STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. BUILDING _____ B. WING _____	C 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CORNERSTONE NURSING AND REHABILITATION CENTER	**711 SUSAN TART ROAD BOX 948 DUNN, NC 28334**

(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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225		5/30/14

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

Electronically Signed | 05/23/2014

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 225	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to complete a 24 hour report and a 5 day working report and submit it to the Health Care Personnel Registry and the facility failed to thoroughly investigate an injury of unknown origin for 1 of 3 (resident #1) residents reviewed for injuries. Findings included: Resident #1 was admitted on 11/3/09 with cumulative diagnoses cerebral vascular accident with hemiplegia, seizures, arthritis, diabetes and osteoporosis. Her annual minimum Data Set dated 4/3/14 indicated she had sever cognitive impairment and required extensive assistance with bed mobility, total assistance one using a lift, non-ambulatory and total assistance for all other activities of daily living. Resident #1 was care planned for a lift for transfer with the assistance of one with last review date of 4/29/14. A review of an incident report dated 5/1/14 indicated resident #1 was noted with abnormal rotation of the right leg by the 11-7 shift staff. There was observed swelling to the right thigh and evidence of pain. Witness statements from the 3rd shift NA #1 indicated resident #1 was yelling when she came in at 11:00 PM. She recalled resident #1 yelling most of the shift and other staff working was witness to her yelling. NA #1 notified the nurse that resident #1's right foot was turned outward the right thigh was swollen. The witness statement from nurse #1 stated NA#1 reported resident #1 was fussy but would quiet down. She administered her breathing treatment and medicated her with Tylenol for pain. It was around 3:30 AM, NA#1 reported concern about resident #1's right leg. Nurse #1	F 225	Cornerstone Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Cornerstone Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Cornerstone Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute resolution, formal appeal procedure and/ or any other administrative or legal proceeding. 1. 24 hour and 5 day report completed by Administrator and faxed to NCHCPR on 5/15/14. The investigation for the injury of unknown origin was initiated by the DON on 5/1/14 and completed on 5/15/14 by the Administrator. 2. 100% audit was initiated and completed on 5-15-14 for last 30 days of all incidents by DON, ADON, and QI Nurse to ensure any identified injuries of unknown origin were thoroughly investigated and submitted to the Health Care Personnel Registry. All areas of concern were addressed by ADON on	

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F 225	Continued From page 2 assessed her and resident #1 was able to move both legs and did not yell. At the end of the shift she stated the right foot looked more rotated. In a review of the hospital emergency room record dated 5/1/14, resident #1 was diagnosed with a right femur fracture and assessed with moderate to severe pain on 5/1/14. In an interview on 5/14/14 at 11:20 AM, the director or nursing (DON) provided an investigation of the injury to resident #1 on 5/1/14. The investigation was dated 5/2/14 and included a discussion of the injury with the responsible party (RP). Statements were taken from all staff that worked with resident #1 on 4/30/14 and 5/1/14 and according the DON, it was determined due to resident #1's diagnosis of osteoporosis, history of placing her legs over the side of the bed and a habit of bouncing her legs up and down when in her chair, the injury was likely pathological in nature. The RP was in agreement with the outcome of the DON's investigation. In a telephone interview on 5/14/14 at 2:50 PM, the nurse practitioner (NP) stated she recalled the orders for the x-ray and pain medication but they ended up sending Ms. Bushless to the hospital at the request of the RP. The NP stated the injury was likely pathological in nature due to her history of severe osteoporosis and no evidence of falls or trauma. In an interview at 5/14/14 at 1:30 PM, the administrator stated he was unaware that injuries of unknown origin needed to be reported to the state agencies utilizing the 24 hour and 5 working day reports. In an interview on 5/14/14 at 4:00 PM, the	F 225	5/16/14. 3. The Administrator and Director of Nursing were in-serviced by the corporate clinical director on 5/15/14 regarding thoroughly investigating and completing 24 hour and 5 day report and submitting to the Health Care Personnel Registry for all injury of unknown origins. Department managers and licensed staff in-service initiated 5-15-14 by the Staff Facilitator and completed on 5-22-14 by DON and Administrator regarding guidelines for reporting and investigating incidents of unknown origin. Department managers and licensed staff will not be allowed to work until in-serviced. All newly hired department managers and licensed staff will be in-serviced by Staff Facilitator upon hire regarding guidelines for reporting and investigating incidents of unknown origin. 100% in-service with CNA□s and therapy staff initiated 5/23/14 and will be completed on 5/28/14 by Staff Facilitator regarding observing and reporting injury of unknown origin to the hall nurse. This will include but not limited to bruising, swelling, redness, or any physical abnormality. CNA□s and therapy staff will not be allowed to work until in-serviced. All resident incidents monitored daily by QI nurse and RN Supervisor utilizing Resident Event Tracking Log to ensure any identified injuries of unknown origin were thoroughly investigated and submitted to the Health Care Personnel Registry. All identified areas of concern	

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F 225	Continued From page 3 administrator and the DON stated that the fracture that occurred with resident #1 was believed to be pathological in nature based on their investigation but the facility should have submitted the 24 hour and 5 day working report.	F 225	were corrected by DON and Administrator. QI nurse, Staff Facilitator or RN Supervisor will complete the Accident with Injury Tracking Tool daily for any resident with an injury. Any injury of unknown origin will be reported to the DON and Administrator immediately. DON or ADON will review Accident with Injury Tracking tool for 100% of all injuries x 1 month, 50% of all injuries x 1 month and then 10% of all injuries x 1 month. DON or ADON will initial and date the Accident with Injury Tracking tool for those residents reviewed. Any incidents of Injury of Unknown Origin will be reported to the Administrator immediately. The Administrator will ensure that a 24 hour report and 5 day working report have been complete and thoroughly investigated for all identified injuries or unknown origins. Administrator will sign off report monthly as an ongoing monitor of incidents. 4. The QI committee will review the results of the audits at weekly QI meeting for identification of potential issues with follow up taken as deemed appropriate and to determine the continued need and frequency of monitoring.	
F 309 SS=G	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,	F 309		5/30/14

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F 309	Continued From page 4 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 staff interviews and record review, the facility failed to intervene for a resident experiencing pain with associated injury for 1 of 3 resident's (resident #1) reviewed for pain. Findings include: Resident #1 was admitted on 11/3/09 with cumulative diagnoses cerebral vascular accident with hemiplegia, seizures, arthritis, diabetes and osteoporosis. Her annual Minimum Data Set dated 4/3/14 indicated she had severe cognitive impairment and required extensive assistance with bed mobility, total assistance of one using a lift, non-ambulatory and total assistance for all other activities of daily living. Resident #1 was care planned for pain associated with osteoporosis, arthritis and decreased mobility. A nursing note dated 5/1/14 and timed 8:07 AM, read that resident #1 was fussy during the beginning of third shift. Nursing assistant (NA) #1 was concerned about resident #1's right upper leg. Nurse #1 assessed the leg and noted slight swelling but resident #1 able to move both legs without problem. There was no noted increased grimacing when moving her right leg. A nursing note dated 5/1/14 and timed 2:41 PM, read the third staff noted abnormal rotation and edema to resident #1's right upper leg. The leg was outwardly rotated and absent of obvious	F 309	Cornerstone Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Cornerstone Nursing and Rehabilitation Center□s response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Cornerstone Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute resolution, formal appeal procedure and/ or any other administrative or legal proceeding. 1. Resident #1 assessed 5-1-14 by DON; MD notified of assessment and new order received for alternative pain medication and x-ray of right leg. Pain medication obtained from facility emergency kit and administered by hall nurse on 5/1/14. Results of x-ray received on 5/1/14 and called to MD by DON; order received to	

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F 309	Continued From page 5 signs of trauma such as bruising. There was noted increased pain. An x-ray was ordered. A review of an incident report dated 5/1/14 indicated resident #1 was noted with abnormal rotation of the right leg by the third shift staff. There was observed swelling to the right thigh and evidence of pain. Witness statements from NA #1 indicated resident #1 was yelling when she came in at 11:00 PM. She recalled resident #1 yelling most of the shift and other staff working witnessed her yelling. NA #1 notified the nurse that resident #1's right foot was turned outward the right thigh was swollen. The witness statement from nurse #1 stated that NA #1 reported resident #1 was fussy but would quiet down. She administered her breathing treatment and medicated her with Tylenol for pain at the beginning of the shift. It was around 3:30 AM, NA#1 reported concerns about resident #1's right leg. Nurse #1 assessed her and resident #1 was able to move both legs and did not yell. At the end of the shift she stated the right foot looked more rotated. In an interview on 5/14/14 at 12:10 PM, nurse #2 who worked first shift on 5/1/14 stated nurse #1 reported to her that resident #1 was fussy on third shift and that NA #1 thought something was wrong with her leg. Nurse # 1 and nurse #2 went to assess resident #1. Nurse #2 stated she knew immediately something was wrong with resident #1's right leg and she was moaning. Nurse #2 went and got the staff facilitator and physical therapist to assess resident #1's leg. Nurse #2 advised nurse #1 she needed to notify the physician and get an order for an x-ray. Nurse #2 stated she was unsure if nurse #1 notified the RP. Nurse #2 stated the x-ray technician stated	F 309	obtain orthopedic consult. Orthopedic consult appointment received for 5-5-14. MD notified of orthopedic consult appointment date on 5/1/14 by DON. Order requested by DON and ADON to send resident to Emergency Room for evaluation. Resident #1 responsible party notified of new orders for alternative pain medication and order to send to Emergency Room on 5/1/14 by hall nurse. Resident #1 transferred to Emergency room 5-1-14. Resident #1 not present at time of survey. 2.100% audit of all residents initiated 5/15/14 and completed on 5/22/14 by DON, ADON, QI Nurse, and Staff Facilitator to assess all residents for pain utilizing Pain Assessment Tool for documentation. The MD was immediately notified of all residents having breakthrough pain and ineffective pain management by the ADON. PCC Communication Board was reviewed daily 5/15/14 - 5/22/14 by ADON and /or RN Supervisor. This was to ensure MD/RP notification was completed by the hall nurse for all residents noted with breakthrough pain, new pain, or ineffective pain management. 100% audit of all residents progress notes for past 30 days will be initiated on 5/23/14 and completed on 5/28/14 by Staff Facilitator, QI nurse, Treatment Nurse, MDS Coordinator, and MDS Nurse for documentation of signs and symptoms of pain to ensure all residents identified with new signs and symptoms of pain and/or ineffective pain management, or pain associated with an injury has been	

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F 309	Continued From page 6 resident #1 was experiencing pain during x-ray so he stopped and spoke with the assistant director of nursing (ADON) about resident #1 pain. Nurse #2 stated the x-ray was positive for a right femur fracture and she notified the RP and physician. The physician ordered an orthopedic consult and a medication for pain. Nurse #2 stated she was unable to get an appointment with an orthopedic doctor until the following Monday but due to resident #1's pain, the RP requested resident #1 to be sent to the hospital for an evaluation. She stated she administered the ordered pain medication to resident #1 at 12:00 PM prior to her being transported to the hospital. In an interview on 5/14/14 at 12:20 PM, nurse #3 recalled resident # 1 slept most of the day on second shift on 4/30/14. She recalled the NA #3 put resident #1 to bed at the early part of second shift and it was at the end of the shift she noted resident #1 yelling. Nurse #3 stated she did not go and assess resident #1 because she had reported off to nurse #1. In an interview on 5/14/14 at 12:40 PM, NA #2 stated she worked with resident #1 on first shift 4/30/14 and she had gotten resident #1 up in her chair using the lift before lunch and when she left for the day, resident #1 was still sitting up in her chair. NA #2 stated resident #1's care guide indicated she was a lift with one person assistance. She exhibited her usual behavior of babbling but expressed no yelling or evidence of pain. In a telephone interview on 5/14/14 at 12:45 PM, NA #1stated she heard resident #1 yelling when she came in on for her shift at 11:00 PM on 4/30/14. NA #1 stated she requested nurse #1	F 309	assessed by the hall nurses, intervened, and MD/RP notified. 100% in-service initiated by Staff Facilitator on 5/16/14 and will be completed on 5/28/14 by Staff Facilitator and DON with all CNA□s and therapy staff regarding reporting to hall nurse, signs and symptoms of pain. CNA□s and therapy staff will not be allowed to work until in-serviced is received. All newly hired CNA□s and therapy staff will be in-serviced by Staff Facilitator upon hire in orientation on reporting to hall nurse signs and symptoms of pain. 100% in-service initiated by Staff Facilitator 5/16/14 and completed 5/22/14 by Staff Facilitator and DON with Licensed Nurses regarding assessment of pain to include pain associated with an injury and notification to MD of new signs and symptoms of pain and/or ineffective pain management. Licensed nurses will not be allowed to work until in-serviced is received. All newly hired Licensed Nurses will be in-serviced upon hire in orientation by Staff Facilitator regarding assessment of pain to include pain associated with an injury and notification to MD of new signs and symptoms of pain and/or ineffective pain management. On 5/19/14 ADON, Staff Facilitator, QI nurse, Treatment Nurse, MDS Coordinator, and MDS Nurse were in-serviced by DON regarding monitoring Progress Notes, Pain Alerts, and Behavior documentation utilizing QI Tool for Monitoring Progress Notes for Acute Changes to Include Pain and QI Tool for Monitoring Pain/Behavior Alerts. This will	

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F 309	Continued From page 7 give resident #1 something for pain and she continued with making her first rounds of the shift. NA #1 stated it was about 10 minutes later that resident #1 again began yelling and she noted her peers discussed that something was wrong with resident #1 because it was not like her to yell. Na #1 stated she went into the room and pulled the cover back to check to see if resident #1 was wet and she noticed her thigh was swollen. NA #1 stated she went and told nurse #1 but nurse #1 did not go and assess resident #1 at that time. NA #1 stated at around 3:00 AM or 4:00 AM, she and nurse #1 went together to look at resident #1's right leg. Nurse #1 stated it looked normal but did appear slightly swollen to her right thigh. At the end of her shift, NA # 1 noted resident #1 was still yelling when she left at 7:00 AM. In an interview on 5/14/14 at 1:40 PM, the ADON stated resident #1 never yelled or screamed and her normal behavior was verbal gibberish. She recalled the staff facilitator telling her that resident #1's leg did not look right but she did not appear in pain. She recalled getting an order for an x-ray and the x-ray technician coming to her and stated the leg was likely fractured and he was not going to move her leg. The ADON stated she was at the physician's office picking up some paperwork and spoke with the nurse practitioner about resident #1 pain and got an order for a narcotic pain medication and orders to send resident #1 to the hospital since an orthopedic consult was unlikely till the following week. In a telephone interview on 5/14/14 at 1:45 PM, NA #3 stated when she came in at 3:00 PM on 5/1/14, resident #1 was sitting up in her chair. She stated she used the lift to put resident #1 into	F 309	ensure new signs and symptoms of pain and/or ineffective pain management is assessed by the hall nurse and MD/RP notified. 3. All resident progress notes, Pain Alerts, Behavior Documentation, and incident reports will be monitored by Staff Facilitator, QI nurse, Treatment Nurse, MDS Coordinator, and MDS Nurse utilizing Pain Audit Tool to ensure all residents identified with new signs and symptoms of pain and/or ineffective pain management, or pain associated with an injury has been assessed by the hall nurses, intervened, and MD/RP notified. All identified areas of concern will be corrected by DON and ADON. Pain Audit Tool will be completed 5 x week x 4 weeks, 3 x week x 4 weeks, then weekly x 4 weeks by QI Nurse, Staff Facilitator, Treatment Nurse, MDS Coordinator, and MDS Nurse. Pain Audit Tool will be monitored for completion by Administrator, DON, or ADON 2 x week x 4 weeks, then weekly x 4 weeks, then monthly x 1 month utilizing QI Tool for New Signs of Pain and/or Ineffective Pain Management. 4.The QI committee will review the results of the audits at weekly QI meeting for identification of potential issues with follow up taken as deemed appropriate and to determine the continued need and frequency of monitoring.	

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F 309	Continued From page 8	F 309		

the bed and made rounds on her at approximately 8:00 PM and again at 10:30 PM. NA #3 recalled resident #1 being wet at 10:30 PM so she rolled resident #1 onto her left side using the lift pad and changed her brief. NA #3 stated resident #1 did not exhibit any overt signs of pain while care was provided. It was at around 10:50 PM, she heard resident #1 yelling. She stated she went into the room to check resident #1 but did not touch her or remove her covers to see her body.

In an interview on 5/14/14 at 2:20 PM, the staff facilitator stated nurse #2 asked her to assess resident #1's right leg. She recalled asking the physical therapist (PT) to go with her to assess resident #1. The staff facilitator stated resident #1's right foot was turned outward and her right thigh was swollen but resident #1 was not yelling out in pain.

In an interview on 5/14/14 at 2:30 PM, the PT stated on assessment of resident #1's right leg on 5/1/14, she observed resident #1 thrashing about in the bed. She was not screaming but she was crying and grimacing. The PT stated she felt a boney prominence to the right lateral side of the hip and thought resident #1 ' s right leg was either dislocated or fractured. The PT noted the leg being externally rotated as well. She suggested an x-ray of the entire leg and not just the hip to rule out a femur fracture.

In a telephone interview on 5/14/14 at 2:45 PM, NA #4 stated she heard resident #1 yelling and hollering when she came in on third shift 5/1/14. She recalled discussing with her peers that something wrong with resident #1 because she does not normally behave in that manner.

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CORNERSTONE NURSING AND REHABILITATION CENTER	711 SUSAN TART ROAD BOX 948 DUNN, NC 28334

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F 309	Continued From page 9 In a telephone interview on 5/14/14 at 2:50 PM, the nurse practitioner (NP) stated she recalled speaking to the ADON about not being able to get resident #1 into to see an orthopedic doctor and she gave an order for a pain medication. It was decided to send resident #1 to the hospital for evaluation. The NP stated it would be her expectation that any resident with an acute injury expressing pain, the facility contact the physician and send the resident out to the hospital immediately. In a telephone interview on 5/14/14 at 3:00 PM, NA #5 stated resident #1 was known to throw her legs over the side of the bed and she would babble when she was cold or wet. NA #5 stated she was working on 200 hall on 5/1/14 and did not hear resident #1 yelling but she did recall hearing her peers discussing concerns about why resident #1 was yelling. In a telephone interview on 5/14/14 at 3:20 PM, nurse #1 stated she recalled NA #1 approaching her midway through third shift stating that resident #1 was fussy. She stated she gave her Tylenol and later in the shift NA #1 asked her to look at resident #1's right leg. Nurse #1 stated resident #1 was moving her legs but the right leg look more turned outward so she notified the NP around 6:45 AM. The NP ordered an x-ray of right leg. Nurse #1 stated she did not hear resident #1 yelling or screaming on her shift. In a review of the hospital emergency room record, resident #1 was diagnosed with a right femur fracture and assessed with moderate to severe pain on 5/1/14.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345325	A. BUILDING _____ B. WING _____	C 05/14/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 309	Continued From page 10 In an interview on 5/14/14 at 4:00 PM, the administrator and the DON stated it was their expectation that the staff call the physician and not wait when a resident exhibits evidence of pain or injury.	F 309		