MAY 1 5 2013

PRINTED: 05/03/2013 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDES OR SUPPLIER DUNN HEALTH & REMAS CENTER SUMMAY STATEMENT OF DEPRESACES PREFIX TAB FROM INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation conducted 4/26/13. Event IDM 94.P11. F 309 483.2 PPROVIDE CARE/SERVICES FOR SS-D HIGHEST must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocal well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, and pharmacist Interview, the facility failed to menage pain by failure to ensure that pain medication Norco 5/325 mg (milligram) tablet as needed for pain was administered and Fentany 25 mag (microgram) patch was applied every 72 hours for 1 of 1 sampled resident (Resident #86) revoked for pain management. The findings included: Resident #86 was admitted into the facility on 11/29/12, Diagnoses included Generalized Pain, Chronic Pain, and End Stage Renal Disease. The quarterly minimum data set completed that as needed pain medication was received, offered or declined. The presence of pain per the resident pain interview stated that pain was present with a frequency of rarely. Pain was indicated as had an neceded pain was present with a frequency of rarely. Pain was indicated as had an neceded pain was present with a frequency of rarely. Pain was indicated as had an neceded pain was present with a frequency of rarely. Pain was indicated as had an neceded pain was present with a frequency of rarely. Pain was indicated as had an neceded pain was present with a frequency of rarely. Pain was indicated as had an neceded pain was present with a frequency of rarely. Pain was indicated as had an neceded pain was present with a frequency of rarely. Pain was indicated as had an neceded pain was present with a frequency of rarely. Pain was indicated as had an neceded pain was present with a frequency of rarely. Pain	STATEMENT AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	COMPLETED
NAME OF PROVIDER OR SUPPLIER DURN HEALTH & REHAB CENTER DURN NO COMMENTS FOOD INITIAL COMMENTS NO deficiencies were cited as a result of the compleint investigation conducted 4/28/13. Event ID# 94-JP1. F 309 483.26 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychoscalcal well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, and pharmacist interview, the facility failed to manage pain by failure to ensure that pain medication horeous 6/325 mg (milligram) tablet as needed for pain was administered and Fentanyl 25 mcg (minorgram) patch was applied every 72 hours for 1 of 1 sampled resident (Resident #66) reviewed for pain management. The findings included: Resident #86 was admitted into the facility on 11/29/12, Diagnoses included Generalized Pain, Chronic Pain, and End Stage Renal Disease. The quarterly minimum data set completed that as needed poin medication was received, offered or declared. The presence of pain per the resident pain interview stated that pain medicated nate as econopted that as needed poin medication was received as had an frequency of rarely. Pain was indicated as had an received processor of pain per the resident pain interview stated that pain was present with a frequency of rarely. Pain was indicated as had an received processor of pain per the resident pain interview stated that pain medication was not per the resident pain interview stated that pain was indicated as had an received processor of pain per the resident pain interview stated that pain was indicated as had an received processor of pain per the resident pain interview stated that pain was indicated as had an received processor p	•		345173	B. WING			C 04/26/2013
F 000 INITIAL COMMENTS No deficiencies were cited as a result of the complaint investigation conducted 4/28/13. Event ID# 8A.PP11. F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, and pharmacist interview, the facility failed to manage pain by failure to ensure that pain medication forco 5/325 mg (miligrant) toblet as a needed for pain was administered and Fentanyl 25 mg (microgram) patch was applied every 72 hours for 1 of 1 sampled resident (Resident #66) reviewed Generalized Pain, Chronic Pain, and End Stage Renal Disease. The quarterly minimum data set completed on 31/13 indicated Resident #66 was admitted into the facility on 11/29/12, Diagnoses included Generalized Pain, Chronic Pain, and End Stage Renal Disease. The quarterly minimum data set completed on 31/13 indicated Resident #66 was admitted into the facility on 11/29/12, Diagnoses included Generalized Pain, Chronic Pain was admitted that as needed pain medication was received, offered or declined. The presence of pain per the resident pain interview stated that pain was present with a frequency of rarely. Pain was indicated as had an			ER		20	N NORTH ELLIS AVENUE	
No deficiencies were cited as a result of the compleint investigation conducted 4/26/13. Event IDB 94JP11. F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, and pharmacist interview, the facility falled to manage pain by failure to ensure that pain medication Norco 5/325 mg (miligram) tablet as needed for pain was administered and Fentaryl 25 mcg (microgram) patch was applied every 72 hours for 1 of 1 sampled resident (Resident #86) reviewed for pain management. The findings included: Resident #86 was admitted into the facility on 11/29/12. Diagnoses included Generalized Pain, Chronic Pain, and End Stage Renal Disease. The quarterly minimum data set completed on 3/1/13 indicated Resident #86 was opilitively intact. The five day look back period indicated that as needed pain medication was received, offered or declined. The presence of pain per the resident pain interview stated that pain was present with a frequency of rarely. Pain was indicated as had an necessary that and an anagement and plan type of the pain was present with a frequency of rarely. Pain was indicated as had an necessary care and services to attain or to our regulatory obligations. We reserve the right to contest the findings or allegations. We reserve the right to contest the findings or allegations. We reserve the right to contest the findings or allegations. We reserve the right to contest the findings or allegations. No resident experienced any negative outcome from this cited deficiency. F309 Criteria #1: Pain medication was obtained and administered to resident #66 as order by physician. Criteria #2: Complete audit of current residents medication administration records were con	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI	COMPLETION
frequency of rarely. Pain was indicated as had an ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (XS) DATE (XS) DATE	F 309	No deficiencies we complaint investiga ID# 84JP11. 483.25 PROVIDE CHIGHEST WELL BITTER TO THE PROVIDE CHIGHEST WELL BITTER TO THE PROVIDE CHIGHEST WELL BITTER TO THE PROVIDE CHICAGO TO THE FINANCIA CONTROL OF THE PROVIDE CHICAGO THE PROVIDE CHICA	re cited as a result of the tion conducted 4/26/13. Event CARE/SERVICES FOR EING receive and the facility must ary care and services to attain nest practicable physical, social well-being, in a comprehensive assessment AT is not met as evidenced tion, record review, staff armacist interview, the facility ain by failure to ensure that arco 5/325 mg (milligram) repain was administered and nicrogram) patch was applied 1 of 1 sampled resident ewed for pain management. The data set completed on 3/1/13 are data set completed on 3/1/13 are deriod indicated that as ation was received, offered or ence of pain per the resident			materials we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. No resident experienced any negative outcome from this cited deficiency. F309 Criteria #1: Pain medication was obtained and administered resident #66 as order by physic Criteria #2: Complete audit of current residents' medication administration records were conducted by Director of Nursi and designees to identify any residents potentially at risk for medication not being available	to 4/23/13 ing a for
		DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNATU	RE		Notice toward to	(X6) DATE 5 19 13

Any deficiency statement ending with an asterisk (*) conotes 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 9

Daministrator

PRINTED: 05/03/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. 1		CONSTRUCTION	(X3) DATE S COMPL	
AND PLAN UF	CORRECTION	IDEM HE TO A TO IT WORKER		NG		c	1
		345173	B. WNG			04/2	26/2013
	ROVIDER OR SUPPLIER ALTH & REHAB CENTE			201	et address, city, state, zip code 1 North Ellis Avenue JNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	effect on function. Pascale of 00 - 10 reversions of 3. The most 12/31/12 identified pate interventions to contradminister pain medifor pain ever shift, 4) causative factors, 5) 6) observe for non verbain." There was no for review after 12/3. A review of the medi (MAR) revealed an oread "Oxycodone wif (milligrams) take one four hours as needed administered doses. A review of a telephorevealed an order thablets by mouth ever pain." A review of a telephorevealed an order thablets by mouth ever pain." A review of a telephorevealed an order thablets by mouth ever pain." A review of a telephore patch 25 mcg (microhours." A review of a pharm faxed to the facility of please refax the scrif (Fentanyl patch) was order (Fentanyl patch) was order (Fentanyl patch).	ain intensity on a numerical aled a pain level intensity recent care plan dated ain as a problem. Fol pain read in part "1) cation as needed, 2) assess eliminate or reduce place on pain management arbal signs and symptoms of updated or revised care plan I/12. Cation administration record order initiated on 3/11/13 that the Tylenol 5 mg/325 mg are two tablets by mouth every di." The MAR indicated no for April 2013. One order dated 4/6/13 at read "Norco 5/325 mg two ery six hours as needed for the plant of the problem of the plant of the problem of the plant of the problem of the plant of the pla	F	309	Criteria #3: Narcotic Stat bo be obtained from pharmacy to ensure narcotic medications are adily available. Nurses ordered medications that require hard scripts will contact the physic for hard script and make a not on the 24 hour report. The note will contact the physician if predication ordered is not in box for alternative order. Criteria #4: Education will be conducted with licensed nurse staff regarding medication administration, ordering of controlled substances, and or policy and procedures related narcotic stat box by the Dire Nursing or designee.	o are ering cian otation wrse coain stat	5/24/13

FORM CMS-2587(02-99) Previous Versions Obsolete

Facility ID: 923090

	OT ON MILDIOPHIL W		TANA CON	TIPLE	CONSTRUCTION	(X3) DATE	SURVEY
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COMP	
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		345173	B. WING			04/	26/2013
70.00.0	ROVIDER OR SUPPLIER ALTH & REHAB CENTER			20	EET ADDRESS, CITY, STATE, ZIP CODE 11 NORTH ELLIS AVENUE		
DAMA VE	ALIII G MEDAG GERTE			DI	UNN, NC 28334		
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	A review of the MAR mg two tablets by mo for pain on 4/17/13 at location of pain indica 9:50 am. During a medication 9:00 am, Resident #6 from Nurse #2 with fatime of the request. In an interview on 4/2 stated that Norco as available on the med would have to obtain back up pharmacy. During an observation Nurse #2 informed R 5/325 mg tablets was medication cart and the uptharmacy. Reside and I need my pain in During an observation Resident #66 was observation Resident #66 w	revealed that Norco 5/325 buth was last administered that 8:50 am, with no specific ated, with effective results at sobservation on 4/23/13 at sobservation on 4/23/13 at sold requested pain medication acial grimace of pain at the sold	TAC			rify order hese	5/24/13
	#66 described his pa scale of 00 - 10 with level to his left lower	23/13 at 9:35 am, Resident in as "aching" on a pain "10" being his current pain back. He indicated he'd r about 2 months to his left					
	}		ŀ				<u> </u>

STATEMENT (AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE COL		COI	TE SURVEY MPLETED C 4/26/2013
	OVIDER OR SUPPLIER		STREET 201 N	ADDRESS, CITY, STATE, ZIP COD IORTH ELLIS AVENUE N, NC 28334		7/80/8010
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F 309	Resident #66 was rubbing his left lov continued facial g. In an interview on stated that she has a hard script for the was not available physician gave armg two tablets by that she administrablets by mouth. Resident #66 initipain. She added was not available requested for pair. In an interview or #66 indicated his to his left lower bunderstand why havailable when he in an interview or #1 stated per his pharmacy profile file dated 4/6/13 as needed every indicated that the send a controlled the proper hard send a controlled the proper hard send in the proper hard send a controlled the proper hard send in the proper hard send in the proper hard send a controlled the proper hard send in the proper hard send a controlled medical controlled controlled medical controlled control	ation on 4/23/13 at 9:45 am, a observed in the smoking area wer back with his hand, with rimace. 4/23/13 at 10:10 am, Nurse #2 ad called the physician to obtain the Norco due to the medication in the facility. She added the morder to administer Tylenol 500 amouth for pain. She concluded ered the Tylenol 500 mg two at 10:00 am (1 hour delay from all request) for breakthrough she was not sure why the Norco at the time that Resident #66 m. 4/23/13 at 10:15 am, Resident pain level was "10 and aching" ack and that he didn't his pain medication was not e requested it for pain. 4/23/13 at 4:18 pm, pharmacist review of Resident #66 there was a telephone order on for Norco 5/325 mg two tablets six hours. The pharmacist is pharmacy could not dispense or a medication to the facility without script signed by the physician. Included it was the facility ensure that the hard script for a ation was sent to the pharmacy, escribed medication was supplied	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES		Tarine.	The state of the s		. <u>0938-0391</u>
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE COMPI	.ETED
		345173	B. WNG			li e	, 26/2013
	OVIDER OR SUPPLIER ALTH & REHAB CENTE	R		2	REET ADDRESS, CITY, STATE, ZIP CODE 101 NORTH ELLIS AVENUE DUNN, NC 28334		
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F 309	In an interview on 4// assistant director of facility did not have a place for administrat nurses followed a fa administration of as medications. She ele expected to contact order for such each expectation was tha administered as ord medications were av management. The A expected if a reside medication was ava and administered in that she expected th request form pharm requested on 4/8/13 was received and a In a telephone inter medication Nurse # the primary nurse fo from 7:00 am - 7:00 was not aware that the pharmacy on 4// telephone and hard patch to be refaxed that she did not rec applied to Resident nurse was respons four hour chart che were carried out.	25/13 at 9:42 am, the nursing (ADON) stated the a standing order system in ion of medications, wherein, cility protocol for needed pain (PRN) aborated the nurses were the physician to obtain an time. The ADON indicated to pain meds were ered per the MAR and that vailable at all times for pain ADON indicated that she not complained of pain that the ilable on the medication cart amediately. She concluded he Fentanyl clarification acy to have been refaxed as to ensure the medication dministered as ordered. View on 4/26/13 at 3:05 pm, 3 acknowledged that she was an order faxed from 8/13 that requested the script order for the Fentanyl to pharmacy. She indicated all the Fentanyl patch ever #66 and that the night shift lible for completing the twenty cks to ensure physician orders	F	309			
1	that she was the pr	imary nurse for Resident #66					

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X3) DATE S COMPL	ETED
	345173	B. WING		1	6/2013
	ER	20	01 NORTH ELLIS AVENUE	The state of the s	
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on 4/8/13 from 7:00 that she recalled N on 4/8/13 at 7:00 preceived for a Fent that she did not foll assumed that Nurs order". She concludapplying and/or ren Resident #66. Resident #66 medi Fentanyl 25 mcg prodered by the phy MAR from 4/7/13 the 483.60(a),(b) PHAF ACCURATE PROCEIVE and biological them under an agres \$483.75(h) of this puniticensed personal taw permits, but on supervision of a lice. A facility must prove (including proceduracquiring, receiving administering of all the needs of each of the facility must error alicensed pharmacon all aspects of the	o pm - 7:00 am. She stated urse #3 verbally stating to her m, that there was a new order anyl patch. Nurse #4 added ow up on the order due to she e #3 "had taken care of the ded she did not recall ever noving a Fentanyl patch from cal records concluded that the atch was never applied as sician every 72 hours, per the nrough 4/23/13. RMACEUTICAL SVC - CEDURES, RPH ovide routine and emergency als to its residents, or obtain element described in part. The facility may permit hel to administer drugs if State ly under the general ensed nurse. ide pharmaceutical services res that assure the accurate g, dispensing, and drugs and biologicals) to meet resident. Inploy or obtain the services of cist who provides consultation e provision of pharmacy	F 309	negative outcome from this cited deficiency. F425 Criteria #1: Resident # 66's medications were clarified w physician, new orders obtain and medications were administered per physician of Criteria #2: Director of Nurse and designee audited nurse's stations for any faxed request clarification, and audited medication administration recommends.	rith ed rders. sing ts for cords.	4/23/13
			have ordered medications.	- 1	4/23/13
	Continued From pa on 4/8/13 from 7:00 that she recalled No on 4/8/13 at 7:00 preceived for a Fent that she did not foll assumed that Nurs order". She concludapplying and/or ren Resident #66. Resident #66 medi Fentanyl 25 mcg pa ordered by the phy MAR from 4/7/13 the 483.60(a),(b) PHAF ACCURATE PROCEIVE and biological them under an agres §483.75(h) of this puniticensed personn law permits, but on supervision of a lice. A facility must prove (including procedur acquiring, receiving administering of all the needs of each of the supplemental aspects of the received on all aspects of the content of the facility must error all the faci	CORRECTION JA5173 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 on 4/8/13 from 7:00 pm - 7:00 am. She stated that she recalled Nurse #3 verbally stating to her on 4/8/13 at 7:00 pm, that there was a new order received for a Fentanyl patch. Nurse #4 added that she did not follow up on the order due to she assumed that Nurse #3 "had taken care of the order". She concluded she did not recall ever applying and/or removing a Fentanyl patch from	TOWNIDER OR SUPPLIER ALTH & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 5 on 4/8/13 from 7:00 pm - 7:00 am. She stated that she recalled Nurse #3 verbally stating to her on 4/8/13 at 7:00 pm, that there was a new order received for a Fentanyl patch. Nurse #4 added that she did not follow up on the order due to she assumed that Nurse #3 "had taken care of the order". She concluded she did not recall ever applying and/or removing a Fentanyl patch from Resident #66. Resident #66 medical records concluded that the Fentanyl 25 mcg patch was never applied as ordered by the physician every 72 hours, per the MAR from 4/7/13 through 4/23/13. 483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in \$483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy	TOWNDER OR SUPPLIER ALTH & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MMST BE PRECEDED BY FULL (REGULATORY OR LSC IDENTIFYMO INFORMATION) Continued From page 5 on 4/8/13 from 7:00 pm - 7:00 am. She stated that she recalled Nurse #3 verbally stating to her on 4/8/13 at 7:00 pm, that there was a new order received for a Fentanyl patch. Nurse #4 added that she included Norse #3 had taken care of the order". She concluded she did not recall ever applying and/or removing a Fentanyl patch from Resident #86. Resident #86 medical records concluded that the Fentanyl 25 mg patch was never applied as ordered by the physician every 72 hours, per the MAR from 4/7/13 through 4/23/13. The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in squaysision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	COMPLETION Dentification Number: 345173 S. WING

•	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE	SURVEY PLETED
		345173	B. WING			1	C /26/2013
DUNN KE	ROVIDER OR SUPPLIER ALTH & REHAB CENTER			20	EET ADDRESS, CITY, STATE, ZIP CODE 01 NORTH ELLIS AVENUE UNN, NC 28334 PROVIDER'S PLAN OF CORRECTION		
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F 425	This REQUIREMENT by: Based on record revipharmacist interview, follow up on a clarific mcg (mircorgrams) parespond to the pharmensure the medication sampled resident (Reincluded: The pharmacy service in part read the respondent of the pharmacy service in part read the respondent of the pharmacy potherwise may be required to the pharmacy order that was faxed of the telepharmacy order that was faxed of the physicia "Fentanyl Patch 25 mevery 72 hours." A review of a pharmacy patch 25 mevery 72 hours."	is not met as evidenced iew, staff interviews, and the pharmacy failed to ation order for Fentanyl 25 atch when the facility did not nacy clarification request to n was supplied for 1 of 1 sident #66). The findings e agreement dated 7/12/13 unsibility of the pharmacy is acy products to the facility prompt and timely manner, products to facility daily or as quired." mitted into the facility on included Generalized Pain, d Stage Renal Disease. The ata set completed on 3/1/13 if6 was cognitively intact. cy clarification message I an attached hard script on top of a telephone order hone order not readable in none/hard script order was an on 4/7/13 and read cg (micrograms) apply cy clarification message that ty from the pharmacy on staff - please refax - the	F	425	Criteria#3: Clarification receifrom pharmacy via fax will be addressed by the licensed Nursesigned to that resident during shift the fax was received. Up completion, the nurse will document the status of clarification directly on the far and then place the fax with the hour report located at the nursestation. If clarification has not been resolved prior to end of nurse's shift, it will be passed oncoming nurse for completic and a notation made on the 24 hour report, Follow up on completed clarifications will made during clinical risk management rounds. Criteria #4: Current licensed Nursing staff will be educated pharmacy and facilities practic related to clarification of order Director of Director of Nursing designee.	e rse ng the pon / xe 24 se's pt l to on 4 be	5/24/13

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF D	ROVIDER OR SUPPLIER	345173	B, WING	<u> </u>		04/	/26/2013
V =	ALTH & REHAB CENTER	₹		20	EET ADDRESS, CITY, STATE, ZIP CODE D1 NORTH ELLIS AVENUE UNN, NC 28334		
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F 425	attached." A review of the medic for April 2013 revealed ordered to be applied applied as ordered by In an interview on 4/2 #1 when questioned of from pharmacy persones pond to the pharma 4/8/13 regarding the It was ordered by the properson of the pharmacy personnel was not reswith the facility related the pharmacy had fax sought clarification. In a telephone interview medication Nurse #3 the primary nurse for from 7:00 am - 7:00 pwas not aware that the pharmacy on 4/8/ telephone and hard spatch to be refaxed to that she did not recall applied to Resident #1 nurse was responsible four hour chart checks were carried out. In a telephone interviewed to that she was the primon 4/8/13 from 7:00 primon 4/8/13 from 7:00 primon 7:00	cation administration record and Fentanyl 25 mcg patch levery 72 hours was not with physician. 23/13 at 4:18 pm, pharmacist why there was no follow up not when the facility did not eacy's clarification request on Fentanyl 25 mcg patch that hysician to be applied every #1 indicated that pharmacy sponsible for following up did to clarification orders that each over to the facility that ew on 4/26/13 at 3:05 pm, acknowledged that she was Resident #66 on 4/8/13 im. She indicated that she ere was an order faxed from	F	425	Criteria #5 Director of nursing designee will audit pharmacy clarification orders to ensure timely response daily x 2 week weekly x 2, monthly x 2. Res from these audits will be reviet by the facility Quality Assurant Committee for further recommendations as deemed necessary.	ks, ults	5/24/13

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					SURVEY
	345173	B. WNG			1	C 26/2013
			201	1 NORTH ELLIS AVENUE		
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on 4/8/13 at 7:00 pm, received for a Fentan that she did not follow assumed that Nurse storder." She concluded	that there was a new order yl patch. Nurse #4 added r up on the order due to she #3 "had taken care of the d she did not recall ever	F	425			
		-				
	SUMMARY STA (EACH DEFICIENC') REGULATORY OR I Continued From page on 4/8/13 at 7:00 pm, received for a Fentan that she did not follow assumed that Nurse # order." She concluded applying and/or remov	CONTINUED FROM PAGE 8 ON A 1/8/13 at 7:00 pm, that there was a new order received for a Fentanyl patch. Nurse #4 added that she did not follow up on the order due to she assumed that Nurse #3 "had taken care of the order." She concluded she did not recall ever applying and/or removing a Fentanyl patch from	Continued From page 8 on 4/8/13 at 7:00 pm, that there was a new order received for a Fentanyl patch. Nurse #4 added that she did not follow up on the order due to she assumed that Nurse #3 "had taken care of the order." She concluded she did not recall ever applying and/or removing a Fentanyl patch from	CONTINUED FROM PAGE 10 PREFIX TAG 10 PREFIX	A BUILDING 345173 B. WNG STREET ADDRESS, CITY, STATE, ZIP CODE 201 NORTH ELLIS AVENUE DUNN, NC 28334 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 on 4/8/13 at 7:00 pm, that there was a new order received for a Fentanyl patch. Nurse #4 added that she did not follow up on the order due to she assumed that Nurse #3 "had taken care of the order." She concluded she did not recall ever applying and/or removing a Fentanyl patch from	DENTIFICATION NUMBER: 348173 B. WING OVAI OVAI STREET ADDRESS, CITY, STATE, ZIP CODE 201 NORTH ELLIS AVENUE DUNN, NC 28334 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 8 on 4/8/13 at 7:00 pm, that there was a new order received for a Fentanyl patch. Nurse #4 added that she did not follow up on the order due to she assumed that Nurse #3 "had taken care of the order." She concluded she did not recall ever applying and/or removing a Fentanyl patch from Resident #66.

PRINTED: 05/24/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A BUILDING 01 - MAIN BUILDING 01 0 2018 (X3) DATE SURVEY COMPLETED

345173

B. WING

05/23/2013

NAME OF PROVIDER OR SUPPLIER

DUNN REALTH & REHAB CENTER

CONSTRUCTION STREET ADDRESS, CITYSSTAND AP CODE 201 NORTH ELLIS AVENUE **DUNN, NC 28334**

			Olaisi iso toona	Comp description (CF)
(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	Surveyor: 27871 This Life Safety Code(LSC) survey was conducted as per The Gode of Federal Register at 42 CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type I -fire resident construction, three story, with no complete automatic sprinkler system. Building a replacement facility.	K 000	By submitting the enclosed materials we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceeding and submit these responses pursuant to our regulatory obligations. No resident experienced any negative outcome from this cited deficiency. K 069	
K 069 SS=E	The deficiencies determined during the survey are as follows: NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96	K 069	Criteria #1: A stainless steel splash guard was installed between the fryer and food processer to provide protection from grease splatter.	7/7/13
e e e e e e e e e e e e e e e e e e e	This STANDARD is not met as evidenced by Surveyor: 27871 Based on observations and staff interview at approximately 8:30 am onward, the following items were noncompliant, specific findings	t 3.	Criteria #2: Complete audit of facility kitchen was conducted by Maintenance Director to identify any other areas/equipment needing splash guards installed to prevent splashing of hot substances.	7/7/13
K 076 SS⊭E	include: deep fat fryer in kitchen did not have splash guard's on fryer. 42 CFR 493.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.	, K 076	Criteria #3: All staff will be educated on identification and reporting safety concerns of equipment. Criteria #4: An Audit will be conducted by Maintenance Director or designee daily x2 weeks, weekly x2 and Monthly x 2 to ensure splash guard is in good repair	7/7/13
	(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.	A Vint	and preventing splatter to the food processing area. Results from these audits will be reviewed by the facility Quality Assurance Committee for further recommendations as deemed necessary.	7/7/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.

Facility ID: 923090

STATEMEN AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION D1 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		345173	B. WING	·	ر المراجعة المراجعة المراجعة المراجعة ال	05/	23/2013
	ROVIDER OR SUPPLIER EALTH & REHAB CEI	VTER		2ξ	eet address, city, state, zip code of north ellis avenue UNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SO IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X6) COMPLETION DATE
K 076	Continued From pa (b) Locations for su 3,000 cu.ft. are ven 4.3.1.1.2, 19.3.2.4	poly systems of greater than	K	076	No resident experienced any negati- outcome from this cited deficiency. K 076 Criteria #1: Oxygen cylinder was immediately removed and placed in storage that provided support.		7/7/13
	Surveyor: 27871 Based on observati approximately 8:30 Items were noncom	s not met as evidenced by: ons and staff interview at am onward, the following pliant, specific findings nder was unsupported in med.	¥		Criteria #2: Administrator and Dire of Maintenance audited facility to identify oxygen cylinders potentiall being stored without support. No Oxygen cylinders were found to be with out support.	y not	7/7/13
	42 CFR 483.70(a)	<i>ਜੰ</i>			Criteria#3: All staff will be educated the proper storage of oxygen cylind including the need for support.		<i>7/7/</i> 13
		*	r 1,	Commence of the Commence of the state of the	Criteria #4: Director of nursing or designee will audit facility daily x 2 weeks, weekly x 2, monthly x 2. to ensure all oxygen cylinders are store properly with support. Results from audits will be reviewed by the facility Quality Assurance Committee for fur recommendations as deemed necess	ed these ty orther	7/7/13
				والمناوات والمساولة والمراوات والمراوات والمتحددة والمتحددة والمتحددة والمتحددة والمتحددة والمتحددة			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/24/2013 FORM APPROVED OMB NO. 0938-0391

		& MEDICAID SERVICES /			OMB NO. 0938-03
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	PLE CONSTRUCTION 3 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
		3451/8	B. WING_		05/23/2013
	PROVIDER OR SUPPLIER EALTH & REHAB CEN	YTER		REET ADDRESS, CITY, STATE, ZIP CODE 201 NORTH ELLIS AVENUE DUNN, NC 28334	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETIC
K 000	conducted as per Ti at 42 CFR 483.70(a Health Care section publications. This bi construction, three s automatic sprinkler	de(LSC) survey was the Code of Federal Register); using the 2000 Existing of the LSC and its referenced uilding is Type I -fire resident story, with no complete system. Building a	K 000	of any specific findings or allegat We reserve the right to contest the findings or allegations as part of proceeding and submit these respursuant to our regulatory obligat No resident experienced any negations outcome from this cited deficiency.	curacy ions. ne f any ponses ions.
K 069 SS≖E	are as follows: NFPA 101 LIFE SAI Cooking facilities are	ermined during the survey FETY CODE STANDARD protected in accordance 6, NFPA 96	× K 069	K 069 Criteria #1: A stainless steel splat guard was installed between the fifood processer to provide protecti grease splatter.	ryer and 7/7/13
- 1	Surveyor: 27871 Based on observation approximately 8:30 approximately	not met as evidenced by the sand staff interview at monward, the following violant, specific findings are in kitchen did not have the sand	CEI W 17	areas/equipment needing splash g installed to prevent splashing of h substances.	nance 7/7/13 uards ot
K 076	42 CFR 493.70(a)	ety code standard	/ K 076	Scritcha#3: All staff will be educ identification and reporting safety concerns of equipment.	7/7/13
	protected in accorda Standards for Health	Care Facilities.		Criteria #4: An Audit will be conby Maintenance Director or design daily x2 weeks, weekly x2 and Me 2 to ensure splash guard is in good and preventing splatter to the food	nee onthly x I repair
	(a) Oxygen storage l 3,000 cu.ft. are enck separation.	ocations of greater than seed by a one-hour		processing area. Results from thes will be reviewed by the facility Qu Assurance Committee for further recommendations as deemed nece	e audits lality 7/7/13

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

PRINTED: 05/24/2013

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 05/23/2013 345173 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 201 NORTH ELLIS AVENUE **DUNN HEALTH & REHAB CENTER DUNN, NC 28334** PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) No resident experienced any negative K 076 K 076 | Continued From page 1 outcome from this cited deficiency. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 K 076 4,3.1.1,2, 19.3,2,4 Criteria #1: Oxygen cylinder was immediately removed and placed in 7/7/13 storage that provided support. Criteria #2: Administrator and Director This STANDARD is not met as evidenced by: of Maintenance audited facility to Surveyor: 27871 identify oxygen cylinders potentially not Based on observations and staff interview at being stored without support. No 7/7/13 approximately 8:30 am onward, the following items were noncompliant, specific findings Oxygen cylinders were found to be stored include: oxygen cylinder was unsupported in med. with out support. room on 3rd floor. Criteria#3: All staff will be educated on 42 CFR 483,70(a) the proper storage of oxygen cylinders 7/7/13 including the need for support. Criteria #4: Director of nursing or designee will audit facility daily x 2 weeks, weekly x 2, monthly x 2. to ensure all oxygen cylinders are stored properly with support. Results from these audits will be reviewed by the facility Quality Assurance Committee for further 7/7/13 recommendations as deemed necessary.