursing staff were supposed go to get the ice chest and fill them with fresh ice and return them to the floor. Nurse #3 stated she | F 441 | STANDARD DISCLAIMER:<br>This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).<br><br>No residents were specifically identified as having been affected by this alleged deficient practice.<br><br>The ice coolers were emptied and cleaned immediately upon identifying the deficiency. The lids for the scoops were placed on the ice scoop containers. 12/18/12<br><br>For those residents having the potential to be affected by the same alleged deficient practice, all nursing and dietary staff, including any staff designated to pass ice have been inserviced on the following: 1) proper procedure for emptying the ice coolers of standing water and filling the coolers with ice often; and 2) ensuring the ice scoop containers have a cover on them at all times when not in use. 1/20/13<br><br>To ensure compliance, the Director of Nursing, , Dining Services Manager and/or Administrator shall 1) make observations of the ice coolers to ensure the coolers have ice and little standing water; 2) the ice scoop containers have lids on them at all times. Observations shall be made daily for one week, weekly for three weeks and monthly for two months to ensure compliance. 2/7/13<br><br>Any identified non-compliance shall be remediated and reported to the Quality Assurance Committee monthly for three months and quarterly thereafter. On-going | |

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was unaware the lid was broken off the ice scooper container and stated the ice scoop should be in a covered container when not in use.

On 12/18/12 at 12:45 pm the administrator stated the coolers should not have standing water inside them and the containers should have a lid to contain the ice scoop.

On 12/18/12 1:00 pm the director of nursing (DON) stated there should be no standing water and scoops should be in covered container. The DON stated the water should be emptied and fresh ice added to each ice chests as needed by the nursing staff.

On 12/19/12 at 9:15 am the dietary manager stated the ice chest and the ice scoopers were sanitized by the dietary department. The dietary manager stated he was unaware of that the ice scoop container lids broken off the scoop containers on 2 of the 4 ice chest carts. The dietary manager stated the ice scoops should be housed in a container with a working lid and minimal standing water should be in the ice chest at any given time.

2. On 12/16/12 at 3:45 pm the ice chest for the 200 hall was observed in the hallway with the lid closed. Upon inspection the ice chest was noted to be half-full of standing water with no ice inside. There was no observed lid covering the ice scooper resting in the scooper container.

On 12/17/12 at 11:45 am on the 200 hall, the ice chest was observed sitting in the hallway with the lid closed. Upon inspection the ice chest was noted half-full of standing water and a small

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amount of ice inside. There was no observed lid covering the ice scooper standing in the scooper container.

On 12/17/12 at 2:10 pm on the 200 hall, the ice chest was observed sitting in the hallway with the lid closed. Upon inspection the ice chest was noted one-fourth full of standing water with no ice. There was no observed lid covering the ice scooper resting in the scooper container. Nurse #1 stated there should be no standing water in the cooler and the ice scoop should be stored in a covered container when not in use.

On 12/18/12 at 12:40 pm, nursing assistant (NA) #2 on the 200 hall stated the ice chest should only contain ice. There should be no standing water and no ice scoop inside the cooler. NA #2 stated the ice scoop was to be stored in the container on the side of the cart holding the ice chest. NA #2 stated she did not notice the lid was broken off the ice scoop container and that it should be covered at all times when not in use. NA #2 was not aware of the cleaning schedule for the ice chest.

On 12/18/12 at 12:45 pm the administrator stated the coolers should not have standing water inside them and the containers should have a lid to contain the ice scoop.

On 12/18/12 1:00 pm the director of nursing stated there should be no standing water and scoops should be in covered container. The DON stated the water should be emptied and fresh ice added to each ice chests as needed by the nursing staff.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345380 | A. BUILDING _____ B. WING _____ | 12/19/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE REHAB AND HC CTR AT VILLAGE GR | 1601 PURDUE DRIVE FAYETTEVILLE, NC 28304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 441 | Continued From page 11 | F 441 | | |

On 12/19/12 at 9:15 am the dietary manager stated the ice chest and the ice scoopers were sanitized by the dietary department. The dietary manager stated he was unaware of that the ice scoop container lids broken off the scoop containers on 2 of the 4 ice chest carts. The dietary manager stated the ice scoops should be housed in a container with a working lid and minimal standing water should be in the ice chest at any given time.

3. On 12/16/12 at 4:00 pm on the 300-A hall, the ice chest was observed sitting in the hallway with the lid closed. Upon inspection the ice chest was one-fourth full of standing water and with no ice inside.

On 12/17/12 at 11:15 am on the 300-A hall, the ice chest was observed sitting in the hallway with the lid closed. Upon inspection the ice chest was noted half-full of standing water with no ice inside

On 12/18/12 at 9:55 am on the 300-A hall, the ice chest was sitting in the hallway with the lid closed. Upon inspection the ice chest was one-fourth full of standing water with a small amount of ice floating in the water.

On 12/18/12 at 10:00am Nurse # 3 stated the ice chest should not contain standing water inside the ice chest. Nurse #3 stated the dietary department cleans the coolers before they leave each day and that the 11-7 nursing staff was responsible for filling the ice chest each day and return them to the floor. Nurse #3 stated it was up to the nursing staff to replenish the ice and empty the water fro the ice chest as needed.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345380 | A. BUILDING _____ B. WING _____ | 12/19/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE REHAB AND HC CTR AT VILLAGE GR | 1601 PURDUE DRIVE FAYETTEVILLE, NC 28304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 441 | Continued From page 12 | F 441 | | |

On 12/18/12 at 12:45 pm the administrator stated the coolers should not have standing water inside them and the containers should have a lid to contain the ice scoop.

On 12/18/12 1:00 pm the director of nursing stated there should be no standing water and scoops should be in covered container. The DON stated the water should be emptied and fresh ice added to each ice chests by the nursing staff as needed.

On 12/19/12 at 9.15 am the dietary manager stated the ice chest and the ice scoopers were sanitized by the dietary department. The dietary manager stated he was unaware of that the ice scoop container lids broken off the scoop containers on 2 of the 4 ice chest carts. The dietary manager stated the ice scoops should be housed in a container with a working lid and minimal standing water should be in the ice chest at any given time.

4. On 12/18/12 10:15 am on the 300-B hall, the ice chest was observed sitting the hallways with the lid closed. Upon inspection the ice chest was half-full of standing water with a small amount of ice floating in the water.

On 12/18/12 at12:05 pm 300-B hall, the ice chest was observed sitting in the haliway with the lid closed. Upon inspection the ice chest was one-fourth full of standing water with no ice inside.

On 12/18/12 at12:07 pm, NA #1 working on the 300-B hall stated 11-7 shift gets the ice chest from the dietary department and fills the ice chest

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345380 | A. BUILDING _____ B. WING _____ | 12/19/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE REHAB AND HC CTR AT VILLAGE GR | 1601 PURDUE DRIVE FAYETTEVILLE, NC 28304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 441 | Continued From page 13 | F 441 | | |

with ice each morning. The 3-11 shift takes the ice chests to the dietary department after dinner. NA #1 stated there should not be standing water in the ice chest and the ice scooper should be used to fill the resident ' s ice pitcher. NA #1 stated the ice scoop should not be left inside the ice chest but placed inside the container with a lid.

On 12/18/12 at 12:45 pm the administrator stated the coolers should not have standing water inside them and the containers should have a lid to contain the ice scoop.

On 12/18/12 1:00 pm the director of nursing stated there should be no standing water and scoops should be in covered container. The DON stated the water should be emptied and fresh ice added to each ice chests by the nursing staff as needed.

On 12/19/12 at 9:15 am the dietary manager stated the ice chest and the ice scoopers were sanitized by the dietary department. The dietary manager stated he was unaware of that the ice scoop container lids broken off the scoop containers on 2 of the 4 ice chest carts. The dietary manager stated the ice scoops should be housed in a container with a working lid and minimal standing water should be in the ice chest at any given time.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345380 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | FEB 18 2013<br>01/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE REHAB AND HC CTR AT VILLAGE GR | 1601 PURDUE DRIVE<br>FAYETTEVILLE, NC 28304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, one story, with a complete automatic sprinkler system.<br><br>The deficiencies determined during the survey are as follows: | K 000 | STANDARD DISCLAIMER:<br>This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s). | |
| K 027<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7<br><br>This STANDARD is not met as evidenced by:<br>42 CFR 483.70(a)<br>By observation on 1/29/13 at approximately noon the following door openings in the smoke barrier was observed as non-compliant; specific findings include the smoke door, across from room 325, did not close and seal. | K 027 | The smoke door , across from room 325, has been repaired to ensure it closes properly and has a smoke tight seal.<br><br>There are no other areas affected by this same alleged deficient practice(s).<br><br>To ensure that this alleged deficient practice does not recur, the door has been repaired and now has new hinges and larger screws.<br><br>The Director of Maintenance will ensure that it functions properly by monitoring all facility doors on a weekly basis for four weeks.<br><br>The plan of correction for this alleged deficient practice shall be incorporated into the minutes of the facility's most recent Quality Assurance Committee meeting minutes. | 2/6/2013<br><br>2/6/2013<br><br>2/6/2013<br><br>2/6/2013 On-going<br><br>2/6/2013 on-going |
| K 029<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire | K 029 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Sabrina Miles — LNHA — 2/15/13

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.

DRS

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345380 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 01/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| THE REHAB AND HC CTR AT VILLAGE GR | 1601 PURDUE DRIVE<br>FAYETTEVILLE, NC 28304 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| K 029 | Continued From page 1<br>extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1<br><br>This STANDARD is not met as evidenced by:<br>42 CFR 483.70(a)<br>By observation on 1/29/13 at approximately noon the following hazardous areas were observed as non-compliant; specific findings include:<br>A. Room 223 used for storage without having a UL listed door closure. (Item corrected)<br>B. Bedroom 221 and 346 were used for storage of two clean linen carts each. The bedrooms/storage did not have a UL listed closure on the door. | K 029 | STANDARD DISCLAIMER:<br>This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).<br><br>The items stored in room 223 were removed immediately. The clean linen carts for 221 and 223 were removed immediately as well.<br><br>All staff is being in-serviced on not storing items in rooms that do not have a UL listed closure on the door..<br><br>To ensure that this alleged deficient practice does not recur, in-service training will occur quarterly for all staff by the Maintenance Director or his designee.<br><br>The Director of Maintenance or his designee will report any system failures monthly to the Quality Assurance Committee for further evaluation. | 2/6/2013<br><br>3/4/2013<br><br>2/6/2013 Ongoing<br><br>2/6/2013 Ongoing |
| K 038 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1<br><br>This STANDARD is not met as evidenced by:<br>42 CFR 483.70(a)<br>By observation on 1/29/13 at approximately noon the following exit access was observed as | K 038 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345380 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING _____ | 01/29/2013 |

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| THE REHAB AND HC CTR AT VILLAGE GR | 1601 PURDUE DRIVE<br>FAYETTEVILLE, NC 28304 |

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| K 038 | Continued From page 2<br>non-compliant, specific findings include;<br>A. The egress locking system at the back main entrance did not function per NCSBC or LSC. Facility confirmed that the locking system was new. Note: Plan review sould be conducted through the Construction Section.<br>B. The egress locking system at the back side gate did not function per NCSBC or LSC. Facility confirmed that the locking system was old and not in use. If system is not in use remove old magnetic device so system could not be readily reengaged. | K 038 | STANDARD DISCLAIMER:<br>This Plan of Correction is prepared as a necessary requirement for continued participation in the Medicare and Medicaid programs and does not, in any manner, constitute an admission to the validity of the alleged deficient practice(s).<br><br>The locking system at the back main entrance has been disabled. One of the magnetic panels was removed. The locking system at the back side gate was disabled. One of the magnetic panels was removed.<br><br>There are no other areas affected by this same alleged deficient practice(s).<br><br>To ensure that this alleged deficient practice does not recur, no door will have locking systems placed without going through the Construction Section . | 2/8/2013<br><br>2/8/2013<br><br>2/8/2013 |

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|---|---|---|---|
| | 345380 | A. BUILDING 02 - BLDG 0202<br>B. WING _____ | 01/29/2013 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| THE REHAB AND HC CTR AT VILLAGE GR | 1601 PURDUE DRIVE<br>FAYETTEVILLE, NC 28304 |

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|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III construction, one story, with a complete automatic sprinkler system.<br><br>There were no Life Safety Code Deficiencies noted at time of survey. | K 000 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.