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 _____	01/15/2015

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 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff and physician interviews, the facility failed to provide urinary catheter care for 1 of 3 residents reviewed for catheter care (Resident #78). The facility failed to wash hands and change gloves after cleaning the stool and providing catheter care for 1 of 3 residents reviewed for urinary catheter use (Resident #139). The facility failed to provide follow up with urology for a resident (Resident #139) with an indwelling catheter and Hematuria (blood in urine). Findings included: 1. Resident #78 was admitted into the facility on 9/11/14. Diagnosis per record review included Urinary Tract Infection, Retention of Urine, Chronic Kidney Disease, Hemiplegia and Stroke. The quarterly Minimum Data Set completed on 12/12/14 indicated Resident #78 cognitive status was severely impaired. Bed mobility required extensive assistance of two persons' physical assist. Toilet use and personal hygiene was indicated as total dependence of one person	F 315	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 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.	2/12/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/09/2015

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F 315	Continued From page 1 physical assist. Indwelling catheter (urinary) was listed with bowel as always incontinent. A review of the care plan with a target date of 12/31/14 listed altered urinary elimination with an indwelling urinary catheter. Care intervention read "Catheter care per facility protocol." A review of the bowel movement sheet for dated 1/13/15, NA (Nursing Assistant) #2 documented Resident #78 had a small, formed bowel at 1:11 pm. On 1/13/15 at 3:42 pm, during an observation with NA #3, Resident #78's urinary catheter was observed with dried matter on the catheter tube near the meatus. On 1/13/15 at 3:44 pm, in an interview, NA #3 stated urinary catheter care was not a routine part of daily care to residents. NA #3 added he only documented in the electronic system daily to include: amount of urine emptied from the urinary drainage bag and if a resident had a catheter. On 1/13/15 at 3:50 pm, in an interview, Nurse #4 indicated the NAs and the treatment nurse was responsible for performing urinary catheter care on the residents. On 1/13/15 at 3:56 pm, in an interview, NA #4 stated urinary catheter care was not part of her daily routine she provided to the residents. NA #4 indicated she only empties the urinary drainage bag and recorded the results in the electronic system. On 1/13/15 at 4:00 pm, in an interview, NA #5, primary NA for Resident #78 from 3pm - 11pm;	F 315	Resident #78 catheter tubing was cleaned by Hall Nurse on 1/13/15 and assessed for any signs or symptoms of infection. NA #2, NA #3, NA #4, NA #5, Nurse #4, Nurse #5 and Nurse #6 were in-serviced on proper procedure for catheter care and to provide catheter care daily and as needed, by the Staff Facilitator on 1/14/15. Catheter care was redone on resident #139 by the Treatment Nurse on 1/14/15. NA #6 was in-serviced on washing hands and changing gloves after cleaning stool and the proper procedure for providing catheter care on 1/14/15 by the Staff Facilitator. A return demonstration was completed with NA #6 on 1/21/15 by the Staff Facilitator to ensure washing hands and changing gloves after cleaning stool and proper procedure for providing catheter care. MD was notified of missed urology report by the Treatment Nurse on 1/14/15 for resident #139 and urology appointment was scheduled, which resident attended on January 22,2015,by the Ward clerk. Resident #78 foley catheter was discontinued on 1/14/15 by the Hall Nurse. 100% audit of all residents with foley catheters to include residents #78 and #139 was assessed by the Treatment Nurse, for cleanliness to include brown matter on 1/12/15 thru 1/15/15. Proper catheter care was provided to all residents with foley catheters on 1/12/15 thru 1/15/15 to include resident #78 and resident #139 by the Treatment Nurse.	

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F 315	Continued From page 2 stated he was not responsible for providing urinary catheter care to Resident #78. NA #5 acknowledged he was the primary NA for Resident #78 from 3pm to 11 pm and as it related to the urinary catheter he was only responsible for empting the urinary drainage bag and record the results of the urine amount in the electronic system. On 1/14/15 at 10:00 am, in an interview, Nurse #5 (treatment nurse) stated her responsibility was to change the urinary catheter once a month for residents. She indicated she did not provide catheter care because the NAs were responsible for providing catheter care to the residents. On 1/14/15 at 10:10 am, in an interview, Nurse #6 stated she was not responsible for providing urinary catheter care. She stated the NAs were responsible for completing catheter care with morning care. On 1/14/15 at 11:34 pm, in an interview, the Director of Nursing (DON) indicated NAs were responsible for providing urinary catheter care daily and as needed. The DON stated she was not aware the NAs were not aware they were responsible for providing urinary catheter care. On 1/14/15 at 2:15 pm, in an interview, NA #2; the primary NA for Resident #78 on 1/13/15 from 7 am - 3 pm, stated she did not perform urinary catheter care for Resident #78 as part of daily care on 1/13/15. NA #2 indicated normally she did not do anything with urinary catheters, however if a resident had a bowel movement, she would clean the urinary catheter with a prepackaged moisture wipe, but she did not provide any care to the catheter on 1/13/14.	F 315	100% audit to include NA #2, NA #3, NA #4, NA #5, Nurse #4, Nurse #5, and Nurse #6 was initiated by the Staff Facilitator on 1/19/15 on return demonstration for all C.N.A□s and nurses on catheter care to include cleaning of stool, washing of hands and changing of gloves during and after perineal care. Any concerns that were observed during return demonstrations were immediately corrected by the Staff Facilitator. 100% audit of all resident□s appointments to include resident #139 was completed for the last 90 days to include newly admitted residents, this was initiated on 1/15/15 by MDS Coordinator, MDS Nurse, Medical Records, Ward Clerk and Treatment Nurse for any missed appointments to include urology appointments that were scheduled. Any concerns that were observed during this audit were corrected by Treatment Nurse and Hall Nurses to include MD notification, and reschedule appointment as appropriate. 100% in-service with all C.N.A□s and licensed nurses to include # NA #2, NA #3, NA #4, NA #5, Nurse #4, Nurse #5, and Nurse #6 on proper procedure for providing catheter care to include cleaning of stool, washing of hands and changing of gloves during and after perineal care by Staff Facilitator on 1/14/15. In-service was initiated on 2/4/15 to the Ward Clerk to notify Hall Nurse of all missed appointments and to reschedule missed appointments. 100% of licensed nurses were in-serviced to notify the attending physician if a resident was unable to	

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F 315	Continued From page 3 On 1/15/15 at 1:02 pm, in an interview, the DON indicated urinary catheter care include cleaning the urinary catheter with soap and water. 2a. Resident #139 was admitted to the facility on 10/27/14 with medical diagnoses which included chronic kidney disease, unspecified urinary retention, and indwelling urinary catheter. The most recent quarterly Minimum Data Set (MDS) dated 1/2/15 documented the resident was moderately cognitively impaired. The care plan dated 1/7/15 documented the resident had an altered pattern of elimination with indwelling catheter. The goal stated for the problem was the resident would be free from urinary tract infection through the next review period with interventions which included catheter care per facility protocol. On 1/14/15 at 11:32 am, an observation was made of NA #6 providing incontinent care and catheter care for Resident #139. The NA began by cleaning the resident rectal area which was soiled with stool. With the same gloved hands (visibly stained with stool), the NA proceeded to perform catheter care. NA #6 held the catheter tubing at the meatus and cleaned the tubing in an up and down motion with a disposable cleansing wipe. The NA did not move the catheter bag resulting in tension on the tubing. Immediately following the catheter care, NA # 6 stated she should have changed her gloves before performing catheter care. During an interview on 1/15/15 at 1:49pm, the Director of Nursing (DON) stated it was her expectation for the staff to change her gloves after cleaning the stool and before she proceeded to do the catheter care.	F 315	attend the follow up appointment to include urology appointments by Staff Facilitator on 1/14/15. A Resident Care Audit Tool will be used by QI Nurse, ADON, MDS Coordinator, MDS Nurse, Staff Facilitator and Treatment Nurse for observation for proper catheter care to include cleaning of stool, washing of hands and changing of gloves during and after perineal care for all residents with urinary catheters to include resident #78 and resident #139 3X a week X4 weeks; weekly X4 weeks, and monthly X1 month. These observations will include staff NA #2, NA #3, NA #4, NA #5, Nurse #4, Nurse #5, and Nurse #6. When an order comes in for an appointment, the Hall Nurse will notify the Ward Clerk. The Ward Clerk will schedule the appointment per MD order. The Ward Clerk will notify the Hall Nurse if the resident is unable to attend the appointment for any reason. The Hall Nurse will notify the MD if resident misses an appointment and a new one will be rescheduled by the Ward Clerk. The ADON will review telephone orders utilizing the Telephone Order Audit for Appointments Tool for all new appointments 3X a week X4 weeks; weekly X4 weeks; then monthly X1 month and a QI Appointment Audit Tool will be used to ensure all residents to include resident # 139 attended their appointment as scheduled, that MD was notified for any missed appointments, and appointment was rescheduled. Any areas of concern observed will be immediately corrected by ADON. The DON will	

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F 315	Continued From page 4 2b. Resident #139 was admitted to the facility on 10/27/14 with medical diagnoses which included chronic kidney disease, unspecified urinary retention, and indwelling urinary catheter. The most recent quarterly Minimum Data Set (MDS) dated 1/2/15 documented the resident was moderately cognitively impaired. The care plan dated 1/7/15 documented the resident had an altered pattern of elimination with indwelling catheter. The goal stated for the problem was the resident would be free from urinary tract infection through the next review period with interventions which included catheter care per facility protocol. A review of the discharge instructions on the Transfer Summary dated 10/27/14 documented in part " Follow up with his urologist of choice or physician #3 (urologist) in the next two weeks for a voiding trial and monitoring of hematuria thought to be secondary to bladder injury. " On 1/15/15 at 10:01am during an interview, the Assistant Director of Nursing (ADON) stated Resident #139 had an appointment scheduled with Urology for November 18, 2014. She further stated the responsible party for Resident #139 was not available to go on the appointment on November 18, 2014. The ADON stated the appointment was not rescheduled because the facility was waiting for the responsible party to provide the facility with a date when she would be available to accompany Resident #139 on the urology appointment to complete the required paperwork. On 1/15/15 at 11:57am in an interview, the ward secretary stated it was her responsibility to schedule the appointments for the resident in the facility. She stated Resident #139 had an appointment scheduled with urology for	F 315	monitor the Resident Care Audit Tool, QI Appointment Audit Tool and Telephone Order Audit for Appointments Tool for completion 3X a week X4 weeks; weekly X4 weeks, and monthly X1 month. The Quality Improvement Executive Committee will review the results of the Resident Care Audit Tools and the Appointment Audit Tool monthly X 3 months for any other recommendations, take action as appropriate, and to monitor continued compliance in this area.	

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F 315	Continued From page 5 November 18, 2014. The ward secretary reported the responsible party was unable to come to the appointment on November 18, 2014. She further stated she rescheduled the appointment with urology on yesterday (1/14/15) for January 22, 2015. The ward secretary further stated the facility had been waiting for the responsible party to provide the facility with a date that she would be able to accompany Resident #139 on the urology appointment as required by the doctor ' s office. During an interview on 1/15/15 at 1:49pm, the Director of Nursing (DON) stated it was her expectation for the staff to ensure the resident went for the follow up appointment. She further stated she expected the staff to notify the attending physician if the resident was unable to attend the follow up appointment.	F 315		
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 record review, observations and staff interviews, the facility failed to withdraw the correct dosage of insulin as ordered by the physician, to be administered to 1 of 6 residents observed during a medication pass (Resident #81). Findings included: According to Lexi-Comp's Drug Information Handbook 13th edition, Novolin Regular (used to treat diabetes) is a rapid-acting insulin. Onset is	F 333	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.	2/12/15

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F 333	Continued From page 6 30 minutes to one hour and peak effect 2-3 hours. Further instructions warns a high alert medication, which have a heightened risk of causing significant patient harm when used in error. Resident #81 was admitted into the facility on 1/6/12. Diagnoses included Diabetes Mellitus as listed on the January 2015 physician orders. A review of the signed January 2015 physician order directed Novolin Regular 5 units to be administered subcutaneous (underneath the skin) at 12:00 noon. On 1/12/15 at 11:44 am, during a medication observation, Nurse #2 withdrew 6 units of Novolin insulin into an insulin syringe from an insulin vial at the medication cart, then prepared to enter Resident #81's room to administer the insulin. Nurse #2 was stopped and upon verification of the insulin in the syringe; 6 units of insulin was observed. At 11:45 am, in an observation Administrative Nurse #3 in the presence of Nurse #2; Administrative Nurse #3 stated "The insulin in the syringe is over 5 units." She added, "The insulin is not exactly 5 units but somewhat over." An observation at 11:53 am, Nurse #2 withdrew the correct dosage of Novolin Regular insulin as ordered "5 units" in the syringe, then administered the insulin into Resident #81's right upper arm underneath the skin. The resident's blood sugar was assessed 142 by Nurse #2. On 1/12/15 at 11:58 am, in an interview, Nurse #2 stated after pulling up the insulin in the syringe, she only looked at the #5 increment on the insulin syringe and did not look on the side of the insulin syringe, to see if there was additional insulin	F 333	Cornerstone Nursing and Rehabilitation Center 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. On 1/12/15, resident #81 insulin was re-drawn and administered for 5 units per MD order by nurse #2. Nurse #2 was in-serviced on the five rights of proper medication administration per MD order by DON on 1/12/15. On 1/19/15, a 100% medication pass audit with all licensed nurses and medication aides on proper medication administration to include five rights was initiated by MDS Coordinator, MDS Nurse, Staff Facilitator, Treatment Nurse, ADON and Nurse Consultant to ensure proper medication administration. The licensed nurses medication pass observations included drawing up correct dosage of insulin per MD order. Any issues identified during the medication pass audit was immediately corrected by MDS Coordinator, MDS Nurse, Staff Facilitator, Treatment Nurse, and ADON. On 1/12/15, 100% in-service to all licensed nurses and medication aides was	

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F 333	Continued From page 7 beyond the 5 increment. On 1/15/15 at 10:26 am, in an interview, the Director of Nursing stated she expected the correct dosage of insulin to have been withdrawn into the syringe and for Nurse #2 to have looked at the syringe in its entirety to ensure the correct dosage as order by the physician.	F 333	initiated regarding appropriate medication administration to include the five rights by Staff Facilitator and DON. 100% in-service to all nurses was initiated on 2/5/15 regarding the proper procedure for drawing up correct dosage of insulin per MD order and Medication Administration by the Staff Facilitator and DON. All newly hired licensed nurses will be in-serviced by Staff Facilitator and all newly hired Registered Nurses will be in-serviced by the DON and/or ADON on appropriate medication administration to include proper procedure of drawing up correct dosage of insulin per MD order in orientation. All newly hired medication aides will be in-serviced by Staff Facilitator on appropriate medication administration to include five rights in orientation. The QI Medication Pass Audit Tool will be utilized by the MDS Nurse Coordinator, MDS Nurse, Treatment Nurse, and Staff Facilitator, and ADON 2X week X4 weeks; then weekly for 4 weeks; then monthly X1 month to ensure each hall nurse and medication aide is in compliance with medication administration and the five rights. The licensed nurses observation will include drawing up correct dosage of insulin per MD order. The DON will review and monitor the QI Medication Pass Audit Tool for appropriate medication administration to residents to include resident #81 for compliance 2X a week for 4 weeks; then weekly X4 weeks; then monthly X1 month. Immediate retraining will be conducted for the licensed nurse or	

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F 333	Continued From page 8	F 333	medication aide for any identified issues observed during the medication pass audits by MDS Coordinator, MDS Nurse, Staff Facilitator, Treatment Nurse, and ADON.	
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal	F 334		2/12/15

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F 334	Continued From page 9 immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to administer the influenza vaccination when the consent was obtained for 1 of 5 residents reviewed for influenza (flu)	F 334	Cornerstone Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that	

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F 334	Continued From page 10 immunizations (Resident # 65). Findings included: Resident #65 was admitted to the facility on 11/12/14 with medical diagnoses which included: symbolic dysfunction and congenital mitral insufficiency. Review of the medical record revealed a signed Consent/Release Form for Resident #65 dated 11/12/14. The signed Consent/Release Form had "yes" checked for flu vaccine authorization. Further review of the medical record revealed there was no documentation of administration of the vaccination. During an interview on 1/13/15 at 3:20 pm, the QI Nurse stated she was responsible for administering the influenza vaccinations to the residents in the facility. She further stated she had not administered the vaccination to Resident #65 because she did not have time to verify if the resident was previously vaccinated. In an interview on 1/15/15 at 12:20 pm, the Director of Nursing stated it was her expectation for the vaccination to be administered when the consent was obtained.	F 334	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 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. Resident #65 had consented on 11/19/14 to receiving the influenza vaccine. The RP declined for resident #65 to receive the influenza vaccine on 1/13/15. The QI Nurse was in-serviced on 2/4/15 by DON on the policy and procedure for ensuring resident consents are obtained for immunization vaccines to include influenza vaccines and are administered timely. A 100% flu and pneumococcal immunization audit was completed for all residents to include resident #65 in the facility by the Nurse Consultant on 1/12/15 comparing consents to administration of immunization vaccine to ensure residents have received the immunizations per the consent. All missing flu and	

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F 334	Continued From page 11	F 334	pneumococcal immunizations that were consented and not given were administered by QI Nurse on 1/12/15 & 1/13/15. The Admissions Coordinator was in-serviced by DON on 2/5/15 in regards to the Consent/Release Form that is given to all residents newly admitted to facility to include Flu Vaccine and Pneumococcal education upon admission. The QI nurse was in-serviced on 2/4/15 by DON on timely administration of the flu and pneumococcal immunizations for all residents per consent. The Admissions Coordinator will receive consent or refusal upon a resident□s admission for pneumococcal and flu vaccinations and document on Consent/Release Form. A copy of the Consent/Release Form will be forwarded to the QI nurse by the Admissions Coordinator. The QI nurse will obtain annual consent for the flu vaccine immunizations. The QI nurse will administer the flu and pneumococcal immunizations as appropriate for all obtained consents and document in the resident medical record. The QI Immunization Audit Tool will be utilized by the ADON 2x week x4 weeks, then weekly x 4 weeks, then monthly x1 month to ensure immunizations, to include pneumococcal and influenza vaccines are administered, resident consents are obtained for newly admitted residents and information was documented accurately and timely.	

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F 334	Continued From page 12	F 334	The DON will monitor the QI Immunization Audit Tool 2 x week x 4 weeks, then weekly x 4 weeks, then monthly x 1 month. The results of the QI Immunization Audit Tool will be shared monthly with the Executive Quality Assurance Committee x 3 months. Additional action will occur if deemed necessary and to determine the need of and/or frequency for continued monitoring.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		2/12/15

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F 431	Continued From page 13 The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to remove expired and discontinued medications from 2 of 5 medication storage areas (200 hall medication cart and 400 hall medication cart). The findings included: Review of the facility's policy "Disposal of Unused Medications" revised 1/1/14 documented in part "Medications shall be returned to pharmacy for the following reasons: the medication is not released to the resident upon the resident's discharge from the facility, a medication is discontinued by the physician or by automatic stop order policy or medication reaches its expiration date." 1. Resident # 46 was readmitted to the facility on 4/3/2013 with medical diagnoses which included unspecified debility. An observation of the 200 hall medication cart was made on 1/13/15 at 11:45 am. The observation revealed two capsules of Tamiflu	F 431	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 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. All discontinued medications for Resident	

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F 431	Continued From page 14 medication for Resident # 46. Review of a physician order dated 12/29/2014 documented "Tamiflu 75 mg one capsule by mouth twice a day times 5 days." Further review of the January 2015 Medication Administration Record revealed the order for Tamiflu was stopped on 1/2/15." On 1/13/15 at 11:45 am during an interview, Nurse #8 confirmed the order for Tamiflu for Resident #46 was discontinued. She stated it was the responsibility of the nurse that administered the last dose to remove the medication from the medication cart. In an interview on 1/15/15 at 12:24 pm, the Director of Nursing stated it was her expectation for the staff to remove the discontinued and expired medications and return to the pharmacy. 2. Resident # 66 was admitted to the facility on 8/27/2007 with medical diagnoses which included unspecified glaucoma and hypertension. An observation of the 400 hall medication cart was made on 1/14/15 at 3:00 pm. The observation revealed a bottle of Xalatan 0.005% eye drops for Resident #66 with an expiration date of 1/4/15. Review of the Physician orders for January 2015 for Resident #66 revealed an active order for Xalatan 0.005% instill one drop in each eye at bedtime. On 1/14/15 at 3:10 pm during an interview, Nurse #6 confirmed the Xalatan eye drops for Resident #66 had an expired expiration date and stated it was the responsibility of all nurses to remove the expired medications from the medication cart. In an interview on 1/15/15 at 12:24 pm, the	F 431	#46 were removed from medication cart to include Tamiflu capsules by the hall nurse on 1/13/15 and medication returned to pharmacy. Nurse #8 was in-serviced by the Staff Facilitator on 1/29/15 regarding removal of discontinued medications from medication cart upon discontinuation of medications or discharge of resident. Expired Xalatan eye drops for Resident #66 were removed from medication cart by hall nurse on 1/14/15 and medication was sent back to pharmacy. Expired and discontinued Novolin R insulin for resident #17 was removed from medication cart and discarded into the sharps container on 1/15/15. Nurse #6 was in-serviced by the Staff Facilitator on 1/29/15 regarding removal of expired and discontinued medications from medication carts. 100% Medication Cart Audit was initiated on 1/14/15 by MDS Coordinator, MDS nurse, Treatment Nurse, QI Nurse, and ADON to ensure all expired and discontinued medications were removed from medication carts and sent back to the pharmacy as appropriate. Any areas of concern during this audit were immediately corrected and medications were returned to pharmacy by the MDS Coordinator, MDS nurse, Treatment Nurse, QI Nurse, and ADON upon observation. 100% in-service to all licensed nurses to include Nurse #6, Nurse #8, and was initiated on 1/29/15 by Staff Facilitator regarding removal of expired and	

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F 431	Continued From page 15 Director of Nursing stated it was her expectation for the staff to remove the discontinued and expired medications and return to the pharmacy. 3. Resident #17 was admitted to the facility on 1/22/2013 with medical diagnoses which included Diabetes Mellitus Type 2. On 1/14/15 at 3:00 pm, an observation of the 400 hall medication cart revealed an unopened bottle of Novolin R dispensed 11/11/14 for Resident #17. Review of Resident #17's medical record revealed a physician order dated 12/4/14 that read "D/C (discontinue) RISS (Regular Insulin Sliding Scale). Continue with current accuchecks." On 1/14/15 at 3:10 pm during an interview, Nurse #6 stated it was the responsibility of all nurses to remove the expired medications from the medication cart. In an interview on 1/15/15 at 12:24 pm, the Director of Nursing stated it was her expectation for the staff to remove the discontinued and expired medications and return to the pharmacy. On 1/15/15 at 3:30 pm, the Assistant Director of Nursing confirmed Resident #17 no longer had an order for Regular insulin.	F 431	discontinued medications from medication carts. All newly hired licensed nurses will be in-serviced on removal of expired and discontinued medication from medication carts in orientation by Staff Facilitator. The Hall Nurse will remove all discontinued medications from medication carts upon receipt of the MD order to discontinue the medication. The ADON will review the QI Telephone Order Audit for Discontinued Medications Tool 2 x week x 4 weeks; then weekly x 4 weeks; then monthly x 1 month for all discontinued medications and inspect the medication cart to ensure that medications have been removed by the hall nurse. The Hall Nurse will check expiration dates on all medications prior to administration of the medication to the resident and remove expired medication from the medication cart and return the expired medication to the pharmacy. The QI Medication Cart Audit Tool will be utilized by the MDS Coordinator, MDS nurse, Treatment Nurse, QI Nurse, and ADON 2X a week for 4 weeks; then weekly X4 weeks; then monthly X 1 month to ensure expired and discontinued medications are being removed from medication carts. All identified areas of concern will be addressed by MDS Coordinator, MDS Nurse, Treatment Nurse, QI Nurse, and ADON immediately. The QI Medication Cart Audit Tool and the QI Telephone Order Audit for Discontinued Medications Tool will be monitored by DON 2 X a week for 4	

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F 431	Continued From page 16	F 431	weeks; then weekly X4 weeks; then monthly X1 month to ensure compliance in this area. The results of the QI Medication Cart Audit Tool and QI Telephone Audit for Discontinued Medications Tool will be shared monthly with the Executive Quality Assurance Committee x 3 months. Additional action will occur if deemed necessary and to determine the need of and/or frequency for continued monitoring.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441		2/12/15

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F 441	Continued From page 17 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on an observation, record review and staff interviews, the facility failed to wash hands and change gloves after cleaning the stool and before providing catheter care for 1 of 3 residents reviewed for indwelling catheter use (Resident #139). Findings included: On 1/14/15 at 11:32 am, an observation was made of NA (Nursing Assistant) #6 providing incontinent care and catheter care for Resident #139. The NA began by cleaning the resident rectal area which was soiled with stool. With the same gloved hands (visibly stained with stool), the NA proceeded to perform catheter care. NA#6 held the catheter tubing at the meatus and cleaned the tubing in an up and down motion with a disposable cleansing wipe. Immediately following the catheter care, NA # 6 stated she should have changed her gloves before performing catheter care. On 1/14/15 at 1:29 pm during an interview, the Director of Nursing (DON) stated it was her expectation for the staff to change her gloves	F 441	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 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	

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F 441	Continued From page 18 before performing the catheter care.	F 441	proceeding. Catheter care was provided for resident #139 by hall nurse on 1/14/15. NA #6 was in-serviced on washing hands and changing gloves after cleaning stool and the proper procedure for providing catheter care on 1/14/15 by Staff Facilitator. A return demonstration was completed with NA #6 on 1/21/15 by Staff Facilitator to ensure washing hands and changing gloves after cleaning stool and proper procedure for providing catheter care. 100% audit of all residents with foley catheters to include resident #139 was assessed by Treatment Nurse for cleanliness to include brown matter on 1/12/15 thru 1/15/15. Proper catheter care was provided to all residents with foley catheters on 1/12/15 thru 1/15/15 to include resident #139 by Treatment Nurse. 100% return demonstration audit was initiated by Staff Facilitator on 1/19/15 of all C.N.A□s and nurses on catheter care to include washing hands and changing gloves after cleaning stool and proper procedure for providing catheter care. Return demonstration observations will include NA #6. Any concerns that were observed during return demonstrations were immediately corrected by Staff Facilitator. 100% in-service with all C.N.A□s and licensed nurses to include NA #6 was initiated by Staff Facilitator on 1/14/15 regarding proper procedure for providing	

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F 441	Continued From page 19	F 441	catheter care to include washing of hands and changing gloves after cleaning stool and providing catheter care with care and as needed. A Resident Care Audit Tool will be used by QI Nurse, ADON, MDS Coordinator, MDS Nurse, Staff Facilitator and Treatment Nurse for observation for proper catheter care to include staff are washing hands and changing gloves after cleaning perineal area to include stool for all residents with urinary catheters to include resident #139 3 X a week X 4 weeks; weekly X 4 weeks, and monthly X 1 month. These observations will include NA #6. Any areas of concern observed will be immediately corrected by the QI Nurse, ADON, MDS Coordinator, MDS Nurse, Staff Facilitator and Treatment Nurse. The DON will monitor the Resident Care Audit Tool for completion 3 X a week X 4 weeks; weekly X 4 weeks, and monthly X 1 month. The Quality Improvement Executive Committee will review the results of the Resident Care Audit Tool monthly X 3 months for any other recommendations, take action as appropriate, and to monitor continued compliance in this area.	
F 498 SS=D	483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident	F 498		2/12/15

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F 498	Continued From page 20 assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interviews, the facility failed to validate the ability to perform the task of catheter care for 1 of 1 staff observed performing catheter care (Nursing Assistant #6). Findings included: Review of the facility policy on Perineal Care dated 8/2012 documented in part "Objective: To prevent infection and odors. For Catherized Residents: Cleanse around the meatus and cleanse the catheter tubing. For the male resident: Cleanse the penis and rinse." On 1/14/15 at 11:32 am, an observation was made of NA (Nursing Assistant) #6 providing incontinent care and catheter care for Resident #139. The NA began by cleaning the resident rectal area which was soiled with stool. With the same gloved hands (visibly stained with stool), the NA proceeded to perform catheter care. NA#6 held the catheter tubing at the meatus and cleaned the tubing in an up and down motion with a disposable cleansing wipe. Immediately following the catheter care, NA # 6 stated she should have changed her gloves before performing catheter care. On 1/14/15 at 11:50 am during an interview, the Staff Facilitator stated she was unable to provide any documentation of training provided to the staff on catheter care. In an interview on 1/14/15 at 12:20 pm, NA #6 (date of hire 9/6/14) stated she had not received	F 498	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 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. NA #6 ability to perform the task of catheter care was validated on 1/21/15 by Staff Facilitator and DON on 2/6/15. NA #6 was in-serviced on washing hands and changing gloves during and after cleaning stool and the proper procedure for providing catheter care on 1/14/15 by Staff Facilitator. 100% observation of all tasks to include	

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F 498	Continued From page 21 any training on catheter care at the facility. She further stated the only training she had was when she was in CNA (Certified Nursing Assistant) class. The NA stated no one has observed her perform catheter care in the facility before she performed the task alone. On 1/14/15 at 1:16 pm in an interview, the staff facilitator stated she talked about reporting abnormal findings with the catheter to the nurse with the NA's (Nursing Assistants) during orientation class. She further stated she do not physically observe the staff performing catheter care (validate) prior to the staff performing the task in the facility. On 1/14/15 at 1:29 pm during an interview, the Director of Nursing (DON) stated it was her expectation for the staff facilitator to validate the skills prior to the NA staff performing the skill on a resident.	F 498	catheter care for all C.N.A□s, to include NA#6 and licensed nurses was initiated on 2/4/15 by Staff Facilitator and ADON to validate the ability to perform tasks utilizing skills check list. All staff were immediately re-trained for all identified areas of concern during observation by Staff Facilitator and ADON. The Staff Facilitator was in-serviced by the DON on 2/5/15 regarding the expectation that all C.N.A□s and licensed nurses are observed, and to validate the ability to perform all tasks to include catheter care per the skills check list during orientation prior to staff giving care to residents. All C.N.A□s and licensed nurses to include NA #6 were in-serviced on washing hands and changing gloves during and after cleaning stool and the proper procedure for providing catheter care on 1/14/15 by Staff Facilitator. The newly hired C.N.A□s and licensed nurses will be observed in orientation by the Staff Facilitator to validate the ability to perform all tasks to include catheter care per the skills check list prior to staff giving care to residents. All C.N.A□s to include NA #6 and licensed nurses will be observed annually by the Staff Facilitator to validate the continued ability to perform all tasks to include catheter care per the skills check list. The ADON will observe 10% of the newly hired C.N.A□s and licensed nurses in orientation or annual skills check list performance to ensure the Staff Facilitator is validating their ability to perform all tasks on the skills check list to	

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 _____	01/15/2015

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**

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F 498	Continued From page 22	F 498	include catheter care, and initial the skills check list upon completion, weekly X 4 weeks; then biweekly x 1 month; then monthly X 1 month. A Resident Care Audit Tool will be used by QI Nurse, ADON, MDS Coordinator, MDS Nurse, Staff Facilitator and Treatment Nurse for observation for proper catheter care to ensure C.N.A□s and licensed nurses to include NA #6 are washing hands and changing gloves during and after cleaning perineal area to include stool for all residents with urinary catheters 3 X a week X 4 weeks; weekly X 4 weeks, and monthly X 1 month to include resident #139. The DON will monitor the Resident Care Audit Tool for completion 3 X a week X 4 weeks; weekly X 4 weeks, and monthly X 1 month. The DON will monitor the skills check list for completion and ADON's initials weekly x 4 weeks; then bi-weekly x 1 month; then monthly x 1 month. The results of the Skills Check List and the Resident Care Audits will be shared monthly with the Executive Quality Assurance Committee x 3 months. Additional action will occur if deemed necessary and to determine the need of and/or frequency for continued monitoring.	