STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345555	A. BUILDING _____ B. WING _____	C 10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRABTREE VALLEY REHAB CENTER	3830 BLUE RIDGE ROAD RALEIGH, NC 27612

(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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and record review, the facility failed to conceal a urinary drainage bag to ensure privacy for 1 of 4 (resident #171) residents reviewed for urinary catheters. Findings included: Resident #171 was admitted to the facility with cumulative diagnoses of dementia and urinary retention. The most recent quarterly Minimum Data Set (MDS) dated 10/03/13 indicated resident #171 had severe cognitive impairment, required total assistance with all activities of daily living (ADLs) and coded for a urinary catheter. In an observation on 10/30/13 at 11:30 AM, resident #171 was sitting in a wheelchair in her room with the door open. The urinary drainage bag was observed out of the privacy bag attached to the wheelchair and touching the floor. The urinary drainage bag was observable from the hallway. In another observation on 10/31/13 at 11:15 AM, resident #171 was observed sitting in a wheelchair in the hallway outside the beauty shop. The urinary drainage bag was secured the back of the wheelchair. There was no privacy bag concealing the urinary drainage bag. During a continuous observation from 11:15 AM to 11:30	F 241	**This plan of correction constitutes our Credible Allegation of Compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the conclusion set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state laws.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: LNHA — (X6) DATE: 11/14/13

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 241	Continued From page 1 AM, numerous staff members were observed walking past resident #171 sitting in the hallway. On 10/31/13 at 11:30 AM, the director of nursing (DON) noticed the exposed urinary drainage bag. The DON asked a staff member to remove resident #171 from the hallway and ensure the urinary drainage bag was covered. The DON stated the urinary drainage bag should always be covered to ensure privacy. In an interview with nurse #1 on 10/31/13 at 11:40 AM, she stated resident #171 should have a privacy bag covering the urinary drainage bag at all times. Nurse #1 confirmed she was assigned to resident #171 on 10/30/13 and 10/31/13 and was not aware the urinary drainage bag was exposed. In an interview with nursing assistant (NA) #1 on 10/31/13 at 11:40 AM, she stated she had gotten resident #171 up on 10/30/13 and again on 10/31/13. She stated the urinary drainage bag should be in a privacy bag at all times. NA #1 stated that on 10/31/13 she got resident #171 up for a shower and used a different wheelchair that did not have a privacy bag attached to it. NA #1 stated she should have put the privacy bag on the wheelchair resident #171 was transported to the shower room in. NA #1 stated the shower aide must have put resident #171 in the hallway outside the beauty shop after her shower. In an interview with the shower aide on 10/31/13 at 12:00 PM, she stated resident #171 was brought to the shower room in a different wheelchair. She recalled no privacy bag being on the wheelchair. The shower aide stated she returned resident #171 to the same wheelchair	F 241	Resident #171 bag was immediately changed to a "Fig Leaf" bag that is the drainage bag and cover in one. All other residents with catheters were checked for privacy bags and found to be in compliance. Nurses/designee will be responsible to ensure all residents with foley catheters have been provided a cover for the drain bag within 4 hours of admission. The DON/designee will audit all residents requiring catheter bags for privacy bags a minimal of 1x weekly for 3 months, then monthly for 3 months. Results will be reported during monthly QA meeting to the committee who will determine the duration of future audits.	11-1-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 241	Continued From page 2 she was transported to the shower room in and NA #2 wheeled her from the shower room. The shower aide stated the urinary drainage bag should be covered for resident privacy. In an interview with NA #2 on 10/31/13 at12:05 PM, she recalled transporting resident #171 from the shower room to the beauty shop. NA #2 stated she did not notice if the urinary drainage bag was in a privacy bag when she left resident #171 sitting in the hallway outside the beauty shop. NA #2 stated the urinary drainage bag should be concealed in a privacy bag for dignity. In an interview with the unit manager on 10/31/13 at 12:10 PM, she stated the urinary drainage bag should not be uncovered to allow anyone to see urine and the staff was aware of this privacy concern. The unit manager stated the facility had urinary drainage bags to conceal the urine but the bag in place was the one from where the suprapubic catheter was placed on last week. In an interview with the administrator on 10/31/13 at 12:4 0 PM, she stated her expectation was for either the drainage bag be changed from the see through bag to a concealed blue bag or be placed in a slip cover to conceal the urine.	F 241		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff	F 333		

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F 333	Continued From page 3 interviews, the facility failed to administer the correct dosage of Dilantin as ordered by the physician for 1 of 8 residents observed during a medication pass (Resident #169). The findings included: Resident #169 was admitted into the facility on 6/17/13 with a diagnosis of seizure disorder. The annual minimum data set completed on 8/16/13 indicated Resident #169 was cognitively intact. The care plan initiated on 6/25/13 through 11/16/13 (goal date) indicated as an intervention for seizure disorder that medications would be administered per the physician order. A review of the medication administration record for October 2013 read "Phenytoin Sodium 100 mg (milligrams) (for Dilantin) Give two caps 200 mg by mouth every day with 50 mg=250 mg for seizure disorder." A review of the signed physician orders for October 2013 read "Phenytoin Sodium 100 mg (for Dilantin) Give two caps 200 mg by mouth every day with 50 mg=250 mg for seizure disorder." During a medication observation on 10/31/13 at 8:27 am, Nurse #2 administered Dilantin 100 mg two tablets (200 mg total) by mouth to Resident #169. In an interview on 10/31/13 at 9:12 am, Nurse #2 when questioned regarding the incorrect dosage of Dilantin administered to the resident stated the medication order read to give 200 mg only. Nurse #2 reported that she had informed Nurse #3 on 10/30/13 to ensure that Dilantin 200 mg was transcribed to the medication administration	F 333	The DON ensured that Resident # 169 is receiving the correct dosage of Dilantin 250 mg and corrected the orders to reflect such. All residents receiving Dilantin, MARS were checked and all were in compliance with the orders. 100% audit of physician orders, MARS, of all residents receiving Dilantin will be completed by 11-22-13. The DON/designee in-serviced all nursing staff on 11-5-13 as to ensuring accurate MARS. Medication orders will be checked off by two nurses, as it relates to Dilantin orders- Unit Managers will audit daily and prn for compliance and report to the DON. The DON and/ designee will audit nurses via medication pass audits, minimal of weekly for 4 weeks, and on an on-going PRN basis.	11-5-13 11-22-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345555	A. BUILDING _____ B. WING _____	C 10/31/2013

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F 333	Continued From page 4 record correctly as she thought that the resident was suppose to receive Dilantin 200 mg (total dosage) and that the additional 50 mg had been discontinued. Nurse #2 added that Nurse #3 reported back to her per review of the chart that she did not see an order to discontinue Dilantin 50 mg and that the resident was to receive Dilantin 250 mg every day. In an interview on 10/31/13 at 9:20 am, Nurse #3 indicated that when Nurse #2 informed her on 10/30/13 to discontinue Dilantin 50 mg (for a total dosage of 200 mg) she informed Nurse #2 that after reviewing the chart she did not see an order to do such and that the resident was to receive Dilantin 250 mg (total dosage). In an interview on 10/31/13 at 10:30 am, the Pharmacist stated that per her review of Resident #169's profile the current order to be administered was "Phenytoin Sodium 100mg (for Dilantin) Give 250 mg for seizure disorder every day." She concluded there was no order on file for 200 mg to be administered as a total dosage, nor had the 50 mg been discontinued since admission. In an interview on 10/31/12 at 3:12 pm, the Director of Nursing stated per her review of the clinical record Resident #169 should have received Dilantin 250 mg.	F 333	Findings will be reported to the QA committee on a minimal monthly basis for the next 3 months. The QA committee will determine the duration of future audits.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete;	F 514		

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F 514	Continued From page 5 accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to ensure the medication administration record was accurate which resulted in the wrong dosage of Dilantin administered to 1 of 8 residents reviewed during medication reconciliation (Resident #169). The findings included: Resident #169 was admitted into the facility on 6/17/13 with a diagnosis of seizure disorder. The annual minimum data set completed on 8/16/13 indicated Resident #169 was cognitively intact. The care plan initiated on 6/25/13 through 11/16/13 (goal date) indicated as an intervention for seizure disorder that medications would be administered per the physician order. A review of the admission FL2 (medications) signed by the physician on 6/3/13 indicated the following was ordered: 1) Dilantin 50 milligrams (mg) one tablet daily 2) Dilantin 100 mg two caps daily. A review of the admission orders (medications) dated 6/17/13 and signed by the physician on 6/19/13 indicated the following was ordered:	F 514		

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F 514	Continued From page 6 Dilantin 250 mg daily for seizure disorder. A review of the medication administration record (MAR) for July 2013, August 2013, September 2013 and October 2013 revealed Dilantin 50 mg was ordered to be given with Dilantin 200 mg for a total dosage of 250 mg daily. Dilantin 50 mg was documented as: 1) "Discontinued" on July 24, 2013 MAR with no identifying staff signature. 2 "Discontinued" on the August 2013 MAR with no identifying staff signature. 3) "Crossed through" on the September 2013 MAR with no identifying staff signature. 4) "Discontinued" on the October 2013 MAR with no identifying staff signature. The MAR from July 25, 2013, August 2013, September 2013 and October 2013 reflected Dilantin 200 mg was administered daily instead of 250 mg daily as ordered by the physician. During a medication observation on 10/31/13 at 8:27 am, Nurse #2 administered Dilantin 100 mg two tablets (200 mg total) by mouth to Resident #169. In an interview on 10/31/13 at 9:12 am, Nurse #2 when questioned regarding the incorrect dosage of Dilantin administered to the resident stated the medication order read to give 200 mg only. Nurse #2 further reported that she had informed Nurse #3 on 10/30/13 to ensure that Dilantin 200 mg was transcribed to the medication administration record correctly as she thought that the resident was suppose to receive Dilantin 200 mg (total dosage) and that the additional 50 mg had been discontinued. Nurse #2 added that Nurse #3	F 514	The DON ensured that Resident # 169 is receiving the correct dosage of Dilantin 250 mg and corrected the orders to reflect such. All residents receiving Dilantin, MARS were checked and all were in compliance with the orders. 100% audit of physician orders, MARS, of all residents receiving Dilantin will be completed by 11-22-13. The DON/designee in-serviced all nursing staff on 11-5-13 as to ensuring accurate MARS. Medication orders will be checked off by two nurses, as it relates to Dilantin orders- Unit Managers will audit daily and prn for compliance and report to the DON. The DON and/ designee will audit nurses via medication pass audits, minimal of weekly for 4 weeks, and on an on-going PRN basis.	11-5-13 11-22-13

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F 514	Continued From page 7 reported back to her per review of the chart that she did not see an order to discontinue Dilantin 50 mg and that the resident was to receive Dilantin 250 mg every day. Nurse #2 acknowledged that she had not administered the additional Dilantin 50 mg since the day it was signed as discontinued (on July 24, 2013 per the MAR). In an interview on 10/31/13 at 9:20 am Nurse #3 indicated that when Nurse #2 informed her on 10/30/13 to discontinue Dilantin 50 mg (for a total dosage of 200 mg) she informed Nurse #2 that after reviewing the chart she did not see an order to do such and that the resident was to receive Dilantin 250 mg (total dosage). In an interview on 10/31/13 at 10:30 am, the Pharmacist stated that per review of Resident #169's profile the current order to be administered was "Phenytoin Sodium 100 mg (for Dilantin) Give 250 mg for seizure disorder every day." She concluded there was no order on file for 200 mg to be administered as a total dosage, nor had the 50 mg been discontinued since admission. In an interview on 10/31/12 at 3:12 pm, the Director of Nursing stated per review of the clinical record Resident #169 should have received Dilantin 250 mg daily and that Dilantin 50 mg should not have been discontinued on the MAR without a physician order to do so.	F 514	Findings will be reported to the QA committee on a minimal monthly basis for the next 3 months. The QA committee will determine the duration of future audits.	

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

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DEC 02 2013
CONSTRUCTION SECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345555	A. BUILDING 01 - BLUE RIDGE HEALTHCARE CENTER B. WING	11/13/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GRABTREE VALLEY REHAB CENTER	3830 BLUE RIDGE ROAD RALEIGH, NC 27612

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K 000	INITIAL COMMENTS 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 V (111) protected construction, one story, with a complete automatic sprinkler system. The fire alarm failed to activate and was not tested any farther , the facility was under a fire watch The deficiencies determined during the survey are as follows:	K 000	This plan of correction constitutes our Credible Allegation of Compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the conclusion set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provision of federal and state law.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire 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 This STANDARD is not met as evidenced by: A. Based on observation on 11/13/2013 the corridor storage room near the Rehab. Dept. did have a closer. on it. B. The storage room at the 400 hall nurses station did not close and latch. 42.CFR 483.70 (a)	K 029	K029 1. A. Closer applied to storage room near Rehab. B. Closer adjusted to correct deficient practice. Door is closing and latching properly. 2. Maintenance director or designee inspected all storage doors to ensure operational compliance. 3. Maintenance director/designee will monitor all storage doors to ensure operational compliance, monthly for a period of 3 months. 4. Maintenance director/designee will report findings of the QA committee on a monthly basis for the next 3 months.	11-15-13 11-19-13

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

admin 11-22-13

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.

CP

B-PASS -92381

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K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 11/13/2013 the following doors required more than one motion of the hand to to exit the room, a.soiled linen at the 100/200 nurses station also the mens room there b.the kitchen doors (all doors) c. the soiled utility room at 300 hall nurses station. d. the employees beark room 42 CFR 483.70 (a)	K 038	1. A. The door knobs will be changed out to the a. Soiled linen room 100/200 nurses station and the mens room there. b. All doors to the main kitchen c. Soiled utility room at 300 hall nurses station d. The employee breakroom 2. Maintenance director/designee will inspect all doors in the facility for one motion of the hand ability to exit. 3. The maintenance director/designee will monitor all applicable doors in the facility to ensure compliance is accomplished. 4. Findings will be reported to the QA committee on a monthly basis for the next 3 months.	12-26-13
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: A. Based on observation ob11/13/2013 there	K 076	K076 ?	

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	345555	A. BUILDING 01 - BLUE RIDGE HEALTHCARE CENTER B. WING	11/13/2013

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K 076	Continued From page 2 were full and empty 02 cylinders mixed and unsecured in the 02 room near323.	K 076	K076 1. O2 cylinders were inspected and put in the appropriate storage areas in the storage room near 323. 2. Maintenance director/designee will educate staff on the importance of correctly storing the 02 cylinders. 3. Maintenance director/ designee will monitor all 02 storage rooms to ensure proper storage of cylinders, weekly for 4 weeks, then monthly for 4 months. 4. Findings will be reported to the QA committee on a monthly basis for a period of 4 months.	12-6-13
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: A. Based on observation on 11/13/2013 the hot water temp. on the 400 hall was 119.5 degrees F	K 130	K130 1. 400 hall water temperature was adjusted to meet compliance. 2. Maintenance director/designee inspected water temperatures on each hall to ensure all temperatures were in compliance. 3. Maintenance director/designee will monitor water temps weekly to ensure compliance. 4. Findings will be reported to the QA committee on a monthly basis for a period of 4 months.	11-13-13 11-15-13