PRINTED: 09/02/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED
		345070	B. WING _	B. WING		1	09/2015
NAME OF PROVIDER OR SUPPLIER DURHAM NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, ST 411 S LASALLE STREET DURHAM, NC 27705	TATE, ZIP CODE		00.20.10
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CCTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	3	F	000			
F 159	complaint investigation ID# ZIO511. 8/31/15 IDR panel de 483.10(c)(2)-(5) FAC	ILITY MANAGEMENT OF	F	159			8/1/15
SS=B				TITLE			(X6) DATE

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

(X6) DATE

Electronically Signed 07/30/2015

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.

PRINTED: 09/02/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345070		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 07/09/2015	
		B. WING			
	NAME OF PROVIDER OR SUPPLIER DURHAM NURSING & REHABILITATION CENTER				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 159	through quarterly starthe resident or his or The facility must notic Medicaid benefits where resident's account resident's account restriction 1611(a)(3)(B) amount in the account the resident's other reaches the SSI resorresident may lose elimiterview, the facility sampled residents (F#93 #40, #22, #35, #representative of resupplemental securit limit. The findings included Review of the Quarter Funds dated December 183 statements of residents of resident	ial record must be available tements and on request to her legal representative. If yeach resident that receives ten the amount in the aches \$200 less than the rone person, specified in yof the Act; and that, if the nt, in addition to the value of tonexempt resources, burce limit for one person, the gibility for Medicaid or SSI. If is not met as evidenced ew, record review and staff failed to notify 10 of 72 Resident #19, #15, #8, #42, 72 and #45) and/or the ident funds exceeding the record for the ident funds exceeding the record in part: under idents who are eligible for eccurity income) or medical effect the difference between and the applicable eligibility	F 15	"This Plan of Corrections is prepared submitted as required by law. By submitting this Plan of Correction, Durham Nursing and Rehabilitation Center does not admit that the deficier listed on this form exists, nor does the Center admit to any statements, finding facts, or conclusions that form the basifor alleged deficiency." F159 1. Corrective actions for those found to be affected. On 7/13/15 the Business Office Manager notified the residents and/or representative of the following numbered residents (19, 15, 8, 42, 93, 22, 35, 72, and 45) by written documentation of the trust balance whould exceed the SSI resource limit.	ocy g, s
	8/25/11. Review of th	admitted to the facility on se trust fund account was 5 at 1:47 PM. The trust		 Corrective actions for those having potential to be affected. On 7/13/15, the Business Office Manager and 	ne

Facility ID: 923264

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345070 B. WING			C 07/09/2015			
NAME OF P	ROVIDER OR SUPPLIER		 	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 011	09/2013
TO THE OT THE	TO VIDER OR OUT FEET						
DURHAM	NURSING & REHABILITA	ATION CENTER			11 S LASALLE STREET		
				ט	URHAM, NC 27705		
(X4) ID PREFIX TAG			ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 159	F 159 Continued From page 2		F 1	159			
F 159	account revealed a bawas no documentation Resident #19 and/or in notified the account be Medicaid resource limber of receptionist indicated money and dispersed She was not aware of allowed for a Medicair residents were Medicair residents were Medicair and returned with the involved with the mark of administrator indicated updated to include secertified mail and noting residents and purchas and returned with the involved with the mark of the limber of the limbe	alance of \$3213.63. There in presented to indicate that the representative had been alance had exceeded the nit. In 7/9/15 at 11:16 AM, the that she managed the the funds to the residents. If any limits on the amount diversident or which aid. The business office died the accounts. The BOM interview. In 7/9/15 at 12:09 PM, the dicated she assisted sed items they requested receipt. She wasn 't hagement of resident funds. In 7/9/15 at 2:13 PM, the dicated she assisted sed items they requested receipt. She wasn 't hagement of resident funds. In 7/9/15 at 2:13 PM, the did the policy would be anding the statements by fying the we they were at the threshold mits of the Medicaid ent would be assisted in as to prevent exceeding the did not 5-7-15. Review of the seconducted on 7-9-15 at account revealed a balance of	F 1	159	Administrator reviewed all accounts an any resident with a balance of \$1600.0 or greater, the resident and/or representative was notified with written documentation. The Business Office Manager mailed a letter certified to the representative. If the representative party/resident does not respond to the certified letter by 7/31/15, the staff at the Center will purchase items that benefit resident and keep receipts in the busin office file. 3. Measures/Systemic changes to ensudeficient practice will not occur. The Business Office Manager will review al accounts every month during month enclose process. Written notification to a resident/representative via Certified Mand with their monthly Trust statement advising them of balance reaching SSI threshold limit to contact the business office. To assure a check and balance the Business Office Manager will review this process monthly for 4 months and quarterly thereafter and report findings Administrator. 4. To monitor performance and efficact the monthly results will be reported dur the Quality Assurance meeting for 4 months and then as needed if identified as recurrent issue.	ne the ess ure I nd ny ail	
	representative had be	that Resident #5 and/or the een notified the account d the Medicaid resource					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345070			IPLE CONSTRUCTION NG	(X3)	(X3) DATE SURVEY COMPLETED C			
		B. WING						
	ROVIDER OR SUPPLIER NURSING & REHABILIT			STREET ADDRESS, CITY, STATE, ZIP CODE 411 S LASALLE STREET DURHAM, NC 27705				
(X4) ID PREFIX TAG			ID PREFIX TAG	((EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE		
F 159	receptionist indicated money and dispersed She was not aware of allowed for a Medica residents were Medica residents were Medica manager (BOM) han was not available for During an interview of social worker (SW) in residents and purchas and returned with the involved with the main During an interview of administrator indicate updated to include secertified mail and not resident/representati to exceed the of the allowance. The resid spending their monie Medicaid allowance. 3. Resident #8 was a facility on 4-1-14 and Review of the trust fun 7/9/15 at 9:47 AM a balance of \$3685.4 documentation presentation prese	on 7/9/15 at 11:16 AM, the I that she managed the I the funds to the residents. If any limits on the amount id resident or which caid. The business office dled the accounts. The BOM interview. In 7/9/15 at 12:09 PM, the indicated she assisted items they requested a receipt. She wasn 't inagement of resident funds. In 7/9/15 at 2:13 PM, the end the policy would be ending the statements by ifying the event were at the threshold imits of the Medicaid ent would be assisted in is to prevent exceeding the ending the statements by infinite of the facility on readmitted on 6-15-15. In account was conducted in the trust account revealed in the representative had been contained had exceeded the init.	F1	59				
	During an interview of	on 7/9/15 at 11:16 AM, the						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345070	B. WING			C 07/09/2015
	ROVIDER OR SUPPLIER	TATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 411 S LASALLE STREET DURHAM, NC 27705	· · · · · · · · · · · · · · · · · · ·	5770372013
(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 159	money and disperse She was not aware allowed for a Medica residents were Medical manager (BOM) har was not available for During an interview social worker (SW) is residents and purchand returned with the involved with the maximum During an interview administrator indical updated to include socertified mail and not resident/representate to exceed the of the allowance. The resides spending their monimum Medicaid allowance. 4. Resident #42 was facility on 9/11/07 ar Review of the trust fon 9/25/14 at 9:44 Arevealed a balance of documentation president#42 and/or	d that she managed the d the funds to the residents. Of any limits on the amount aid resident or which caid. The business office adled the accounts. The BOM or interview. On 7/9/15 at 12:09 PM, the asset items they requested ased items they requested are receipt. She wasn't anagement of resident funds. On 7/9/15 at 2:13 PM, the add the policy would be anding the statements by tifying the aive they were at the threshold limits of the Medicaid dent would be assisted in as to prevent exceeding the admitted on 7/5/12. Und account was conducted and account was conducted and account was conducted and account account the f\$2830.08. There was no account the representative had been balance had exceeded the	F 19	59		
	_	on 7/9/15 at 11:16 AM, the d that she managed the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345070			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 07/09/2015	
		B. WING					
	ROVIDER OR SUPPLIER NURSING & REHABILIT	TATION CENTER		41	REET ADDRESS, CITY, STATE, ZIP CODE 1 S LASALLE STREET JRHAM, NC 27705	1 017	03/2013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TIVE ACTION SHOULD BE CED TO THE APPROPRIATE	
F 159	She was not aware of allowed for a Medica residents were Medimanager (BOM) hand was not available for During an interview of social worker (SW) in residents and purchast and returned with the involved with the involved with the maximum and interview administrator indicate updated to include socertified mail and not resident/representation to exceed the of the allowance. The resides spending their monitor Medicaid allowance. 5. Resident #93 was facility on7/25/13.	d the funds to the residents. of any limits on the amount hid resident or which caid. The business office dled the accounts. The BOM interview. on 7/9/15 at 12:09 PM, the endicated she assisted ased items they requested be receipt. She wasn't magement of resident funds. on 7/9/15 at 2:13 PM, the ending the statements by tifying the ve they were at the threshold limits of the Medicaid lent would be assisted in the statement of the Medicaid lent would be assisted as a statement of the Medicaid lent would be assisted as a statement of the Medicaid lent would be assisted as a statement of the Medicaid lent would be assisted as a statement o	F	159			
	receptionist indicated	on 7/9/15 at 11:16 AM, the d that she managed the d the funds to the residents.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345070	345070 B. WING			C 07/09/2015	
	NAME OF PROVIDER OR SUPPLIER DURHAM NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 411 S LASALLE STREET DURHAM, NC 27705		11/09/2015	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 159	allowed for a Medica residents were Medi manager (BOM) har was not available for During an interview social worker (SW) i residents and purcha and returned with the involved with the made administrator indicat updated to include socertified mail and no resident/representat to exceed the of the allowance. The residents were medical mail and no resident to exceed the of the allowance.	of any limits on the amount aid resident or which caid. The business office idled the accounts. The BOM interview. On 7/9/15 at 12:09 PM, the indicated she assisted ased items they requested are receipt. She wasn't inagement of resident funds. On 7/9/15 at 2:13 PM, the red the policy would be rending the statements by tifying the live they were at the threshold limits of the Medicaid in the sto prevent exceeding the	F1	59			
	facility on 11/6/07 and Review of the trust from 7/9/15 at 9:47 AM a balance of \$2001.1 documentation press. Resident #93 and/or notified the account Medicaid resource limburing an interview receptionist indicates money and disperse She was not aware callowed for a Medicaid resource limburing an interview of the second sec	ented to indicate that the representative had been balance had exceeded the mit. on 7/9/15 at 11:16 AM, the d that she managed the d the funds to the residents. of any limits on the amount					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345070	B. WING		C 07/09/2015		
	ROVIDER OR SUPPLIER NURSING & REHABIL	ITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 411 S LASALLE STREET DURHAM, NC 27705			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION		
F 159	Continued From page 7 manager (BOM) handled the accounts. The BOM was not available for interview. During an interview on 7/9/15 at 12:09 PM, the social worker (SW) indicated she assisted residents and purchased items they requested and returned with the receipt. She wasn't involved with the management of resident funds. During an interview on 7/9/15 at 2:13 PM, the administrator indicated the policy would be updated to include sending the statements by certified mail and notifying the resident/representative they were at the threshold to exceed the of the limits of the Medicaid allowance. The resident would be assisted in spending their monies to prevent exceeding the Medicaid allowance.		F 159				
	facility on 10/14/08 Review of the trust on 7/9/15 at 9:47 Al a balance of 2656.4 documentation pres Resident#22 and/or	ented to indicate that the representative had been balance had exceeded the					
	receptionist indicate money and disperse	on 7/9/15 at 11:16 AM, the ed that she managed the ed the funds to the residents. of any limits on the amount					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTII	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345070	B. WING		07/09/2015
	NAME OF PROVIDER OR SUPPLIER DURHAM NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 411 S LASALLE STREET DURHAM, NC 27705	1 07/03/2013
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 159	Continued From pag	ge 8	F 1	59	
	residents were Med manager (BOM) har was not available for During an interview social worker (SW) residents and purch and returned with the involved with the material material and interview administrator indicate updated to include social certified mail and not resident/representate to exceed the of the allowance. The resident	on 7/9/15 at 12:09 PM, the indicated she assisted ased items they requested a receipt. She wasn't anagement of resident funds. on 7/9/15 at 2:13 PM, the ted the policy would be sending the statements by stifying the ive they were at the threshold limits of the Medicaid dent would be assisted in es to prevent exceeding the			
	facility on 3/12/07 at Review of the trust on 7/9/15 at 9:47 AN a balance of \$9829. documentation pres Resident#35 and/or notified the account Medicaid resource li During an interview receptionist indicate money and disperse She was not aware allowed for a Medica residents were Med	ented to indicate that the representative had been balance had exceeded the			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G	` '	(X3) DATE SURVEY COMPLETED		
		345070	B. WING _			C 07/09/2015	
	NAME OF PROVIDER OR SUPPLIER DURHAM NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 411 S LASALLE STREET DURHAM, NC 27705	1 01100/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 159	social worker (SW) in have direct contact with informing the resident the residents accourtexceeding the resourtexceeding the residents and purchased administrator indicates updated to include a certified mail and no resident/representation to exceed the of the allowance. The residents	on 7/9/15 at 12:09 PM, the indicated that she did not with the notification process of int and/or representative of int balances approaching or rece limits. She assisted ased items they requested are receipt. On 7/9/15 at 2:13 PM, the led the policy would be lending the statements by tifying the live they were at the threshold limits of the Medicaid lent would be assisted in less to prevent exceeding the	F 1:	59			
	facility on 8/24/11 and Review of the trust from 7/9/15 at 9:47 AM a balance of \$3508.2 documentation present the account Medicaid resource limburing an interview receptionist indicated money and disperse	ented to indicate that the representative had been balance had exceeded the mit. on 7/9/15 at 11:16 AM, the d that she managed the d the funds to the residents. of any limits on the amount					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345070	B. WING _			C 07/09/2015
	ROVIDER OR SUPPLIER NURSING & REHABILI	TATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 411 S LASALLE STREET DURHAM, NC 27705		0770372013
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 159	manager (BOM) har was not available for During an interview social worker (SW) residents and purch and returned with the involved with the maximum and interview administrator indicated updated to include secretified mail and no resident/representate to exceed the of the allowance. The resist spending their moniful Medicaid allowance. 10. Resident #45 was facility on 4/30/09 and	icaid. The business office indled the accounts. The BOM or interview. on 7/9/15 at 12:09 PM, the indicated she assisted ased items they requested e receipt. She wasn't anagement of resident funds. on 7/9/15 at 2:13 PM, the sted the policy would be sending the statements by otifying the tive they were at the threshold limits of the Medicaid dent would be assisted in es to prevent exceeding the	F 1	59		
	on 7/9/15 at 9:47 All a balance of \$2158. documentation pres Resident#40 and/or notified the account Medicaid resource I During an interview receptionist indicate money and disperse She was not aware allowed for a Medicaresidents were Medicaresidents were Medicaresidents were selected to the selection of the se	M. The trust account revealed 37. There was no ented to indicate that the representative had been balance had exceeded the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
345070		B. WING		C 07/09/2015		
	NAME OF PROVIDER OR SUPPLIER DURHAM NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 411 S LASALLE STREET DURHAM, NC 27705	1 07700/2010	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 159	social worker (SW) in residents and purcha and returned with the	interview. n 7/9/15 at 12:09 PM, the dicated she assisted sed items they requested	F 15	59		
F 371 SS=D	administrator indicate updated to include se certified mail and noti resident/representativ to exceed the of the li allowance. The reside	Inding the statements by fying the ve they were at the threshold mits of the Medicaid ent would be assisted in as to prevent exceeding the OCURE,	F 37	71	7/24/15	
	considered satisfacto authorities; and	sources approved or ry by Federal, State or local stribute and serve food ons				
	by: Based on observatio record review, the factorial sanitary conditions in	is not met as evidenced ns, staff interviews, and cility failed to maintain the kitchen by 1) ensuring rigerator was clean 2)		F371 1. No resident named in this citation 2. Corrective action for those affected Any resident may be affected therefore	d.	

PRINTED: 09/02/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345070	B. WING _			C 07/09/2015	
	ROVIDER OR SUPPLIER NURSING & REHABILI	TATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP CODE 411 S LASALLE STREET DURHAM, NC 27705			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 371	the dry storage cont debris from 6 clear premove the grease at table lids 5) separatuse food items 5) fa pans in 1 of 1 dry storemove the food del cart. The findings include 1. During an observative walk in refrigerar dried foods and liquir refrigerator. During an interview dietary manager (DI volume of spillage ir indicated the refrige after each shift and 2. During an observation was found insofthicken liquid. In a containers that held had large volumes of the inside and outside the properties. During an interview DM indicated that the been left in the containers that held had large volumes of the dry storage containers and outside the properties of the dry storage containers and observative was 6 clear containers was 6	dried foods and liquids from ainers 3) clean the dried food oreparation containers, 4) and food from 12 serving et dented cans from ready to illed to air dry 2 wet serving orage areas and 7) Clean and oris and grease from hot plate d: ation on 7/6/5 at 10:100AM, tor had a large volume of ids splattered throughout the on 7/6/15 at 10:00AM, the on 7/5/15 at 10:00AM, a side the dry storage container addition, the dry storage the flour, sugar and onions of dried foods and liquids on	F3	on 7/24/15 the Dietary M and sanitized the refriger was removed and remain was discarded. The stor were emptied and cleane storage bins were cleaneremoved due to non-use were cleaned/sanitized a in use. The dented cansidented can section. The removed and clean/sanitized warmer was disassemble cleaned. 3. Measures and system ensure compliant practic Dietary Manager in-servistaff on proper sanitation equipment, refrigerators, storage, cleaning schedusanitizing and proper dry overall compliance with sidietary. On 7/24/15 the implemented weekly/dail schedules with monitorin 4. Monitoring for perforn efficacy. The Dietary Mawill utilize daily/monthly oschedules with monitorin Dietary Manager will over and address daily as well Manager will review wee The outcomes of the mobe reviewed at Quality Amonths to assure compliate Regional Manager will monthly QA visits and to the storage of the mobe reviewed at Quality Amonthly QA visits and to the storage of the mobe reviewed at Quality Amonthly QA visits and to the storage of the mobe reviewed at Quality Amonthly QA visits and to the storage of the mobe reviewed at Quality Amonthly QA visits and to the storage of the mobe reviewed at Quality Amonthly QA visits and to the storage of the mobe reviewed at Quality Amonthly QA visits and to the storage of the mobe reviewed at Quality Amonthly QA visits and to the storage of the mobe reviewed at Quality Amonthly QA visits and to the storage of the storage of the mobe reviewed at Quality Amonthly QA visits and to the storage of the storage of the storage of the mobe reviewed at Quality Amonthly QA visits and to the storage of the	rator. The scoop inder of thickener rage containers rad. The clear red/sanitized and red/sanitized and removed if not red were placed in red silver pans were red and deep ric changes to red all dietary regarding all regarding all reproper food red all dietary regarding all regarding tools red anagement team releaning reg tools. resee the tools		

Facility ID: 923264

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		345070	B. WING _			C 07/09/2015	
	NAME OF PROVIDER OR SUPPLIER DURHAM NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 411 S LASALLE STREET DURHAM, NC 27705		07/09/2013	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		SHOULD BE	(X5) COMPLETION DATE			
F 371	the dried food on the containers and indicashould have been the were placed on the containers and indicashould have been the were placed on the containers are storage and storage rack that had and food build up on During an interview of DM confirmed the graph the lids. He indicated cleaned and thorough placed on the dry storage are storage and storage and storage are storage. The cans included the containers was 6 dented from the cans included the containers are storage and the containers and the containers are storage and the containers and the containers and the containers are storage and the containers and the containers are storage and the containers are storage and the containers and the containers are storage and the containers are storage and the containers are storage and the containers and the containers and the containers are storage and the cont	on 7/6/15, the DM confirmed inside and outside of the ated that the containers oroughly checked before they dry storage cart. ation on 7/6/15 at 10:00AM, atable lids stored on the dry diarge volumes of grease athe lid surfaces and edges. on 7/6/15 at 10:00AM, the rease and food build up on diathat the lids should be ally checked before they were orage rack. ation on 7/6/15 at 10:00AM, cans stored in the dry storage and (2) stewed tomatoes, (2) peaches.	F3				
	checking for dented added the cans show when found dented. 6. During an observation	e was responsible for cans prior to storage. He ald be returned to vendor ation on 7/6/15 at 10:00AM, ans that were stacked wet on					
	DM indicated that all not be stacked on to	on 7/6/15 at 10:00AM, the kitchen equipment should p another and should air dry.					
	7. During a follow-up	kitchen observation on					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	(X3) DATI	(X3) DATE SURVEY COMPLETED	
		345070	B. WING		0.7	C	
NAME OF PROVIDER OR SUPPLIER DURHAM NURSING & REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 411 S LASALLE STREET DURHAM, NC 27705		7/09/2015	
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	CTIVE ACTION SHOULD BE COMPLET NCED TO THE APPROPRIATE DATE		
F 371	During an interview of indicated the plate war	ne plate warmer had dry mer. on 8/8/15 at 11:30AM, the DM armer should be cleaned f every meal. The warmer	F 3'	71			