DEPAR	MENT OF HEALTH	AND HUMAN SERVICES			FORM APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	-	OM	B NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION ()	X3) DATE SURVEY COMPLETED
		345325	B. WING		01/15/2015
NAME OF I	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE	
CORNER	STONE NURSING AN	ID REHABILITATION CENTER		711 SUSAN TART ROAD BOX 948 DUNN, NC 28334	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 315 SS=D	RESTORE BLADD Based on the reside assessment, the far resident who enters indwelling catheter resident's clinical co catheterization was who is incontinent of treatment and servi infections and to re- function as possible This REQUIREMEN by: Based on record re- physician interviews urinary catheter car for catheter care (R failed to wash hand cleaning the stool a 1 of 3 residents rev (Resident #139). Th follow up with urolo #139) with an indwe (blood in urine). Fin 1. Resident #78 wa 9/11/14. Diagnosis Urinary Tract Infect Chronic Kidney Dis The quarterly Minim 12/12/14 indicated was severely impain	ent's comprehensive cility must ensure that a s the facility without an is not catheterized unless the ondition demonstrates that necessary; and a resident of bladder receives appropriate ces to prevent urinary tract store as much normal bladder exiew, observations, staff and s, the facility failed to provide re for 1 of 3 residents reviewed cesident #78). The facility Is and change gloves after and providing catheter care for iewed for urinary catheter use he facility failed to provide gy for a resident (Resident elling catheter and Hematuria	F 315		eses that ents. as a tion f nent or any tion ny of
		nd personal hygiene was ependence of one person		and/or any other administrative or leg proceeding.	gal
LABORATOR	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE

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

(X6) DATE 02/09/2015

PRINTED: 02/13/2015

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.

Electronically Signed

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/13/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		345325	B. WING			01/1	15/2015
	PROVIDER OR SUPPLIER	ID REHABILITATION CENTER		71	REET ADDRESS, CITY, STATE, ZIP CODE 11 SUSAN TART ROAD BOX 948 UNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 315	listed with bowel as A review of the care 12/31/14 listed alter indwelling urinary c "Catheter care per A review of the bow 1/13/15, NA (Nursin Resident #78 had a pm. On 1/13/15 at 3:42 with NA #3, Reside observed with driec near the meatus. On 1/13/15 at 3:44 stated urinary cather of daily care to resid documented in the include: amount of drainage bag and if On 1/13/15 at 3:50 indicated the NAs a responsible for performed on the residents. On 1/13/15 at 3:56 stated urinary cather daily routine she pro- indicated she only c bag and recorded to system. On 1/13/15 at 4:00	welling catheter (urinary) was always incontinent. e plan with a target date of red urinary elimination with an atheter. Care intervention read	F 3	15	Resident #78 catheter tubing was cl by Hall Nurse on 1/13/15 and asses for any signs or symptoms of infection #2, NA #3, NA #4, NA #5, Nurse #4, #5 and Nurse #6 were in-serviced on proper procedure for catheter care as provide catheter care daily and as needed, by the Staff Facilitator on 1/14/15. Catheter care was redone resident #139 by the Treatment Nurse 1/14/15. NA #6 was in-serviced on washing hands and changing gloves cleaning stool and the proper proced for providing catheter care on 1/14/15 the Staff Facilitator. A return demonstration was completed with I on 1/21/15 by the Staff Facilitator to ensure washing hands and changing gloves after cleaning stool and prop procedure for providing catheter car MD was notified of missed urology r by the Treatment Nurse on 1/14/15 tr esident #139 and urology appointm was scheduled, which resident atter on January 22,2015,by the Ward clean 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 a #139 was assessed by the Treatmen Nurse, for cleanliness to include bro matter on 1/12/15 thru 1/15/15. Pro catheter care was provided to all resident #78 and resident #139 by the Treatment Nurse	sed on. NA Nurse n and to on se on se on se after dure 15 by NA #6 g er re. report for hent nded erk. y nd nt per sidents	

Facility ID: 923073

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI II TI	IPLE CONSTRUCTION	OMB NO.	E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		IG		PLETED
		345325	B. WING		01/*	15/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	
CORNER	RSTONE NURSING AN	ND REHABILITATION CENTER		711 SUSAN TART ROAD BOX DUNN, NC 28334	948	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETIC DATE
F 315	Continued From pa	ige 2	F 31	5		
	urinary catheter car acknowledged he w Resident #78 from to the urinary catheter empting the urinary results of the urine system. On 1/14/15 at 10:00 (treatment nurse) s change the urinary residents. She indic catheter care becar for providing catheter On 1/14/15 at 10:10 stated she was not urinary catheter car responsible for com morning care. On 1/14/15 at 11:34 Director of Nursing responsible for prov daily and as needer not aware the NAs responsible for prov On 1/14/15 at 2:15	esponsible for providing re to Resident #78. NA #5 vas the primary NA for 3pm to 11 pm and as it related ter he was only responsible for drainage bag and record the amount in the electronic 0 am, in an interview, Nurse #5 tated her responsibility was to catheter once a month for cated she did not provide use the NAs were responsible er care to the residents. 0 am, in an interview, Nurse #6 responsible for providing re. She stated the NAs were npleting catheter care with 4 pm, in an interview, the (DON) indicated NAs were viding urinary catheter care d. The DON stated she was were not aware they were viding urinary catheter care. pm, in an interview, NA #2; the ident #78 on 1/13/15 from 7		 100% audit to include I #4, NA #5, Nurse #4, N Nurse #6 was initiated Facilitator on 1/19/15 of demonstration for all C on catheter care to include I stool, washing of hand gloves during and after concerns that were obstreturn demonstrations corrected by the Staff I audit of all residentOs include resident #139 of the last 90 days to include residents, this was initi MDS Coordinator, MDS Records, Ward Clerk at Nurse for any missed at include urology appoint scheduled. Any concetor observed during this att by Treatment Nurse art include MD notification appointment as appropriation appointment as appropriation and Nurse #6 on propriation providing catheter care of stool, washing of hat 	Aurse #5, and by the Staff on return N.AOs and nurses lude cleaning of s and changing of perineal care. Any served during were immediately Facilitator. 100% appointments to was completed for ude newly admitted ated on 1/15/15 by S Nurse, Medical and Treatment appointments to tments that were rns that were udit were corrected and Hall Nurses to , and reschedule oriate. II C.N.AOs and ude # NA #2, NA se #4, Nurse #5, er procedure for a to include cleaning	
	catheter care for Re care on 1/13/15. N/ not do anything with a resident had a bo clean the urinary ca	she did not perform urinary esident #78 as part of daily A #2 indicated normally she did n urinary catheters, however if wel movement, she would atheter with a prepackaged she did not provide any care to		of gloves during and at Staff Facilitator on 1/14 was initiated on 2/4/15 to notify Hall Nurse of a appointments and to re appointments. 100% of were in-serviced to not physician if a resident	4/15. In-service to the Ward Clerk all missed eschedule missed of licensed nurses ify the attending	

Facility ID: 923073

		AND HUMAN SERVICES				FORM	02/13/2015 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		345325	B. WING	÷		01/ [,]	15/2015
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CORNER	RSTONE NURSING AN	ID REHABILITATION CENTER			/11 SUSAN TART ROAD BOX 948 DUNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 315	On 1/15/15 at 1:02 indicated urinary cat the urinary catheter 2a. Resident #139 y 10/27/14 with media chronic kidney dise retention, and indwa most recent quarter dated 1/2/15 docum moderately cognitiv dated 1/2/15 docum altered pattern of el catheter. The goal s resident would be fit through the next rev which included cath On 1/14/15 at 11:32 made of NA #6 prov catheter care for Re by cleaning the resis soiled with stool. W (visibly stained with perform catheter cat tubing at the meatu up and down motio wipe. The NA did no resulting in tension following the catheter buring an interview Director of Nursing expectation for the	pm, in an interview, the DON theter care include cleaning with soap and water. was admitted to the facility on cal diagnoses which included ase, unspecified urinary elling urinary catheter. The rly Minimum Data Set (MDS) nented the resident was rely impaired. The care plan nented the resident had an limination with indwelling stated for the problem was the ree from urinary tract infection view period with interventions neter care per facility protocol. 2 am, an observation was viding incontinent care and esident #139. The NA began ident rectal area which was ith the same gloved hands stool), the NA proceeded to are. NA #6 held the catheter s and cleaned the tubing in an n with a disposable cleansing of move the catheter bag on the tubing. Immediately er care, NA # 6 stated she ed her gloves before r care. on 1/15/15 at 1:49pm, the (DON) stated it was her staff to change her gloves tool and before she proceeded	F	315	attend the follow up appointment to include urology appointments by S Facilitator on 1/14/15. A Resident Care Audit Tool will be QI Nurse, ADON, MDS Coordinato Nurse, Staff Facilitator and Treatm Nurse for observation for proper ca care to include cleaning of stool, w of hands and changing of gloves d and after perineal care for all resid with urinary catheters to include re #78 and resident #139 3X a week weeks; weekly X4 weeks, and mor month. These observations will ind staff NA #2, NA #3, NA #4, NA #5, #4, Nurse #5, and Nurse #6. Whe order comes in for an appointment Hall Nurse will notify the Ward Cler Ward Clerk will schedule the appoi per MD order. The Ward Clerk will the Hall Nurse if the resident is una attend the appointment for any rea The Hall Nurse will notify the MD if resident misses an appointment ar new one will be rescheduled by the Clerk. The ADON will review telep orders utilizing the Telephone Orde for Appointments Tool for all new appointments 3X a week X4 weeks weekly X4 weeks; then monthly X1 and a QI Appointment Audit Tool w used to ensure all residents to inclu- resident # 139 attended their appo as scheduled, that MD was notified any missed appointments, and appointment was rescheduled. An of concern observed will be immed corrected by ADON. The DON will	taff used by or, MDS ent atheter ashing uring ents sident X4 nthly X1 clude Nurse n an , the rk. The ntment I notify able to son. nd a e Ward ohone er Audit s; month ill be ude intment I for y areas liately	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		PLETED
		345325	B. WING _		01/	15/2015
NAME OF	PROVIDER OR SUPPLIER	• •		STREET ADDRESS, CITY, STATE, ZI	IP CODE	
CORNER	STONE NURSING AN	ND REHABILITATION CENTER		711 SUSAN TART ROAD BOX 94 DUNN, NC 28334	8	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 315	Continued From pa	ige 4	F 31	15		
	2b. Resident #139 1 10/27/14 with medic chronic kidney dise retention, and indw most recent quarter dated 1/2/15 docum moderately cognitiv dated 1/7/15 docum altered pattern of el catheter. The goal s resident would be fit through the next re which included cath A review of the disc Transfer Summary part " Follow up wit physician #3 (urolog a voiding trial and n thought to be secon On 1/15/15 at 10:07 Assistant Director of Resident #139 had with Urology for No stated the responsi was not available to November 18, 2014 appointment was ne facility was waiting provide the facility v available to accompute urology appointment paperwork.	was admitted to the facility on cal diagnoses which included ase, unspecified urinary elling urinary catheter. The rly Minimum Data Set (MDS) mented the resident was vely impaired. The care plan mented the resident had an limination with indwelling stated for the problem was the ree from urinary tract infection view period with interventions meter care per facility protocol. charge instructions on the dated 10/27/14 documented in th his urologist of choice or gist) in the next two weeks for nonitoring of hematuria ndary to bladder injury. " 1am during an interview, the of Nursing (ADON) stated an appointment scheduled vember 18, 2014. She further ble party for Resident #139 o go on the appointment on 4. The ADON stated the ot rescheduled because the for the responsible party to with a date when she would be pany Resident #139 on the nt to complete the required 7am in an interview, the ward		monitor the Resident Car Appointment Audit Tool a Order Audit for Appointm completion 3X a week X4 X4 weeks, and monthly > The Quality Improvemen Committee will review the Resident Care Audit Tool Appointment Audit Tool n months for any other rece take action as appropriat continued compliance in	Ind Telephone ents Tool for 4 weeks; weekly (1 month. t Executive e results of the s and the nonthly X 3 ommendations, e, and to monitor	

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		AND HUMAN SERVICES			FORM	: 02/13/201 APPROVEI . 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		345325	B. WING _		01	/15/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	• -	
CORNER	RSTONE NURSING AN	ND REHABILITATION CENTER		711 SUSAN TART ROAD BOX 948 DUNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC	JLD BE	(X5) COMPLETIO DATE
F 315 F 333 SS=D	the responsible par appointment on No stated she resched urology on yesterda 2015. The ward see facility had been wa to provide the facilit be able to accompa- urology appointmer office. During an interview Director of Nursing expectation for the went for the follow up 483.25(m)(2) RESI SIGNIFICANT MED The facility must en any significant med This REQUIREMEN by: Based on record re- interviews, the facil correct dosage of in physician, to be ado observed during a r #81). Findings inclu	4. The ward secretary reported ty was unable to come to the vember 18, 2014. She further uled the appointment with ay (1/14/15) for January 22, cretary further stated the aiting for the responsible party ty with a date that she would any Resident #139 on the nt as required by the doctor ' s on 1/15/15 at 1:49pm, the (DON) stated it was her staff to ensure the resident up appointment. She further d the staff to notify the if the resident was unable to appointment. DENTS FREE OF D ERRORS usure that residents are free of lication errors. NT is not met as evidenced eview, observations and staff ity failed to withdraw the nsulin as ordered by the ministered to 1 of 6 residents medication pass (Resident	F 31		the roposes ent that ally and esidents. ted as a	2/12/15

Facility ID: 923073

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES		(OMB NO.	APPROVE 0938-039
ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE	E SURVEY PLETED
		345325	B. WING		01/*	15/2015
AME OF I	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE	•	
ORNER	STONE NURSING AN	ND REHABILITATION CENTER		711 SUSAN TART ROAD BOX 948 DUNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 333	Continued From pa	ae 6	F 333	3		
	30 minutes to one f hours. Further instr medication, which f causing significant error. Resident #81 was a 1/6/12. Diagnoses i listed on the Janua A review of the sign order directed Nova administered subcu at 12:00 noon. On 1/12/15 at 11:44 observation, Nurse insulin into an insul at the medication c Resident #81's roon Nurse #2 was stopp the insulin in the sy observed. At 11:45 Administrative Nurse #2; Administrative Nurse #2; Administrative Nurse #2; Administrative Nurse mulin is not exactl An observation at 1 the correct dosage ordered "5 units" in the insulin into Res underneath the skin was assessed 142 On 1/12/15 at 11:58	A am, during a medication att, then prepared to enter m to administer the insulin admitted into the facility on included Diabetes Mellitus as ry 2015 physician orders. The January 2015 physician obin Regular 5 units to be utaneous (underneath the skin) 4 am, during a medication #2 withdrew 6 units of Novolin in syringe from an insulin vial art, then prepared to enter m to administer the insulin. Ded and upon verification of ringe; 6 units of insulin was am, in an observation se #3 in the presence of Nurse Nurse #3 stated "The insulin in 5 units." She added, "The y 5 units but somewhat over." 1:53 am, Nurse #2 withdrew of Novolin Regular insulin as the syringe, then administered ident #81's right upper arm n. The resident's blood sugar by Nurse #2.		 Cornerstone Nursing and Rehabil Center response to this Statemer Deficiencies does not denote agree with the Statement of Deficiencies does it constitute an admission the deficiency is accurate. Further, Cornerstone Nursing and Rehabil Center reserves the right to refute the deficiencies on this Statemen Deficiencies through Informal Dis Resolution, formal appeal proced and/or any other administrative or proceeding. On 1/12/15, resident #81 insulin w re-drawn and administered for 5 to MD order by nurse #2. Nurse #2 in-serviced on the five rights of pr medication administration per MD by DON on 1/12/15. On 1/19/15, a 100% medication p audit with all licensed nurses and medication aides on proper medic administration to include five right initiated by MDS Coordinator, MD Staff Facilitator, Treatment Nurse and Nurse Consultant to ensure p medication administration. The I nurses medication pass observat included drawing up correct dosa insulin per MD order. Any issues identified during the medication p was immediately corrected by ME Coordinator, MDS Nurse, Staff Fa Treatment Nurse, and ADON. 	at of eement s nor at any litation e any of t of pute ure legal vas units per was oper o order wass cation ts was S Nurse, , ADON oroper icensed ions ge of ass audit DS	
	she only looked at t syringe and did not	up the insulin in the syringe, the #5 increment on the insulin look on the side of the insulin ere was additional insulin		On 1/12/15, 100% in-service to al licensed nurses and medication a		

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CENTER	RS FOR MEDICARE	AND HUMAN SERVICES			O	FORM / //B NO.	02/13/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		345325	B. WING			01/1	5/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CORNER	STONE NURSING AN	ND REHABILITATION CENTER	711 SUSAN TART ROAD BOX 948 DUNN, NC 28334				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 333	Director of Nursing correct dosage of in into the syringe and	ment. 6 am, in an interview, the stated she expected the nsulin to have been withdrawn d for Nurse #2 to have looked entirety to ensure the correct	F 3	33	initiated regarding appropriate medi administration to include the five rig Staff Facilitator and DON. 100% in-service to all nurses was initiated 2/5/15 regarding the proper procedu drawing up correct dosage of insulin MD order and Medication Administr by the Staff Facilitator and DON. At newly hired licensed nurses will be in-serviced by Staff Facilitator and a newly hired Registered Nurses will be in-serviced by the DON and/or ADO appropriate medication administrati- include proper procedure of drawing correct dosage of insulin per MD or orientation. All newly hired medicati- aides will be in-serviced by Staff Facilitator on appropriate medicatio administration to include five rights orientation. The QI Medication Pass Audit Tool witilized by the MDS Nurse, and Facilitator, and ADON 2X week X4 withen weekly for 4 weeks; then mont month to ensure each hall nurse an medication administration and the fi- rights. The licensed nurses observa- will include drawing up correct dosa insulin per MD order. The DON will	hts by on ure for n per ation II all be DN on on to g up der in ion n in will be ator, Staff weeks; hly X1 d th ive ation uge of	
					review and monitor the QI Medication Pass Audit Tool for appropriate medication administration to residents to includ resident #81 for compliance 2X a w 4 weeks; then weekly X4 weeks; the monthly X1 month. Immediate retra- will be conducted for the licensed m	on dication e eek for en aining	

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		AND HUMAN SERVICES			F	ORM	02/13/201 APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			: CONSTRUCTION (X	(X3) DATE SURVEY COMPLETED	
		345325	B. WING			01/	15/2015
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 711 SUSAN TART ROAD BOX 948 DUNN, NC 28334				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 333	Continued From pa	ige 8	F 3:	33	medication aide for any identified issu observed during the medication pass audits by MDS Coordinator, MDS Nu Staff Facilitator, Treatment Nurse, an ADON.	rse,	
F 334 SS=D	483.25(n) INFLUEN IMMUNIZATIONS	VZA AND PNEUMOCOCCAL	F 33	34			2/12/15
	that ensure that (i) Before offering the each resident, or the representative recerbenefits and potent immunization; (ii) Each resident is immunization October annually, unless the contraindicated or the immunized during the transmunization; and (iv) The resident or representative has immunization; and (iv) The resident's redocumentation that following: (A) That the resider the benefits and point the benefits and point the the benefits and point the the benefits and point the the benefits and point (B) That the resider influenza immunizations of the benefits and point the benefits and point (B) That the resider influenza immunizations of the benefits and point (B) That the resider influenza immunizations of the benefits and point (B) That the resider influenza immunizations of the benefits and point (B) That the resider influenza immunizations of the benefits and point (B) That the resider influenza immunizations of the benefits and point (B) That the resider influenza immunizations of the benefits and point (B) That the resider influenza immunizations of the benefits and point (B) That the resider influenza immunizations of the benefits and point (B) That the resider influenza immunizations of the benefits and point (B) That the resider influenza immunizations of the benefits and point (B) The the resider influenza immunizations of the benefits and point (B) The the resider influenza immunizations of the benefits and point (B) The the resider influenza immunizations of the benefits and point (B) The the resider influenza immunizations of the benefits and point (B) The the resider influenzations of the benefits (B) The the resider influenzations of the benefits (B) The the resider influenzations of the benefits (B) The the resider influenzation (B) The the resider (B) Th	vives education regarding the ial side effects of the offered an influenza ber 1 through March 31 e immunization is medically he resident has already been his time period; the resident's legal the opportunity to refuse medical record includes indicates, at a minimum, the ent or resident's legal provided education regarding tential side effects of influenza ent either received the tion or did not receive the tion due to medical r refusal.					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	0	COMPLETED	
		345325	B. WING			/15/2015	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z			
CORNER	STONE NURSING A	ND REHABILITATION CENTER		711 SUSAN TART ROAD BOX 94 DUNN, NC 28334	8		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE	(X5) COMPLETIO DATE	
F 334	Continued From pa	age 9	F 3	334			
	•	n resident, or the resident's	10				
	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 immu						
		the resident's legal					
	immunization; and	the opportunity to refuse					
	(iv) The resident's medical record includes						
	documentation that	t indicated, at a minimum, the					
	following:	ant ar regidentia la rel					
		ent or resident's legal provided education regarding					
		otential side effects of					
	pneumococcal imn	nunization; and					
		ent either received the					
	•	nunization or did not receive immunization due to medical					
	contraindication or						
		e, based on an assessment					
		commendation, a second					
		nunization may be given after 5 first pneumococcal					
		ss medically contraindicated or					
		resident's legal representative					
	refuses the second	immunization.					
	This REQUIREME	NT is not met as evidenced					
		eview and staff interviews, the		Cornerstone Nursing an	d Rehabilitation		
		ninister the influenza		Center acknowledges re			
	vaccination when t	he consent was obtained for 1		Statement of Deficiencie	s and proposes		
		ewed for influenza (flu)		this Plan of Correction to			

Facility ID: 923073

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF		1B NO. 0938-039 (X3) DATE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COMPLETED
		345325	B. WING		01/15/2015
IAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
ORNEF	STONE NURSING A	ND REHABILITATION CENTER		711 SUSAN TART ROAD BOX 948 DUNN, NC 28334	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTIO
F 334	Continued From pa	age 10	F 334	4	
	immunizations (Re- included: Resident #65 was a 11/12/14 with medi symbolic dysfunction insufficiency. Reviet revealed a signed (Consent/Release F flu vaccine authoriz medical record reviet documentation of a vaccination. During an interview Nurse stated she w administering the in residents in the fact had not administer #65 because she d resident was previo In an interview on f Director of Nursing	sident # 65). Findings admitted to the facility on cal diagnoses which included: on and congenital mitral ew of the medical record Consent/Release Form for d 11/12/14. The signed form had "yes" checked for zation. Further review of the ealed there was no administration of the y on 1/13/15 at 3:20 pm, the QI vas responsible for influenza vaccinations to the iility. She further stated she ed the vaccination to Resident id not have time to verify if the pusly vaccinated. 1/15/15 at 12:20 pm, the stated it was her expectation to be administered when the		 the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of reside The Plan of Correction is submitted written allegation of compliance. Cornerstone Nursing and Rehabilita Center response to this Statement of Deficiencies does not denote agreed with the Statement of Deficiencies in does it constitute an admission that deficiency is accurate. Further, Cornerstone Nursing and Rehabilita Center reserves the right to refute a the deficiencies on this Statement or Deficiencies through Informal Disput Resolution, formal appeal procedure and/or any other administrative or leproceeding. Resident #65 had consented on 11/t to receiving the influenza vaccine. TRP declined for resident #65 to receive the influenza vaccine on 2/4/15 by on the policy and procedure for ensure resident consents are obtained for immunization vaccines to include influenza vaccines and are administrative. A 100% flu and pneumococcal immunization vaccine to ensure resident so include resident #65 in facility by the Nurse Consultant on 1 comparing consents to administration process to administration vaccine to ensure resident. All missing flu and 	ents. as a tion of ment or any tion ny of f te e gal 19/14 The sive ne QI DON uring ered for all the /12/15 on of idents

Facility ID: 923073

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		AND HUMAN SERVICES				FORM	02/13/2015 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	· · /	E SURVEY PLETED
		345325	B. WING	€		01/ [,]	15/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
CORNER	RSTONE NURSING AN	ND REHABILITATION CENTER	711 SUSAN TART ROAD BOX 948 DUNN, NC 28334				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 334	Continued From pa	ge 11	F	334	pneumococcal immunizations that consented and not given were administered by QI Nurse on 1/12/ 1/13/15. The Admissions Coordinator was in-serviced by DON on 2/5/15 in re to the Consent/Release Form that to all residents newly admitted to fa- include Flu Vaccine and Pneumocc education upon admission. The Q was in-serviced on 2/4/15 by DON timely administration of the flu and pneumococcal immunizations for a residents per consent. The Admissions Coordinator will re consent or refusal upon a resident admission for pneumococcal and fl vaccinations and document on Consent/Release Form. A copy of Consent/Release Form. A copy of Consent/Release Form. A copy of Consent/Release Form. A copy of Consent/Release Form will be forw to the QI nurse by the Admissions Coordinator. The QI nurse will obta annual consent for the flu vaccine immunizations. The QI nurse will administer the flu and pneumococc immunizations as appropriate for a obtained consents and document in resident medical record. The QI Immunization Audit Tool will be utili the ADON 2x week x4 weeks, then x 4 weeks, then monthly x1 month ensure immunizations, to include pneumococcal and influenza vaccin administered, resident consents ar obtained for newly admitted residen information was documented accur and timely.	15 & gards is given acility to occal I nurse on II ceive Os Iu the varded iin cal II n the zed by weekly to nes are ents and	

Event ID: ET4O11

Facility ID: 923073

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		AND HUMAN SERVICES & MEDICAID SERVICES			F	ORM	02/13/2015 APPROVED 0938-0391
-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X:	(X3) DATE SURVEY COMPLETED		
		345325	B. WING			01 /*	15/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CORNER	STONE NURSING AN	ID REHABILITATION CENTER			11 SUSAN TART ROAD BOX 948 DUNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 334	Continued From pa	ge 12	F 3	34			
					The DON will monitor the QI Immuniz Audit Tool 2 x week x 4 weeks, then weekly x 4 weeks, then monthly x 1 month.	ation	
					The results of the QI Immunization Au Tool will be shared monthly with the Executive Quality Assurance Committ 3 months. Additional action will occur deemed necessary and to determine need of and/or frequency for continue monitoring.	ee x if the	
F 431 SS=D	483.60(b), (d), (e) E LABEL/STORE DR	DRUG RECORDS, UGS & BIOLOGICALS	F 4	31			2/12/15
	a licensed pharmac of records of receip controlled drugs in accurate reconciliat records are in order	nploy or obtain the services of sist who establishes a system t and disposition of all sufficient detail to enable an ion; and determines that drug r and that an account of all maintained and periodically					
	labeled in accordan professional princip appropriate access	als used in the facility must be ice with currently accepted les, and include the ory and cautionary e expiration date when					
	facility must store a locked compartment	State and Federal laws, the Il drugs and biologicals in its under proper temperature t only authorized personnel to keys.					

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		AND HUMAN SERVICES			FORM	02/13/2019 APPROVED 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
		345325	B. WING		- 01/'	15/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	-	
CORNER	RSTONE NURSING AN	ND REHABILITATION CENTER		711 SUSAN TART ROAD BO DUNN, NC 28334	X 948	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
F 431	permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distri	ovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to n the facility uses single unit bution systems in which the ninimal and a missing dose car		131		
	by: Based on observation interviews, the facil and discontinued m medication storage cart and 400 hall m The findings include Review of the facilit Unused Medication in part "Medication pharmacy for the for medication is not re- the resident's disch medication is disco automatic stop orde its expiration date." 1. Resident # 46 wa 4/3/2013 with medicu unspecified debility An observation of the	ed: ty's policy "Disposal of is" revised 1/1/14 documented s shall be returned to ollowing reasons: the eleased to the resident upon arge from the facility, a ntinued by the physician or by er policy or medication reaches as readmitted to the facility on cal diagnoses which included he 200 hall medication cart		Cornerstone Nursing Center acknowledges Statement of Deficien this Plan of Correctio the summary of findin correct and in order t compliance with appl provisions of quality of The Plan of Correctio written allegation of of Cornerstone Nursing Center response to th Deficiencies does no with the Statement of does it constitute an deficiency is accurate Cornerstone Nursing Center reserves the of the deficiencies on th Deficiencies through Resolution, formal ap and/or any other adm proceeding.	s receipt of the ncies and proposes on to the extent that ngs is factually to maintain licable rules and of care of residents. on is submitted as a compliance. and Rehabilitation his Statement of t denote agreement f Deficiencies nor admission that any e. Further, and Rehabilitation right to refute any of his Statement of Informal Dispute opeal procedure	
	was made on 1/13/	AF at AALAF and The	1			1

		& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · ·	E SURVEY PLETED
		345325	B. WING _		01/	15/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
CORNER	STONE NURSING AN	ID REHABILITATION CENTER		711 SUSAN TART ROAD BOX 948 DUNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION) CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 431	Continued From pa	ae 14	F 43	1		
	medication for Resi physician order data "Tamiflu 75 mg one times 5 days." Furt 2015 Medication Ac the order for Tamifle On 1/13/15 at 11:45 Nurse #8 confirmed Resident #46 was of the responsibility of the last dose to rem medication cart. In an interview on 1 Director of Nursing for the staff to remo expired medications 2. Resident # 66 wa 8/27/2007 with med unspecified glaucor An observation of th was made on 1/14/ observation reveale eye drops for Resid date of 1/4/15. Revi January 2015 for R order for Xalatan 0. eye at bedtime. On 1/14/15 at 3:10 #6 confirmed the Xa #66 had an expired	ident # 46. Review of a ed 12/29/2014 documented capsule by mouth twice a day ther review of the January dministration Record revealed u was stopped on 1/2/15." 5 am during an interview, d the order for Tamiflu for discontinued. She stated it was the nurse that administered nove the medication from the /15/15 at 12:24 pm, the stated it was her expectation ove the discontinued and s and return to the pharmacy. as admitted to the facility on dical diagnoses which included ma and hypertension.	F 43	 #46 were removed from mediation include Tamiflu capsules is nurse on 1/13/15 and medication pharmacy. Nurse #8 was by the Staff Facilitator on 1/2 regarding removal of discontinuation of medication discharge of resident. Expire eye drops for Resident #66 w from medication cart by hall 1/14/15 and medication was pharmacy. Expired and discontinued from medication cart by hall 1/15/15. Nurse #6 was in-set Staff Facilitator on 1/29/15 reremoval of expired and discomedications from medication from medication cart discarded into the sharps co 1/15/15. Nurse #6 was in-set Staff Facilitator on 1/29/15 reremoval of expired and discomedications from medication from medication cart Audit on 1/14/15 by MDS Coordination 100% Medication Cart Audit on 1/14/15 by MDS Coordination were from medications we from medication carts and set the pharmacy as appropriate of concern during this audit w immediately corrected and m were returned to pharmacy by Coordinator, MDS nurse, Treatment Nurse, Treatment Nurse, Treatment of pharmacy by Coordinator, MDS nurse, Treatment Nurse, Treatment Nurse, Treatment Nurse, Treatment Nurse, Coordinator, MDS nurse, Treatment Nurse, Coordinator, MDS nurse, Treatment Nurse, Treatment Nurse, Treatment Nurse, Treatment Nurse, QI Nurse, QI Nurse, and ADON observation. 100% in-service to all license 	by the hall ation returned in-serviced 29/15 tinued in cart upon ns or ed Xalatan were removed nurse on sent back to continued t #17 was art and ntainer on erviced by the egarding ontinued in carts. was initiated ator, MDS Nurse, and and ere removed ent back to e. Any areas were nedications by the MDS eatment upon	
		s from the medication cart.		include Nurse #6, Nurse #8, initiated on 1/29/15 by Staff I		

Facility ID: 923073

TATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DATE	0938-039
	of correction	IDENTIFICATION NOMBER.	A. BUILDIN	G	COMPLETED	
		345325	B. WING		01/*	15/2015
IAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
ORNE	RSTONE NURSING AN	ND REHABILITATION CENTER		711 SUSAN TART ROAD BOX 948 DUNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 431	Continued From pa	ge 15	F 43	1		
	Director of Nursing for the staff to remo expired medication 3. Resident #17 wa 1/22/2013 with med Diabetes Mellitus T On 1/14/15 at 3:00 hall medication car of Novolin R disper #17. Review of Res revealed a physicia read "D/C (discont Sliding Scale). Con accuchecks." On 1/14/15 at 3:10 #6 stated it was the remove the expired medication cart. In an interview on 1 Director of Nursing for the staff to remo expired medication On 1/15/15 at 3:30	stated it was her expectation ove the discontinued and s and return to the pharmacy. s admitted to the facility on dical diagnoses which included ype 2. pm, an observation of the 400 t revealed an unopened bottle used 11/11/14 for Resident sident #17's medical record n order dated 12/4/14 that inue) RISS (Regular Insulin tinue with current pm during an interview, Nurse e responsibility of all nurses to medications from the 1/15/15 at 12:24 pm, the stated it was her expectation ove the discontinued and s and return to the pharmacy. pm, the Assistant Director of Resident #17 no longer had an		discontinued medications from me carts. All newly hired licensed nur be in-serviced on removal of expir discontinued medication from medication by Staff Facilita The Hall Nurse will remove all discontinued medications from me carts upon receipt of the MD order discontinue the medication. The A will review the QI Telephone Order for Discontinued Medications Tool week x 4 weeks; then weekly x 4 w then monthly x 1 month for all discontinued medications and insp medication cart to ensure that medications have been removed b hall nurse. The Hall Nurse will che expiration dates on all medications administration of the medication to resident and remove expired medi from the medication cart and retur expired medication to the pharmat QI Medication Cart Audit Tool will b utilized by the MDS Coordinator, N nurse, Treatment Nurse, QI Nurse ADON 2X a week for 4 weeks; the weekly X4 weeks; then monthly X month to ensure expired and disco medications are being removed fr medications are being removed fr medication carts. All identified area concern will be addressed by MDS Coordinator, MDS Nurse, Treatmen Nurse, QI Nurse, and ADON imme The QI Medication Cart Audit Tool QI Telephone Order Audit for Discontinued Medications Tool will	ses will ed and lication to DON Audit 2 x veeks; bect the ck prior to the cation n the cy. The be MDS , and n 1 pontinued om as of 5 ant ediately. and the	

Facility ID: 923073

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		AND HUMAN SERVICES & MEDICAID SERVICES			FO	ED: 02/13/2015 RM APPROVED NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY COMPLETED
		345325	B. WING			01/15/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	
CORNER	RSTONE NURSING AN	ID REHABILITATION CENTER			11 SUSAN TART ROAD BOX 948 DUNN, NC 28334	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431 F 441 SS=D	SPREAD, LINENS The facility must es Infection Control Pr safe, sanitary and c to help prevent the of disease and infer (a) Infection Contro The facility must es Program under whi (1) Investigates, co in the facility; (2) Decides what pr should be applied to (3) Maintains a reco actions related to in (b) Preventing Spre (1) When the Infect determines that a re prevent the spread isolate the resident	I CONTROL, PREVENT tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction. I Program tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective ifections. ead of Infection ion Control Program esident needs isolation to of infection, the facility must	F 4		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 Qua Assurance Committee x 3 months. Additional action will occur if deemed necessary and to determine the need o and/or frequency for continued monitoring.	ity

		AND HUMAN SERVICES			FORM	: 02/13/2015 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345325	B. WING _		01/	15/2015
NAME OF F	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, 2		
CORNER	STONE NURSING AN	ID REHABILITATION CENTER		711 SUSAN TART ROAD BOX 94 DUNN, NC 28334	48	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 441	from direct contact direct contact will tr (3) The facility mus hands after each di hand washing is ind professional practic (c) Linens Personnel must han transport linens so infection.	ase or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which dicated by accepted se. ndle, store, process and as to prevent the spread of	F 44	11		
	by: Based on an obser interviews, the facil change gloves after providing catheter of reviewed for indwel #139). Findings inc On 1/14/15 at 11:32 made of NA (Nursin incontinent care an #139. The NA begat rectal area which w same gloved hands the NA proceeded the held the catheter tu cleaned the tubing a disposable cleans following the catheter should have change performing catheter On 1/14/15 at 1:29 Director of Nursing	2 am, an observation was ng Assistant) #6 providing d catheter care for Resident an by cleaning the resident as soiled with stool. With the c (visibly stained with stool), to perform catheter care. NA#6 bing at the meatus and in an up and down motion with sing wipe. Immediately er care, NA # 6 stated she ed her gloves before		Cornerstone Nursing ar Center acknowledges re Statement of Deficiencie this Plan of Correction to the summary of findings correct and in order to m compliance with applical provisions of quality of c The Plan of Correction is written allegation of com Cornerstone Nursing an Center response to this Deficiencies does not de with the Statement of De does it constitute an adr deficiency is accurate. F Cornerstone Nursing an Center reserves the righ the deficiencies on this S Deficiencies through Infe Resolution, formal appe and/or any other administ	eccipt of the es and proposes of the extent that is factually naintain ble rules and are of residents. Is submitted as a upliance. Id Rehabilitation Statement of enote agreement eficiencies nor nission that any further, Id Rehabilitation t to refute any of Statement of cormal Dispute al procedure	

Facility ID: 923073

		AND HUMAN SERVICES				FORM	02/13/2015 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345325	B. WING			01/*	5/2015
NAME OF	PROVIDER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CORNER	RSTONE NURSING AN	ND REHABILITATION CENTER			11 SUSAN TART ROAD BOX 948 JUNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	Continued From pa before performing t	-	F4	141	proceeding.		
					Catheter care was provided for re #139 by hall nurse on 1/14/15. N in-serviced on washing hands and changing gloves after cleaning sto the proper procedure for providing catheter care on 1/14/15 by Staff Facilitator. A return demonstratio completed with NA #6 on 1/21/15 Facilitator to ensure washing hand changing gloves after cleaning sto proper procedure for providing ca- care. 100% audit of all residents with for catheters to include resident #139 assessed by Treatment Nurse for cleanliness to include brown matt 1/12/15 thru 1/15/15. Proper cath care was provided to all residents foley catheters on 1/12/15 thru 1/ include resident #139 by Treatme Nurse. 100% return demonstration was initiated by Staff Facilitator or of all C.N.AOs and nurses on cath care to include washing hands an changing gloves after cleaning sto proper procedure for providing ca- care. Return demonstration obset will include NA #6. Any concerns were observed during return demonstrations were immediately corrected by Staff Facilitator. 100% in-service with all C.N.AOs licensed nurses to include NA #6 initiated by Staff Facilitator on 1/1	A #6 was bool and ool and ool and by Staff ds and bool and theter with 15/15 to nt on audit n 1/19/15 neter d bool and theter vations that , and was	

Event ID: ET4O11

Facility ID: 923073

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		AND HUMAN SERVICES			F	ORM.	02/13/2015 APPROVED 0938-0391
-	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION (X3	(X3) DATE SURVEY COMPLETED	
		345325	B. WING _			01/ [,]	15/2015
NAME OF	PROVIDER OR SUPPLIER	L		ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
CORNE	RSTONE NURSING AN	ND REHABILITATION CENTER			1 SUSAN TART ROAD BOX 948 UNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	(X5) COMPLETION DATE
F 441	483.75(f) NURSE A COMPETENCY/CA The facility must en to demonstrate con	AIDE DEMONSTRATE ARE NEEDS Issure that nurse aides are able inpetency in skills and ary to care for residents'	F 44		catheter care to include washing of ha and changing gloves after cleaning sto as needed. A Resident Care Audit Tool will be use QI Nurse, ADON, MDS Coordinator, M Nurse, Staff Facilitator and Treatment Nurse for observation for proper cathe care to include staff are washing hand and changing gloves after cleaning perineal area to include stool for all residents with urinary catheters to incli resident #139 3 X a week X 4 weeks; weekly X 4 weeks, and monthly X 1 month. These observations will includ NA #6. Any areas of concern observe will be immediately corrected by the Q Nurse, ADON, MDS Coordinator, MDS Nurse, Staff Facilitator and Treatment Nurse. The DON will monitor the Resident Care Audit Tool for completio X a week X 4 weeks; weekly X 4 week and monthly X 1 month. The Quality Improvement Executive Committee will review the results of th Resident Care Audit Tool monthly X 3 months for any other recommendation take action as appropriate, and to mor continued compliance in this area.	ool and d by IDS ter s ude e d l S on 3 ss, e ss, nitor	2/12/15

Facility ID: 923073

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		0938-039 SURVEY
ID PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3	COM	PLETED
		345325	B. WING		01/	15/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CORNER	STONE NURSING AI	ND REHABILITATION CENTER		711 SUSAN TART ROAD BOX 948 DUNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 498	Continued From pa	age 20	F 498	3		
	assessments, and	described in the plan of care.				
	by:	NT is not met as evidenced tion, record review and staff		Cornerstone Nursing and Reha	abilitation	
	interviews, the facil to perform the task	lity failed to validate the ability of catheter care for 1 of 1 staff ng catheter care (Nursing		Center acknowledges receipt o Statement of Deficiencies and p this Plan of Correction to the ex the summary of findings is factor	f the proposes dent that ually	
	dated 8/2012 docu prevent infection an	ty policy on Perineal Care mented in part "Objective: To nd odors. For Catherized		correct and in order to maintain compliance with applicable rule provisions of quality of care of r The Plan of Correction is subm	s and esidents. itted as a	
	cleanse the cathete resident: Cleanse t	e around the meatus and er tubing. For the male he penis and rinse."		written allegation of compliance Cornerstone Nursing and Reha Center response to this Statem Deficiencies does not denote a	bilitation ent of greement	
	made of NA (Nursin incontinent care an	2 am, an observation was ng Assistant) #6 providing id catheter care for Resident		with the Statement of Deficienc does it constitute an admission deficiency is accurate. Further,	that any	
	rectal area which w same gloved hands the NA proceeded held the catheter tu cleaned the tubing	an by cleaning the resident vas soiled with stool. With the s (visibly stained with stool), to perform catheter care. NA#6 ubing at the meatus and in an up and down motion with		Cornerstone Nursing and Reha Center reserves the right to refu the deficiencies on this Stateme Deficiencies through Informal D Resolution, formal appeal proce and/or any other administrative	ute any of ent of Dispute edure	
	following the cather should have chang performing cathete			proceeding. NA #6 ability to perform the task catheter care was validated on Staff Facilitator and DON on 2/0	1/21/15 by 6/15. NA	
	Staff Facilitator sta	0 am during an interview, the ted she was unable to provide of training provided to the are.		#6 was in-serviced on washing changing gloves during and after stool and the proper procedure providing catheter care on 1/14	er cleaning for	

TATEMENT	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	E CONSTRUCTION		SURVEY
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		345325	B. WING _			01/1	5/2015
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CORNER	CORNERSTONE NURSING AND REHABILITATION CENTER				1 SUSAN TART ROAD BOX 948 UNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 498	any training on cath further stated the o she was in CNA (C class. The NA state perform catheter ca performed the task On 1/14/15 at 1:16 facilitator stated she abnormal findings with the NA's (Nurs orientation class. S physically observe care (validate) prior task in the facility. On 1/14/15 at 1:29 Director of Nursing expectation for the	heter care at the facility. She nly training she had was when ertified Nursing Assistant) ed no one has observed her are in the facility before she	F 49	98	catheter care for all C.N.AOs, to inc NA#6 and licensed nurses was initi on 2/4/15 by Staff Facilitator and AI validate the ability to perform tasks utilizing skills check list. All staff we immediately re-trained for all identifiareas of concern during observatio Staff Facilitator and ADON. The Staff Facilitator was in-serviced the DON on 2/5/15 regarding the expectation that all C.N.AOs and licen nurses are observed, and to validat ability to perform all tasks to include catheter care per the skills check list during orientation prior to staff givin to residents. All C.N.AOs and licen nurses to include NA #6 were in-se on washing hands and changing glid during and after cleaning stool and proper procedure for providing cath care on 1/14/15 by Staff Facilitator. The newly hired C.N.AOs and licen nurses will be observed in orientation the Staff Facilitator to validate the a perform all tasks to include cathete per the skills check list prior to staff care to residents. All C.N.AOs to in NA#6 and licensed nurses will be observed annually by the Staff Faci to validate the continued ability to p all tasks to include catheter care per skills check list. The ADON will obs 10% of the newly hired C.N.AOs and licensed nurses in orientation or an skills check list performance to ens	ated DON to ere fied n by d by censed te the le st og care lsed erviced oves the neter sed on by ability to r care f giving nclude erform er the serve nd nual	

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CENTERS F	OR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			0	FORM MB NO.	02/13/2015 APPROVED 0938-0391
STATEMENT OF E AND PLAN OF CC		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEN COMPLETED	
		345325	B. WING			01/	15/2015
NAME OF PROV	IDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CORNERSTO	ONE NURSING AN	D REHABILITATION CENTER			11 SUSAN TART ROAD BOX 948 JUNN, NC 28334		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 498 Co	ntinued From pa	ge 22	F	498	include catheter care, and initial th check list upon completion, weekly weeks; then biweekly x 1 month; th monthly X 1 month. A Resident Ca Tool will be used by QI Nurse, ADC MDS Coordinator, MDS Nurse, Sta Facilitator and Treatment Nurse fo observation for proper catheter car ensure C.N.AOs and licensed nurs include NA #6 are washing hands a changing gloves during and after of perineal area to include stool for al residents with urinary catheters 3.2 week X 4 weeks; weekly X 4 week monthly X 1 month to include resid #139. The DON will monitor the R Care Audit Tool for completion 3 X X 4 weeks; weekly X 4 weeks, and monthly X 1 month. The DON will monitor the skills che for completion and ADON's initials x 4 weeks; then bi-weekly x 1 mon monthly x 1 month. The results of the Skills Check List the Resident Care Audits will be sh monthly with the Executive Quality Assurance Committee x 3 months Additional action will occur if deem necessary and to determine the ne and/or frequency for continued monitoring.	v X 4 nen re Audit DN, aff re to ses to and leaning I K a s, and lent esident a week I eck list weekly th; then t and hared ed	

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