**Division of Health Service Regulation** (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING HAL043024 11/16/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 40 RAWLS CLUB ROAD SENTER'S REST HOME FUQUAY VARINA, NC 27526 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 000 D 000 Initial Comments The Adult Care Licensure Section conducted an Responces to the cited deficiencies do annual and follow-up survey, and complaint not constitute an admission or agreement by the facility of the facts alleged or investigation on November 13-16, 2017. The conculsions, set forth in the Statement of Harnett County Department of Social Services Deficiencies. This Plan of Correction is initiated the complaint investigation on October 2, perpared soley as a matter of 2017. complainance with the law. D 074 D 074 10A NCAC 13F .0306(a)(1) Housekeeping And **Furnishings** 10A NCAC 13F .0306 Housekeeping And 10A NCAC 13F .0306 (a)(1) Housekeeping and Furnishings Furnishings (a) Adult care homes shall: (a) Adult care homes shall: Work Plan (1) have walls, ceilings, and floors or floor (1) have walls, ceilings, and floors or floor intitiated by coverings kept clean and in good repair. coverings kept clean and in good repair; 1/5/18 Scope of work has been indentified and a work plan will be initiated as of 1/5/18 Facility will assure that walls, ceilings, and floors or floor coverings will be kept clean This Rule is not met as evidenced by: and in good repair by utilizing Maintenance Based on observations and interviews, the facility Work Ordersystem to notify Maintenance failed to assure the walls, ceilings, and floors Company, Buidling Maintenance Services were kept clean and in good repair for 3 common (BMS), of any and all needed repairs. bathroom/shower rooms and 4 resident rooms (8S, 9S, 11S, 14S) on the South Hall of the facility Facility will use "Work Order Request" form. Blank copies of form will be maintained in the and for 3 common bathroom/shower rooms, the employee break room, available to all spa room, and 4 resident rooms (1N, 2N, 7N, employees. 11N) on the North Hall of the facility. Any employee may complete form. Completed Work Order Request forms will The findings are: be turned into ED. ED will enter all Work Order Request into 1. Observation of the common bathroom on the Impulse system. right side of the South Hall (women's hall) on 11/13/17 at 4:15 p.m. revealed: -There was a 1.5 inches by 24 inches area of rust on top of the base heater. -The wall above the soap dispenser had a 4 inches by 3 inches area that had no paint and Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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**Division of Health Service Regulation** (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING HAL043024 11/16/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 40 RAWLS CLUB ROAD SENTER'S REST HOME FUQUAY VARINA, NC 27526 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) D 074 D 074 Continued From page 1 Continued from page 1 chipped plaster. Facility employees will receive training -There was a 2 inches by 2 inches area of rust on on work order request form and process the floor in the corner behind the door. -There were multiple gray colored stains of Facility Maintenance Service, BMS, has various sizes on the back of the door. sanded and painted all base heaters in all -The floor between the two toilets had 2 areas common bathrooms. each 1 inch by 1 inch with missing tile. Facility housekeeping staff have cleaned -There was dust covering the ceiling vent. all dust from ceiling vents. Housekeeping will clean ceiling vents no less than weekly. Observation of the common bathroom on the left back side of the South Hall on 11/13/17 at 4:25 p.m. revealed: Facility Maintenance will remove and/or paint all ceiling vents to assure rust removal -There were multiple areas of various sizes of rust on top of the base heater. Facility Maintenance will schedule painting of -There was a 1 inch by 2 inches area of rust on all resident rooms and bathrooms the floor in the corner behind the door. -There was a 36 inches by 2 inches gray colored Facility is working with contractor on replacement stain on the back of the door. of broken/damaged tile and/or flooring. -There were two areas (3 inches by 2 inches and 2 inches by 2 inches) of rust on the wall under the ED and/or designee will conduct weekly sink. facility rounds to ensure on going -The floor between the two toilets had 2 areas 1 complaince inch by 1 inch each with missing tile. -There was dust covering the ceiling vent. Observation of the resident room 14S on 11/13/17 at 4:30 p.m. revealed: -There were 3 black scuff marks (2 inches by 3 inches each) on the wall beside the bed at the window. -The ceiling vent near the door was covered with dust. Observation of the resident room 11S on 11/13/17 at 4:35 p.m. revealed the ceiling vent near the door was covered with dust. Observation of the resident room 9S on 11/13/17 at 4:40 p.m. revealed the ceiling vent near the door was covered with dust. Division of Health Service Regulation

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			A. BUILDING:	and a subscription of the		С
		HAL043024	B, WING		11/16/2	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
SENTER	S REST HOME		S CLUB ROA VARINA, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
D 074	Continued From pa	age 2	D 074			
	4:45 p.m. revealed -The wall above the inches by 12 inches chipped plaster. -The ceiling vent n dust. Observations of the side of the South F 11/13/17 at 4:50 p. -There was a .5 ind left of the toilet page -There was a 2 ind right side wall of the chipped plaster. -There was a 2 ind left side wall of the chipped plaster. -There was a 2 ind left side wall of the chipped plaster. -There was a 2 ind left side wall of the chipped plaster. -There was a 2 ind left side wall of the chipped plaster. -There was a 2 ind the floor in the cor- -There was a 2 ind the floor in the cor- -There was a 2 ind the floor in the cor- -There was a 2 ind the floor betweer inch by 1 inch ead -There was dust co- Interview with Adm Registered Nurse/ Clinical Support Sp p.m. revealed:	e soap dispenser had a 4 es area that had no paint and ear the door was covered with e common bathroom on the lef fall (closest to staff office) on m. revealed: ch round hole in the wall to the per dispenser. thes by 12 inches area on the e shower that had no paint and thes by 12 inches area on the e shower that had no paint and ble areas of various sizes of ase heater. e soap dispenser had a 2 area that had no paint and thes by 2 inches area of rust or ner behind the door. y colored stains of various size door. n the two toilets had 2 areas 1	ft d s			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING.		с
	HAL043024	B. WING		11/16/2017
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
SENTER'S REST HOME		CLUB ROA		
		ARINA, NC		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE COMPLETE
D 074 Continued From p	age 3	D 074		
next few weeks. -The AIC will notify group of the findin to insure they are Refer to interview				
p.m. and 3:52 p.m				
Refer to interview on 11/14/17 at 8:2	with Clinical Support Specialist 8 a.m.			
Refer to interview 11/14/17 at 9:40 a	with a housekeeper on .m.			
Refer to interview 11/14/17 at 9:50 a	with a second housekeeper on .m.			
Refer to interview 11/15/17 at 9:22 a	with a third housekeeper on .m.			
at 10:30 a.m. reve -The first closet do along the bottom p hinge downward.	resident room 1N on 11/13/17 aled: oor had multiple scratches portion of the door from the third vas metal and the scratches			
with a resident wh	w on 11/13/17 at 10:32 a.m. o resided in room 1N revealed ot interviewable and the uccessful.			
Hall on 11/13/17 a -There were two c covered with dust.	air vents had rusted areas on			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY PLETED
		HAL043024	B. WING			6/2017
	PROVIDER OR SUPPLIER	40 RAWLS	DRESS, CITY, ST S CLUB ROAI VARINA, NC	D		
(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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 074	the vents. Interview with a rest at 10:45 a.m. reveations -He was moved to -The ceiling air verther moved into the Observation of rest Hall on 11/13/17 at -There were two can covered with dust. -Both of the ceiling the vents. Interview with a rest at 11:02 a.m. reveations -He did not know the been on the ceiling -He did not know the last cleaned. Observation of the between resident matches -The wall-mounted the floor, just about numerous, large, mo of the unit; there was approximately 3 into was bolted to the violations was bolted to the violations -There were rust-constructions caulking on the floot the bathtub. -There were scatteres stains along the ceiling -He caultions -He caultions -The vere scatteres -There were scatteres -Therew	sident in room 11N on 11/13/17 aled: this room a few months ago. nts were dusty and rusted when room. ident room 7N on the North 11:02 a.m. revealed: eiling air vents that were a air vents had rusted areas on sident in room 7N on 11/13/17 aled: iow long the dust and rust had g air vents. when the ceiling air vents were residents' common bathroom ooms 4N and 6N on 11/13/17 aled: heating unit located next to e the baseboard, had ust-colored areas along the top as a metal rod that extended ches from the heating unit, that vall on each side of the heating ered rust-colored areas along od, as well as various gray ssing paint. olored areas along the or that extended the length of area areas of rust-colored				

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Division of Health Service Regulation

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and the second statement with the second statement of	CONSTRUCTION	(X3) DATE COMP	SURVEY
		HAL043024	B. WING		C 11/16/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SENTER	'S REST HOME		S CLUB ROA VARINA, NC			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLETI DATE
D 074	areas of missing parallel Observation of resi 11:15 a.m. revealed separated from the the door jamb, exte down the length of crevices along the Attempted interview with the resident we revealed the reside the interview was u Observation of the on 11/13/17 at 11:2 two broken tiles ald on the right side of Observation of the resident room 7N of 11:18 a.m. reveale - There was a wall- floor, just above the rust-colored areas - There was a meta approximately 3 ind was bolted to the we unit with scattered length of the rod. - The floor around t the hinged side of broken pieces of til - There were rust st bottom of both side - The metal protect door had missing p - There were two roo diameter in the tile	aint and rust-colored scrapes. ident room 2N on 11/13/17 at d the inside door jamb was e cement wall from the top of ending approximately one foot the door, and creating tiny wall. w on 11/13/17 at 11:15 a.m. ho resided in room 2N ent was not interviewable and insuccessful. bathing spa on the North Hall 20 a.m. revealed there were ong the baseboard of the wall 'the room. common hall bathroom beside on the North Hall on 11/13/17 at d: mounted heating unit near the e baseboard, with numerous along the top of the unit. I rod that extended ches from the heating unit and vall on each side of the heating rust-colored areas along the the bottom of the door frame on the door was uneven with				

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<b>Division of Health</b>	Service	Regulation	
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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COMF	SURVEY
		HAL043024	B. WING		C 11/16/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
SENTER	'S REST HOME		CLUB ROA			
010.15	SUMMARY ST	ATEMENT OF DEFICIENCIES	ARINA, NC	PROVIDER'S PLAN OF	COBBECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC'	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TON SHOULD BE	(X5) COMPLETE DATE
D 074	toilet paper holder. -There were scatte stains along the ce area about 12 inch exhaust fan. -There was missing right side of the wa holder. -The wall above the of missing paint an -There were scatte below the sink. Interview with the A on 11/13/17 at 3:52 -They had puttied a bottom of the door bathroom on North frame specified). -She would have th check it again. Observation of the Room 10N on the I a.m. revealed: -There was a wall- floor, just above the rust-colored areas -There was a meta approximately 3 ind was bolted to the w unit with scattered length of the rod. -There were rust- c the caulking near the length of the bathtere	red areas of rust-colored illing tiles, including a rusted es long near the ceiling g paint and sheetrock on the ill beside the paper towel e soap dispenser had an area d sheetrock. red rust stains on the wall Administrator-in-Charge (AIC) 2 p.m. revealed: around the broken tile at the frame in the common Hall beside room 7N (no time ne maintenance company common hall bathroom beside North Hall on 11/13/17 at 11:28 mounted heating unit near the e baseboard, with numerous along the top of the unit. I rod that extended ches from the heating unit and vall on each side of the heating rust-colored areas along the foor that extended the ub. red areas of rust-colored	D 074			

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
						С
		HAL043024	B. WING		11/	16/2017
NAME OF P	ROVIDER OR SUPPLIEF	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
SENTER'	S REST HOME		S CLUB ROA			
			VARINA, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 074	Continued From p	age 7	D 074			
	-The metal protect door had missing -There were two r diameter in the tile -There were 6 sm wall above the toil -There were sever above toilet paper wall-mounted hea -There were scatt	tive strip at the bottom of the paint and rust stains. ound holes about ½ inches in a floor near the toilet. all round nail/screw holes in the et paper holder. ral brown smears on the wall holder and above the				
	area about 12 incl exhaust fan. -There was missir above and on the paper towel holde	hes long near the ceiling ng paint and areas of putty right side of the wall beside the r. ered rust stains and areas of				
	three maintenance	I/14/17 at 8:00 a.m. revealed e staff from a contracted pany working on the North Hall				
	the North Hall on -The dust had bee vents.	ation of resident room 11N on 11/14/17 at 5:18 p.m. revealed: en cleaned from both ceiling air g air vents had rusted areas on				
	North Hall on 11/1 -The dust had bee vents.	ation of resident room 7N on the 4/17 at 5:19 p.m. revealed: en cleaned from both ceiling air g air vents had rusted areas on				
vision of H		ition of the common hall Room 7N on the North Hall on			Long-	

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Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The second second second second	CONSTRUCTION	(X3) DATE COMP	LETED
		HAL043024	B. WING			6/2017
AME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
ENTER	S REST HOME	40 RAWL	S CLUB ROAL	D		
	OREOTHORIE	FUQUAY	VARINA, NC	27526		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
D 074	Continued From pa	age 8	D 074			
	11/14/17 at 5:21 p.	heating unit near the floor, just				
		ard, had a new coat of white				
	paint.	ard, had a new coat of white				
		und the heating unit had a new				
	coat of white paint.					
1		he bottom of the door frame on				
		the door was uneven with				
	broken pieces of til					
		tains and brown debris at the				
		es of the door frame.	[ [	*		
- 1		ive strip at the bottom of the				
	door had been rep					
		ound holes about ½ inches in	1			1
		floor near the toilet.				
		all holes in the wall above the				
	toilet paper holder.					
		red areas of rust-colored				
		iling tiles, including a rusted				
		es long near the ceiling				
	exhaust fan.	es long hear the centry				
		g paint and sheetrock on the				
		Il beside the paper towel				
	holder.					
		e soap dispenser had an area				
	of missing paint an					1
		ered rust stains on the wall				
	below the sink.					
	A account above t	in af the second second second				
		ion of the common hall				
		Room 10N on the North Hall on				
	11/14/17 at 5:25 p.					
		heating unit near the floor, just				
	paint.	ard, had a new coat of white				
		und the heating unit had a new				
	coat of white paint.	und the heating unit had a new				
	-There was now wi	hite caulking around the base				
	of the bathtub with	a few rust-colored stains that				
	ealth Service Regulation	red by the new caulking.				

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY
			A. BUILDING:			
		HAL043024	B. WING		11/1	; 6/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CENTED	'S REST HOME	40 RAWLS	S CLUB ROA	ND .		
SENTER	S REST HOME	FUQUAY	VARINA, NC	27526		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 074	Continued From pa	age 9	D 074			
	-There were scatte stains along the ce -There were rust st bottom of both side -The metal protecti door had been repl protective strip. -There were two ro diameter in the tile -There were 6 sma wall above the toile -There were scatte stains along the ce area about 12 inch exhaust fan. -There was missing above and on the r paper towel holder. -There were scatte putty on the wall be A second observati 11/16/17 at 8:55 a. staff was in the roo A second observati bathroom between 11/16/17 at 9:05 a. -The wall-mounted the floor, just above coat of white paint. -There were scatte stains along the ce -There were rust-co caulking around the	red areas of rust-colored illing tiles. tains and brown debris at the as of the door frame. we strip at the bottom of the laced with a new silver bund holes about ½ inches in floor near the toilet. Ill round nail/screw holes in the to paper holder. town smears on the wall above red areas of rust-colored iling tiles, including a rusted es long near the ceiling g paint and areas of putty ight side of the wall beside the red rust stains and areas of elow the sink. ion of resident room 1N on m. revealed housekeeping im cleaning the room. ion of the common hall resident rooms 4N and 6N on m. revealed: heating until located next to e the baseboard, had a new red areas of rust-colored iling tiles. olored stains along the e toilet.				
		ion of resident room 2N on m. revealed the inside door				

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TATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY
						С
		HAL043024	B. WING		11/	16/2017
AME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
ENTER	'S REST HOME		S CLUB ROA			
			VARINA, NC	· · · · · · · · · · · · · · · · · · ·		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE	(X5) COMPLE DATE
D 074	Continued From pa	ge 10	D 074			
		d from the cement wall from jamb, extending approximately ength of the door.				
	Refer to interview v	vith the narge (AIC) on 11/13/17 at 3:40				
	Refer to interview v on 11/14/17 at 8:28	vith Clinical Support Specialist a.m.				
	Refer to interview v 11/14/17 at 9:40 a.	vith a housekeeper on m.				
	Refer to interview v 11/14/17 at 9:50 a.	vith a second housekeeper on m.				
	Refer to interview v 11/15/17 at 9:22 a.	vith a third housekeeper on m.				
	on 11/13/17 at 3:40 -The ceiling air ven deep cleaning.	Administrator-in-Charge (AIC) p.m. and 3:52 p.m. revealed: ts were usually cleaned during				
	cleaned each week -The facility's main all the hallways, do	tenance company had painted ors and door frames and they		ж)		
	facility. -The holes in the w	king on more painting at the ralls would be puttied and ntenance company.				
	11/14/17 at 8:28 a. -The facility's main	Clinical Support Specialist on m. revealed: tenance company was at the /17, to work on sinks and to do				
	more painting. -There had been a	long list of needed repairs to removing some half walls in				

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Division	of Health Service Re	gulation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLI	ECONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A, BUILDING:		COMP	LETED
						;
		HAL043024	B. WING			6/2017
		CTREET AD				
NAME OF I	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
SENTER	'S REST HOME		S CLUB ROA			
			VARINA, NC	All and a second s		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 074	Continued From pa	ge 11	D 074	Larray and second se		
	the living room.					
	-The maintenance	company was still working on				
	completing needed	repairs.				
	Interview with a hou	usekeeper on 11/14/17 at 9:40				
	a.m. revealed:					
		of work and she was still in				
	training.	eaning bathrooms was "from				
	top down".	earing bathoons was non				
	-The walls, doors a	nd handles, sink, toilet,				
		were cleaned with a				
	disinfectant.	e of a set cleaning schedule		à'		
	yet since she was s					
	Interview with a sec	cond housekeeper on 11/14/17				
	at 9:50 a.m. revealed	ed:				
		oloyed by facility for 3 months.				
	-The bathrooms we	ere cleaned daily. eaning the bathrooms was to				
		andles, sink, towel handle,				
	shower, shower cu	rtain and privacy curtain				
	around toilet.	anned with a district start				
		eaned with a disinfectant. g vents if they were dirty.				
	-She had not realiz	ed that serveral ceiling vents				
-	were dusty, but wo	uld clean them immediately.				
		AIC if she saw repairs that				
	were needed.					
	Interview with a thir	d housekeeper on 11/15/17 at				
	9:22 a.m. revealed			8		
		s usually deep cleaned one				
	resident room per o	lay. luded moving the furniture and				
	cleaning under it ar	nd dusting it, and cleaning				
	everything in the ro	om.				
	-They swept and m					
Division of L	-They cleaned the ealth Service Regulation	bathrooms every day including	1			
DIVISION OF H	call Service Regulation					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A Contraction of the second	E CONSTRUCTION	(X3) DATE S COMPL	
		HAL043024	B. WING		C 11/10	6/2017
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CENTED	'S REST HOME	40 RAWL	S CLUB ROA	AD		
SCHIER	3 KEST HOWE	FUQUAY	VARINA, NC	27526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLET DATE
D 074	Continued From pa	ige 12	D 074			
	sweeping, mopping toilets.	, showers/bathtubs, and				
D 079	10A NCAC 13F .03 Furnishings	06(a)(5) Housekeeping and	D 079	10A NCAC 13F .0306(a)(5) Houekee Furnishings	ping and	Work pla will be initiated l
	Furnishings (a) Adult care hom (5) be maintained orderly manner, fre hazards;	06 Housekeeping and es shall in an uncluttered, clean and e of all obstructions and ly to new and existing		Scope of work has been identified an plan will be initiated as of 1/5/18 Facility will assure that it maintains at clean and orderly manner, and is free obstructions and hazards. Facility will utilize Maintenance work to notify Maintenance company (BMS all repairs needed.	n unclutterec of all order system	1/5/18 1
	Based on observat interviews, the facil was clean and free resident bathrooms rooms (5S, 9S, 14S facility and in 3 con	rooms and the bath spa on		Facility will use "work order request" Blank forms will be maintained in the breakroom Completed forms will be turned into B ED will enter all work order request in system. Facility staff have been in-serviced o and the importance of completing wor request. Facility has cleaned all bathtubs, cap toilet bolts, and replaced knobs on b heaters.	employee ED. Into Impulse In location Ink order oped all ase	
	bathroom between 11/13/17 at 11:13 a -The bathtub was c multiple black smud -The bolts that and were uncapped on bolts measured app	overed in specks of dirt and		Facility has replaced all shower curt cleaned privacy curtains in all bathro Facility housekeeping will assure to bathtubs, shower curtains and priva during daily cleaning of bathrooms ED/or designee will complete weekly of facility to ensure on going complia	ooms. clean all cy curtains y rounds	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COMF	(X3) DATE SURVEY COMPLETED C	
		HAL043024	B. WING			11/16/2017	
NAME OF F	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, ST	TATE, ZIP CODE			
CONTER	P DEST LIQUE	40 RAWLS	CLUB ROA	D			
SENTER	S REST HOME	FUQUAY \	ARINA, NC	27526			
(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 / DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE	
D 079	Continued From pa	ge 13	D 079				
	Room 7N on the Ne a.m. revealed: -The knob on the w missing and a roun about ½ inch where be. -The metal drain in areas. -There were brown bathtub and a miss stains where the st -The cover for the t missing. -The shower curtai the top of the curta that hooked the cur -There were 5 hole were not attached to curtain to droop do -The privacy curtain brownish red stains -There were 4 rings were not attached to curtain to droop do Observation of the	oilet paper holder was in had rust-colored stains along in and around the metal holes tain to the rod. s of the shower curtain that to the rod causing the shower which had a shower the toilet had s near the top of the curtain. s of the privacy curtain that to the sliding track, causing the which those areas. bathing spa on the North Hall 0 a.m. revealed the window					
	Observation of the Room 10N on the I a.m. revealed:	common hall bathroom beside North Hall on 11/13/17 at 11:28					
	missing and a roun about ½ inch where be.	rall-mounted heating unit was d metal stem was sticking out a the knob was supposed to					
		n had rust-colored stains along in and around the metal holes					

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Division	of Health Service Re	egulation				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	in the second second		(X3) DATE COMP	SURVEY LETED
		HAL043024	B. WING		11/1	6/2017
						0/2011
NAME OF F	ROVIDER OR SUPPLIER			STATE, ZIP CODE		
SENTER	S REST HOME		S CLUB RO. VARINA, NO			
(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)	ULD BE	(X5) COMPLETE DATE
D 079	and the wall-mount faucet was turned of -The water stream prevent the splashi off. -The metal drain in multiple rusted are: -There were brown bathtub with yellow down on the inside -The privacy curtain stains near the mid -The bolts that and were uncapped on were approximately Interview with the A on 11/13/17 at 11:3 -She was not awar water splashing fro resident bathroom -She would get sor the floor. -They would get the Interview with a hou 11:43 a.m. revealed -She had worked a months. -She had not notice the common reside -The bathrooms in day. Interview with the A revealed:	rtain to the rod. e from the wall. ut of the sink and onto the floor ted heating unit when the on. could not be adjusted to ing without turning the faucet the tub had corrosion and as. stains and debris in the ish brown streaks running wall of the tub. In beside the toilet had brown Idle of the curtain. hored the toilet to the floor both sides of the toilet and y 1 inch long. Administrator-in-Charge (AIC) i8 a.m. revealed: e there was a problem with the im the sink in the common on the North Hall. neone to mop the water from e sink repaired. usekeeper on 11/13/17 at	D 079			
	ealth Service Regulation					
STATE FOR			5899	9CXP11	If continuation	sheet 15 of 103

**Division of Health Service Regulation** (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING HAL043024 11/16/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 40 RAWLS CLUB ROAD SENTER'S REST HOME FUQUAY VARINA, NC 27526 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 079 Continued From page 15 D 079 working on repairing the sink in the common resident bathroom on the North Hall. -They were replacing parts on the faucet. Interview with a medication aide on 11/13/17 at 3:50 p.m. revealed: -The baseboard heating units in the bathrooms worked to her knowledge. -The staff used the knobs to turn the units on and off. -She had not noticed the knobs were missing from the heating units. -She could not remember the last time the baseboard heating units in the bathrooms had been used. Observation on 11/14/17 at 8:00 a.m. revealed three maintenance staff from a contracted construction company working on the North Hall in the bathing spa. Interview with Maintenance staff from the facility's maintenance company on 11/14/17 at 8:18 a.m. revealed: -They had replaced the faucet at the sink in the common hall bathroom beside Room 10N today. 11/14/17. -They had brackets for any loose sinks in the facility but it was working better to put bolts into the walls to prevent the sinks from lifting up and they were working on that currently. -There would still be "slight" movement of the sinks but that was normal. A second observation of the common hall bathroom beside Room 7N on the North Hall on 11/14/17 at 5:21 p.m. revealed: -The knob on the heating unit had not been replaced. -The metal drain in the tub had multiple rusted Division of Health Service Regulation

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TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED C 11/16/2017	
	HAL043024	B. WING				
AME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
SENTER'S REST HOME		S CLUB ROA				
		VARINA, NC			1	
PREFIX (EACH DEFICIENC'	ATEMENT 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	TON SHOULD BE	(X5) COMPLET DATE	
missing non-skid s the strip was missi -The cover for the missing. -The shower curtai with a new clean cu -The privacy curtai brownish red stains -There were 4 rings were not attached curtain to droop do A second observat bathroom beside R 11/14/17 at 5:25 p. -The knob on the h with a new black ku -The shower curtai with a new black ku -The shower curtai with a new clean cu -The sink had beer and the water did r the faucet was turr -The metal drain in multiple rusted are -The debris in the f there were light yel down on the inside -The privacy curtai -The bolts that and been covered with A second observat South Hall on 11/14	stains in the bathtub and a trip with brown stains where ng. toilet paper holder was n and rings had been replaced urtain and rings. In beside the toilet had light is near the top of the curtain. Is of the privacy curtain that to the sliding track, causing the wn in those areas. ion of the common hall coom 10N on the North Hall on im. revealed: teating unit had been replaced nob. In and rings had been replaced urtain and rings. In repaired with a new faucet not splash out of the sink when hed on. The tub had corrosion and as. Dathtub had been cleaned but lowish brown streaks running wall of the tub. In had been cleaned. hored the toilet to the floor had a white cap. ion of resident room 5S on the 4/17 at 5:32 p.m. revealed: hite caulking around the back					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C 11/16/2017	
		HAL043024	B. WING			
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
SENTER	S REST HOME	40 RAWLS	CLUB ROA	D		
	o neor nome	FUQUAY	ARINA, NC	27526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y 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)	LD BE	(X5) COMPLET DATE
D 079	Continued From pa	age 17	D 079			
	11/14/17 at 4:49 p.r	orth Hall beside room 4N on m. revealed: tool bag sitting on the floor in				
	contents of the bag -There were multip visible tools on top	le tools in the bag including that included a hammer, a 12				
	tape.	air of pliers, and a roll of duct tended and no staff were orth Hall.				
	Assurance and Reg 11/14/17 at 4:51 p.	/ice President of Quality gulatory Compliance on m. revealed: e the tool bag had been left				
	maintenance comp -They were not sup	posed to leave the tool bag				
	-She would put the	acility (special care unit). tool bag in a secure location maintenance company staff.				
	between resident real at 9:05 a.m. reveal					
	-The bathtub was o multiple black smu	n had been replaced. covered in specks of dirt and dges. ng the toilet to the floor had				
	been covered.					
	Refer to interviews Administrator-in-Ch p.m. and 3:52 p.m.	narge (AIC) on 11/13/17 at 3:40				
sion of L	Refer to interview v Specialist on 11/14 ealth Service Regulation					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	LETED
		HAL043024	B. WING	and a contract of the second	11/16/2017	
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
SENTER	S REST HOME		CLUB ROA			
			ARINA, NC			
(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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLET DATE
D 079	Continued From pa	age 18	D 079			
	Refer to interview v person on 11/14/17	with a contracted maintenance 7 at 11:05 a.m.				
	Refer to interview v 11/14/17 at 9:40 a.	with a housekeeper on m.				
	Refer to interview v 11/14/17 at 9:50 a.	with a second housekeeper on m.				
	Refer to interview 11/15/17 at 9:22 a.	with a third housekeeper on m.				
-	Hall on 11/13/17 at -The hand sink in t wall and moved up -The caulking arou	resident room 5S on the South 11:50 a.m. revealed: the room was loose from the and down when touched. and the back of the sink was g away from the wall.				
	at 11:50 a.m. revea	sident in room 5S on 11/13/17 aled the resident was in bed o answer any questions.				
	right side of the Sc p.m. revealed:	e common bathroom on the buth Hall on 11/13/17 at 4:15				
		ed screws protruding 1.5 base of each side of the two				
	side of the South H revealed:	e common bathroom on the left Hall on 11/13/17 at 4:25 p.m.				
	inches, one on the toilets.	ed screws protruding 1.5 base of each side of the two in around the toilet had a 1 inch				
	by 2 inches dark b -There was no sho ealth Service Regulation	rown spot. ower curtain.				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL043024	B. WING			C 11/16/2017	
	PROVIDER OR SUPPLIER	40 RAWLS	DRESS, CITY, S S CLUB ROA VARINA, NC				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLETE DATE	
D 079	11/13/17 at 4:30 p. missing blinds and Observation of res 4:40 p.m. revealed window was partial two corners. Observations of th side of the South H 11/13/17 at 4:50 p rusted screws prot base of each side Interview with Adm Registered Nurse/ Clinical Support S p.m. revealed: -The observations a facility tour. -The contracted m working the next of repairs. -The AIC would not maintenance grou Refer to interviews Administrator-in-C p.m. and 3:52 p.m Refer to interview Specialist on 11/14 Refer to interview person on 11/14/1	e resident room 14S on .m. revealed the window had 3 10 blinds that were bent. ident room 9S on 11/13/17 at the ceiling vent near the Illy hanging from the ceiling on the common bathroom on the left Hall (closest to staff office) on .m. revealed there were 4 truding 1.5 inches, one on the of the two toilets. Inistrator in Charge (AIC), Clinical Support Specialist, and pecialist on 11/13/17 at 4:55 noted were shown to each via maintenance group would be ouple of weeks to complete otify the contracted p of the new findings for repair. Is with the harge (AIC) on 11/13/17 at 3:40 with the Clinical Support 4/17 at 8:28 a.m. with a contracted maintenance 7 at 11:05 a.m. with a housekeeper on					

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STATEMEN	of Health Service Re T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY	
	OT BOAREDHOR	DENTITION TO A TO A DEAL	A. BUILDING:				
	HAL043024		B. WING			C 11/16/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
SENTER	'S REST HOME	40 RAWL	S CLUB ROA	D			
	o neor nome	FUQUAY	VARINA, NC	27526			
(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 C (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE	(X5) COMPLE DATE	
D 079	Continued From pa	age 20	D 079		and the second se		
	Refer to interview v 11/14/17 at 9:50 a.	with a second housekeeper on m.					
	Refer to interview v 11/15/17 at 9:22 a.	with a third housekeeper on m.					
	on 11/13/17 at 3:40 -They had ordered -She thought the si "maybe this week". -The facility's main all the hallways, do were currently work facility. -The facility was play but she did not hav would be done. -The shower curtai deep cleaning.	inks were supposed to come in					
	11/14/17 at 8:28 a. -The facility's main facility today, 11/14 more painting. -There had been a complete including the living room. -The maintenance completing needed Interview with a com-	tenance company was at the 1/17, to work on sinks and to do long list of needed repairs to removing some half walls in company was still working on d repairs.					
	on 11/14/17 at 11:0	05 a.m. revealed: vorking on painting halls but are oms next.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION         (X) PROVIDER/SUPPLIENCLM DENTIFICATION NUMBER:         (X) PROVIDER/SUPPLIENCLM DENTIFICATION NUMBER:         (X) PROVIDER/SUPPLIENCEM DENTIFICATION SUPPLIENCEM DENTIFICATION SUPPLIENCEM SUPPLIENCEMPTICATION NUMBER:         (X) PROVIDER/SUPPLIENCEMPTICATION SUPPLIENCEMPTICATION PROVIDER/SUPPLIENCEMPTICATION SUPPLIENCEMPTICATION SUPPLIENCEMPTICATION SUPPLIENCEMPTICATION SUPPLIENCEMPTICATION	Division	of Health Service Re	egulation				
HAL043024     Description     C 11/16/2017       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE 40 RAWLS CLUB ROAD FUQUAY VARIA, NC 27525     Continued (PACH DEFICIENCY MUST BE PRECEDED BY FUL (PACH DEFICIENCY MUST BE PRECEDED BY FUL (PACH OFFICIENCY MUST BE OFFICIENCY TAG     PREVENT OF DEFICIENCY (PACH OFFICIENCY MUST BE OFFICIENCY TAG     PREVENT OF DEFICIENCY (PACH OFFICIENCY MUST BE OFFICIENCY TAG     PREVENT OF DEFICIENCY (PACH OFFICIENCY TAG     PREVENT OF DEFICIENCY (PACH OFFICIENCY MUST BE OFFICIENCY (PACH OFFICIENCY MUST BE OFFICIENCY TAG     OPTION (PACH OFFICIENCY (PACH OFFICIENCY TAG     OPTION (PACH OFFICIENCY (PACH OFFICIENCY (	STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	COMPLETED	
HAL043024         B.WING	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:			
NAME OF PROVIDER OR SUPPLEX     STREET ADDRESS, CITY, STATE, ZP CODE       MAKE OF PROVIDER OR SUPPLEX     40 RAWLS CLUB ROAD FUQUAY VARINA, NC 27526       Display     SUMMARY STATEMENT OF DEFIDIENCES (REGULATIONY OR LISE IDENTERYING BAYORMATICN)     Display       Display     SUMMARY STATEMENT OF DEFIDIENCES (REGULATIONY OR LISE IDENTERYING BAYORMATICN)     Display       Display     Continued From page 21 (REGULATIONY OR LISE IDENTERYING BAYORMATICN)     Do 79 (REGULATIONY OR LISE IDENTERYING BAYORMATICN)       D 079     Continued From page 21 (Regulation on covers for the screws. Interview with a housekeeper on 11/14/17 at 9.40 a.m. revealed: -1 twas her 3rd day of work and she was still in training. -The process for cleaning bathrooms was "from top down". -The walls, doors and handles, sink, tollet, showers and floors were cleaned with a disinfectant. -The had been employed by facility for 3 months. -The bathrooms were cleaned with a disinfectant. -The housekeeper on 11/15/17 at 9.22 a.m. revealed: -The floore were cleaned with a disinfectant. -The housekeeper usually deep cleaned one resident room per usually deep cleaned one resident room, -They were and morphed by failing for -They cleaned the bathrooms were y day. -They cleaned the bathrooms were y day.							
SENTER'S REST HOME         40 RAWLS CLUB ROAD PUQUAY VARINA, NC 27528           CMU ID PREFX TAG         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG         D PREFX TAG         PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG         D PREFX TAG         PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY TAG         D PREFX TAG         D PREFX TAG        D PREFX TAG			HAL043024	B. WING		11/1	6/2017
Stantistics Res Holder     FUQUAY VARINA, NC 27626       (%1) D PHETK NC     SUMAMY STATEMENT OF DEFICIENCIES (EXCH DEFICIENCY MUST BE PRECIDED BY FILL RESULTIONY ON LSC IDENTIFYING INFORMATION)     D PRECE PROVIDER'S PLAN OF CORRECTION (EXCH DEFICIENCY)     D PROVIDER'S PLAN OF CORRECTION (EXCH DEFICIENCY)     Comparison (Comparison)       D 079     Continued From page 21 They are working on fixing the protructing screws on each side of the toilets.     D 079     D 079	NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
PRODUCT VALUE         PUCUAY VARIA, NC 27232           PREFIX         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG         PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG         PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG         PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY)         COMPLETE DEFICIENCY)           D 079         Continued From page 21         D 079         D 079         D 079           They are working on fixing the protruding screws on each side of the toilets. -He would order more covers for the screws. Interview with a housekeeper on 11/14/17 at 9:40 a.m. revealed: -I' the walls, doors and handles, sink, toilet, showers and floors were cleaned with a disinfectant.         D 079           -The process for cleaning bathrooms was 'from top down''. -The bathrooms were cleaned daily. -The housekeepers on 11/15/17 at 9:22 a.m. revealed: -The housekeepers usually deep cleaned one resident room per day. -Deep cleaning included moving the furniture and cleaning under it and dusting it, and cleaning everything in the room. -They swept and mopped every day. -They cleaned the bathrooms every day including sweeping, morping, showers/bathlubs, and toilets.		DEDT LIGHT	40 RAWL	S CLUB ROA	D		
Price in the interview of the second of t	SENTER	S REST HOME	FUQUAY	VARINA, NC	27526		
They are working on fixing the protruding screws on each side of the toilets. -He would order more covers for the screws. Interview with a housekeeper on 11/14/17 at 9:40 a.m. revealed: -It was her 3rd day of work and she was still in training. -The process for cleaning bathrooms was "from top down". -The walls, doors and handles, sink, toilet, showers and floors were cleaned with a disinfectant. Interview with a second housekeeper on 11/14/17 at 9:50 a.m. revealed: -She had been employed by facility for 3 months. -The bathrooms were cleaned daily. -The process for cleaning the bathrooms was to disinfect the door handles, sink, towel handle, shower, shower curtain and privacy curtain around toilet. -The floors were cleaned with a disinfectant. -She informed the AIC if she saw repairs that were needed. Interview with a third housekeeper on 11/16/17 at 9:22 a.m. revealed: -The housekeepers usually deep cleaned one resident com per day. -Deep cleaning included moving the furniture and cleaning under it and dusting it, and cleaning everything in the room. -They swept and mopped every day. -They cleaned the bathrooms severy day including sweeping, mopping, showers/bathtubs, and toilets.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETE
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toilets.		sweeping monning	pathrooms every day including				
Division of Health Service Regulation			g, showers/bathtuba, and				
Division of Health Service Regulation							
Division of Health Service Regulation							
	Division of H	ealth Service Regulation					

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If continuation sheet 22 of 103

**Division of Health Service Regulation** 

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	COMPL		
		HAL043024	B. WING			C 11/16/2017	
SENTER	PROVIDER OR SUPPLIER	40 RAWLS FUQUAY	DRESS, CITY, S S CLUB ROA VARINA, NC	27526			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) Complet Date	
D 234	Continued From pa	ge 22	D 234				
D 234	10A NCAC 13F .07 Medical Exam & Im	03(a) Tuberculosis Test, imunizatio	D 234				
	Examination & Imm (a) Upon admissio	03 Tuberculosis Test, Medical nunizations n to an adult care home, each sted for tuberculosis disease		10A NCAC 13F .0703 Tuberculos Medical Exam & Immunizations Facility will assure that any and a		0	
	by the Commission specified in 10A NC subsequent amend	the control measures adopted for Health Services as CAC 41A .0205 including Iments and editions. Copies of		facility will be tested for tuberculo in compliance with the control me adopted by the Commission of He as specified in 10A NCAN 41A.02	sis easures ealth Services	1/2/18	
	the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.		Facility ED and RCC have condu complete chart audit of all resider All idenfied issues were immediat corrected.	nt TB records.			
	Based on record re failed to assure 2 of	This Rule is not met as evidenced by: Based on record review and interview, the facility failed to assure 2 of 5 residents sampled (#3, #4) were tested upon admission for tuberculosis (TB)		Facility ED and/or RCC will revie paperwork, prior to admission for testing.	required TB		
		nce with control measures mmission for Health Services.		Facility ED and/or RCC will meet LHPS RN to review and assure a TB testing is complete and in com	Il second step		
	The findings are: 1. Review of Resident #4's current FL-2 dated 06/08/17 revealed diagnoses included Alzheimer's, dementia, paranoia, vertigo and depression.		Facility ED and/or RCC will condu- chart reviews to assure second T requirements are in compliance.				
revealed an		t #4's Resident Register sion (from another adult care I.					
	revealed: -There was one TB and read as negativ -There was one TB	t #4's tuberculosis (TB) tests skin test placed on 05/23/08 ve on 05/26/08. skin test placed on 05/30/09 ema, chest x-ray" with no date	×				

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Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	COMF	SURVEY PLETED
		HAL043024	B. WING	Contraction of Contra	6/2017	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
SENTER	'S REST HOME		S CLUB ROAL			
			VARINA, NC	27526		
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETI DATE
D 234	and read as 5.0 m -There was no doc skin tests in the rec -There was no doc results in the recor Based on observat interviews, Residen Interview with the F Support Specialist revealed: -She was performit there was no chest facility for Resident -She gave one TB 08/04/17 that was 08/07/17. -She would give Re "as soon as possib 2. Review of Resident revealed diagnose dementia, diabetest revealed she was a 09/02/14.	B skin test placed on 08/04/17 m negative on 08/07/17. umentation of any other TB cord. umentation of any chest x-ray d. ions, record reviews, and nt #4 was not interviewable. Registered Nurse/Clinical on 11/14/17 at 1:05 p.m. ing chart audits and discovered t x-ray on file from the other t #4. test to Resident #4 on read as 5.0 mm negative on esident #4 a second TB test	D 234			
	information in the of -There was a copy with documentation was placed on Sep there was no year	t #3's tuberculosis (1B) closed record revealed: of a printed computer screen in indicating one TB skin test stember 2nd at 12:11 p.m. but specified on the form. ter printed initials on the form				

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				DATE SURVEY	
			A. BUILDING:		С		
		HAL043024	B. WING			11/16/2017	
	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		1	
SENTER	S REST HOME		S CLUB ROA				
(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)	ULD BE	(X5) COMPLET DATE	
D 234	Continued From pa	age 24	D 234				
	read on 09/04 or 0 -There was no doo was read.	umentation the TB skin test sumentation of any other TB					
	Review of hospital closed record reve	records in Resident #3's aled the resident was admitted 06/06/17 and expired on					
	11/15/17 at 6:35 p. -They had been ur testing information -The Executive Dir Care Coordinator ( responsible for ma completed as required was admitted to th -The current ED an	able to locate any other TB for Resident #3. rector (ED) and /or the Resident (RCC) would have been king sure TB testing was ired at the time Resident #3					
D 269	Supervision	901(a) Personal Care and	D 269	10A NCAC13F .0901(a) Personal Supervision	Care and		
	Supervision (a) Adult care hon care to residents a plans and attend to	901 Personal Care and ne staff shall provide personal according to the residents' care of any other personal care ay be unable to attend to for		Facility will assure that staff provid care to residents according to the care plans and attend to any othe care needs residents may be una to for themselves.	resident's r personal	1/2/18	
	This Rule is not m	et as evidenced by:					

Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING HAL043024 11/16/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 40 RAWLS CLUB ROAD SENTER'S REST HOME FUQUAY VARINA, NC 27526 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) D 269 Continued From page 25 D 269 Continued from page 25 FOLLOW-UP TO TYPE A1 VIOLATION. Facility conducted immediate assessments The Type A1 Violation was abated. of all residents to identify personal needs. Non-compliance continues. Assessed needs were met immediately. All residents were immediatly assessed to Based on observation, record reviews and detemine nail care needs. Any resident detemined to need nail care RCC interviews, the facility failed to provide personal provide immediate care; including cleaning and care tasks in accordance with care plans for 3 of clipping. 5 sampled residents (Residents #1, #2 and #5) as evidenced by failing to apply a barrier cream Facility incorporated nail care information into as ordered during incontinent care for Resident Body Evaluation & Observation Form. #2; failing to trim Resident #1's fingernails resulting in excessively long nails which Body Evaluation & Observation forms will be contributed to a self-inflicted scrotal laceration completed on all residents with each shower. return from hospital stay, and/or LOA. ED/RCC requiring sutures; and failing to trim Resident #5's or Designee will monitor weekly to ensure fingernails resulting in excessively long nails compliance which allowed the resident to scratch his lower extrimeties. The findings are: Body Evaluation & Observation forms are kept in wall folder once completed. 1. Review of Resident #2's current FL-2 dated ED/RCC or designee will check and review 11/07/17 revealed: forms within 24 hours to detemine if follow-up -Diagnoses included dementia/Alzheimer's and is needed decubitus ulcers to sacral area. Any follow up required will be conducted -The resident was non-ambulatory, non-verbal immediately and documented in the residents care notes and incontinent of bowel and bladder. All current care were in-serviced on Body Evaluation aduits and process of completion. Review of Resident #2's Resident Register revealed an admission date of 02/17/16. All new care staff will receive training prior to providing care Review of a Licensed Health Professional Support (LHPS) note dated 08/21/17 revealed: -The LHPS nurse observed area of redness with blanching on the resident's right buttock. -The LHPS nurse recommended that a barrier cream be used to areas of redness. Review of a Physician's Order Form for Resident #2 dated 09/12/17 revealed an order to apply a barrier cream to buttocks as needed for irritation. Division of Health Service Regulation

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Division	of Health Service Re	egulation				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					С	
		HAL043024	B. WING		11/1	6/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
SENTER	'S REST HOME	40 RAWLS	CLUB ROA	ND .		
		FUQUAY	ARINA, NC			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 269	Continued From pa	age 26	D 269	Continued from page 26		
D 209	Review of Residen administration (eM 2017 revealed: -There was an entr Dermacloud ointmid aily as needed (P -There was no doo Dermacloud from 0 Review of Residen revealed: -There was an entr Dermacloud ointmid aily PRN for incor -There was no doo Dermacloud from 0 Review of Residen 2017 revealed: -An entry dated 09 ointment, apply to incontinent care. -There was no doo Dermacloud from 0 Observation of Re on 11/14/17 at 9:40 -There was a jar o resident dated 09/ -The 1 pound jar o empty. Interview with a P 11/13/17 at 11:20a -The PCAs did not residents. -The PCA reported	t #2's electronic medication AR) record for September ry dated 09/13/17 for ent, apply to buttocks twice RN) for incontinent care. umentation of application of 09/13/17 - 09/30/17. tt #2's eMAR for October 2017 ry dated 09/13/17 for ent, apply to buttocks twice ntinent care. umentation of application of 10/01/17 - 10/31/17. tt #2's eMAR for November /13/17 for Dermacloud buttocks twice daily PRN for cumentation of application of 11/01/17 - 11/13/17. sident #2's medication on hand Dam revealed: f Dermacloud labeled for the 13/17. f Dermacloud appeared half ersonal Care Aide (PCA) on		Continued from page 26 ED and RCC have complete audits of residents charts and MAF ensure orders for creams/barriers have been implemented. RCC/ED or designee will conduct random aidits of resident orders an to assure PRN creams parries are used/applied as needed.	are Spl nd MARs	1109
Dhistor	-The MA applied b	arrier cream to residents after				
Division of F	lealth Service Regulation					

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TATEMEN	of Health Service R T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY
			A, BUILDING:			
	HAL043024		B. WING	C 11/16/2017		
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
BENTER	S REST HOME		S CLUB ROA			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	HE APPROPRIATE	DATE
D 269	Continued From pa	age 27	D 269			
	reports of redness					
	Interview with a M	A on 11/14/17 at 9:45am				
	revealed:	ad an da ana aka an ind during				
	incontinent care.	ed redness observed during				
	-The MAs applied barrier creams, if ordered,					
		ported redness or irritation. cument application of the				
	barrier cream once					
	-The MA could not	explain why there was no			*	
	documentation of Resident #2.	application of Dermacloud to				
	Review of a Physic	cian's Oder Form for Resident				
		revealed an order for Home				
	right buttocks.	and treat area on resident's				
		Note dated 09/30/17 and				
		Health Nurse revealed new Stage II decubitus on his				
	right buttock.	new orage it dooubling off his				
	Review of a local I	nospital's emergency room				
	(ER) discharge or	ders dated 10/04/17 revealed				
	cellulitis of the right	reated for an abscess with it buttock.				
	Review of a Physic	cian's Order Form for Resident				
	#2 dated 10/06/17	revealed that daily wound care				1
	by Home Health w buttock was heale	as ordered until wound on right d.				
	2. Review of Resi	dent #1's current FL-2 dated				
	10/23/17 revealed	:				
		ed Alzheimer's dementia. constantly disoriented,				
	non-ambulatory an	nd incontinent of bowel and				
	bladder. ealth Service Regulation					

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STATEMEN	of Health Service Re T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		LETED
		HAL043024	B. WING		C 11/16/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREETAL	DRESS, CITY, ST	TATE, ZIP CODE		
SENTER	S REST HOME		S CLUB ROAL	7 channel and a start of the st		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETI DATE
D 269	Continued From pa	age 28	D 269	and the second		
		t #1's Resident Register sion date of 04/19/12.				
	care on 11/13/17 a -There were suture -The resident's fing approximately 1/2					
	11/13/17 at 11:55a -The resident grab incontinent care or cut him.	bed his scrotum during 10/30/17 and his fingernails for provided nail care to				
	at 4:50pm revealed -The Activity Direct would polish the fe and cut the male re- -Sometimes, the R would cut the resid -The PCAs were s do and some don't -The MA had notic	tor did nail care "a lot;" she male residents' nails one day esidents' nails another day. desident Care Coordinator lents' nails. upposed to do nail care; "some			· · ·	
	revealed that nail of by the Home Healt		,			
	discharge summar					

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If continuation sheet 29 of 103

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	SURVEY PLETED
	1000-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-0-	HAL043024	B. WING			6/2017
AME OF F	PROVIDER OR SUPPLIER	STREETAD	DRESS, CITY, ST	ATE, ZIP CODE		
SENTER	'S REST HOME		S CLUB ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 269	Continued From pa	age 29	D 269	31.4		
	-The resident requi wound.	red 15 sutures to close the				
	care physician (PC revealed:	w with Resident #1's primary P) on 11/15/17 at 3:58pm grabbed his scrotum and "dug				
	scratching. -The PCP saw the was at the facility; I	ausing the wound. elf-inflicted from the resident's wound on 11/13/17 when he he planned to remove the ay (11/20/17), when he came				
	back to the facility. Interview with the V Operations on 11/1	/ice President of Clinical 5/17 at 6:20pm revealed:				
	care as needed. -The Activity Direct	upposed to be performing nail or incorporated manicures as activities which did not replace red on care plans.				
	1/12/17 revealed: -Diagnoses include bipolar, edema, ve	ent #5's current FL-2 dated ed Alzheimer's/dementia, nous stasis, lipidosis, rrent dermatitis, history of				
	-Resident #5 was d	constantly disoriented, and incontinent to bowel and				
		t #5's Resident Register sion date of 3/10/99.				
	plan dated 9/7/17 r	t #5's care plan and service revealed staff would provide nt every Thursday on				

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**Division of Health Service Regulation** STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **DENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING HAL043024 11/16/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 40 RAWLS CLUB ROAD SENTER'S REST HOME FUQUAY VARINA, NC 27526 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 269 Continued From page 30 D 269 Review of physician's visit notes dated 10/09/17 revealed resident had several areas of open wounds and scratches across both lower extremities. Observation of Resident #5 on 11/13/17 at 12:00 p.m. revealed: -The resident was sitting in a wheelchair in the front lobby with a chair alarm draped over the back of the wheelchair. -Ace bandages were noted on both of his lower extremities. -The resident's fingernails were long with a dark, brown substance underneath each nail. Observation of Resident #5 on 11/13/17 at 5:05 p.m. revealed: -Resident #5 was seated in the dining room and had been served his supper meal. -The resident was picking at the inside of both ears. -His fingernails were long, and a brown substance was underneath each fingernail. Interview with a Medication Aide (MA) on 11/15/17 at 4:50pm revealed: -The Activity Director did nail care "a lot;" she would polish the female residents' nails one day and cut the male residents' nails another day. -Sometimes, the Resident Care Coordinator would cut the residents' nails. -The PCAs were supposed to do nail care; "some do and some don't." Interview with Medication Aide/Supervisor (MA/S) on 11/15/17 at 5:05 p.m. revealed: -The activity director performed nail care on residents sometimes during the activities, but there was no set schedule for when she did it. Division of Health Service Regulation

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STATEMEN	of Health Service Re T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		HAL043024	B. WING		C 11/16	5/2017
	PROVIDER OR SUPPLIER	40 RAWLS	DRESS, CITY, S S CLUB ROA VARINA, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
D 269	all of them do. Interview with Resi (PCP) on 11/15/17 has had good resp help with blood flow the wounds from the Interview with the V Operations on 11/1 -The PCAs were su care as needed. -The Activity Direct one of the resident daily nail care orde Attempted interview	all be doing nail care but not dent #5's primary care provider at 4:00 p.m. revealed resident onse with the unna boots to v and swelling and to protect he resident scratching. Vice President of Clinical 5/17 at 6:20pm revealed: upposed to be performing nail or incorporated manicures as activities which did not replace				
D 273	to meet the routine of residents. This Rule is not m FOLLOW-UP TO T The Type A2 Violat Non-compliance co Based on observat	202 Health Care all assure referral and follow-up and acute health care needs et as evidenced by: TYPE A2 VIOLATION. tion was abated.	D 273	<ul> <li>10A NCAC 13F .0902(b) He Facility will assure referral a meet the routine and acute of residents.</li> <li>Facility has implemented a assure all health care referr on in a timely manner.</li> <li>Facility will place wall folder Appointments.</li> <li>Facility appointment book w folder.</li> <li>RCC/MCM and/or Transpor assure that all appointments are appointments are appointment book.</li> </ul>	and follow-up to health care needs new process to rals are followed-up r in med room, titled vill remain in wall tion employee will s, referral and/or	1

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING	1 <u></u>		
		HAL043024	B. WING		C 11/16/2017	
AME OF F	ROVIDER OR SUPPLIER	R STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
CHITCH	C DECT HOME	40 RAWLS	CLUB RO	AD		
ENTER	S REST HOME	FUQUAY	ARINA, NC	27526		
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLET DATE
D 273	Continued From p	page 32	D 273	Continued from page 32		
	residents sampled obtain a gastrointe speech therapy, a	care needs were met for 1 of 5 d (#3) as related to failure to estinal consult, physical therapy, and labwork for the resident; and provident to the operatory		RCC/MCM and/or Transportation d assure that all appointments, consu referrals are scheduled timely.	ults, and/or	
	failure to send the resident to the emergency room after initial symptoms of nausea and vomiting. The findings are:			Transportation Driver will assure that any paperwork, perscriptions, and/or documentation which accompanies residents back after healthcare visit, is placed in the Appointment wall folder.		
	revealed: -Diagnoses includ diabetes, hyperte	nt #3's FL-2 dated 09/01/16 led Alzheimer's dementia, nsion, anemia, and rectal pain.		RCC/MCM and/or ED will check Ap wall folder numerous times during assure all healthcare referrals, scri consults are followed-up on.	the day to pts or	
	-The resident was or wheelchair.	s intermittently disoriented. s semi-ambulatory with a walker uired assistance with bathing		RCC/MCM and/ED will document i care notes any healthcare referral including but not limited to consults and therapy visits.	and follow-u	p
	Review of Reside plan dated 01/19/	nt #3's assessment and care		Healthcare referrals and follow-up be discussed in weekly manager r		
	-The resident was forgetful, and nee -The resident was	s sometimes disoriented,		ED/RCC/MCM and Transportation been in-serviced on new process follow-up appointments and referm	of healthcare	
	toileting, ambulati transferring. -The resident req	uired extensive assistance for ion, bathing, dressing, and uired limited assistance with ng hair and mouth care) and		Facility ED will check appointment and/or calender appointment book one month, then randomly to assu is followed	weekly for	
	(EMS) report date revealed: -The chief comple -EMS noted the r 92/42 and heart r	Emergency Medical Services ed 03/17/17 for Resident #3 aint was hypotension. esident's blood pressure was ate was 74. stated the resident was not				

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If continuation sheet 33 of 103

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	HAL043024		B. WING			C 11/16/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
ENTER	'S REST HOME		S CLUB ROAL				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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) COMPLETI DATE	
D 273	Continued From pa	ge 33	D 273	•			
	and had been giver	een running a low grade fever		÷			
	03/23/17 for Reside -The resident was	admitted to the emergency					
	EMS, the facility did accepting the resid	released from the ER but per d not feel comfortable					
	on room air when s the resident was se 03/17/17.	he returned to the facility, so ant back to the ER on					
	acting herself. -The resident was upon arrival to the	ported the resident was not noted to have some wheezing ER but chest x-ray was					
	-The resident was -The resident was	admitted to the hospital. diagnosed with sinusitis. found to have normocytic					
	and her H/H (hema stable. -The resident's her	vere no signs of an active bleed atocrit/hemoglobin) were natocrit was 28.3 (reference					
	(reference range 1 -The etiology of he	and her hemoglobin was 9.0 1.3 - 15.0) on 03/22/17, r altered mental status upon ly acute illness superimposed					
	and discharged ba	lementia. weaned off oxygen therapy ck to the facility on 03/23/17. ions included: CBC (complete					
	blood count) to mo hemoglobin); recor	nitor H/H (hematocrit and nmend follow-up with GI or further evaluation as					

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STATEMEN	of Health Service Re	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COM	PLETED	
		HAL043024	B. WING			C 11/16/2017	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
CNITCH	C DECT HOME		S CLUB ROAL				
DENTER	'S REST HOME	FUQUAY	VARINA, NC	27526			
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
D 273	Continued From pa	age 34	D 273				
	-Discharge summa (resolved), sinusitis (acute), hypokalem (ruled out), atrial fit (chronic), hyperten (chronic), and aner -There were recom speech therapy (S	ary problems included sepsis s (acute), altered mental status nia (resolved), pneumonia prillation (chronic), dementia sion (chronic), diabetes					
	notes and progress	ent #3's health care provider s notes revealed no a gastrointestinal (GI) referral sident #3.					
	1:59 p.m. revealed -She was the Resid when Resident #3 -If there was a refe forms, the RCC wo facility's Transporter -The Transporter w appointments.	dent Care Coordinator (RCC) resided at the facility. erral on hospital discharge build give the paperwork to the er. vas responsible for making the seeing the instructions for a GI					
	11/15/17 at 6:55 p. -Resident #3 had r GI symptoms like indigestion.	cond medication aide on m. revealed: never complained to her about vomiting, heartburn, or nys asked for coffee and					
	11/15/17 at 10:38 a -They could not fin	Clinical Support Specialist on a.m. revealed: d any documentation in nsult for Resident #3.					

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Division	of Health Service Re	egulation				
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
					(	Contraction in the Institution of the Institution
		HAL043024	B. WING		11/1	6/2017
NAME OF	PROVIDER OR SUPPLIER			TATE, ZIP CODE		
SENTER	SENTER'S REST HOME		ARINA, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
D 273	Continued From pa	ge 35	D 273			
	made.	r a GI consult was never				
	and found no docu	hecked the appointment book mentation.				
	11/15/17 at 3:44 p.	v with the Transporter on n. revealed: t her know if an appointment				
	needed to be made					
	document in the appointment book. -She did not receive any paperwork for a GI					
	make an appointm	at #3 and she was not asked to ent for a GI consult.				
	stomach issues.	e of Resident #3 having any				
		w with Resident #3's primary ) on 11/15/17 at 5:41 p.m.				
	-She no longer wor who serviced the fa					
	#3 lived at the facil	for Resident #3 when Resident ity. access to Resident/#3's record.				
	-She was not awar referral.	e of recommendations for a GI				
	about the GI referra					
	stomach issues du -Staff had not repo	not complained about any ring any of her visits. rted any stomach issues for				
	Resident #3.					
	member on 11/13/	w with Resident #3's family 17 at 4:30 p.m. revealed:				
	-The resident went and was supposed further evaluation.	to the hospital in March 2017 to have a GI consult for				
	-It was never done					

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STATEMEN	of Health Service R T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY	
			A. BUILDING:			с	
		HAL043024	B. WING			16/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
ENTER	'S REST HOME		S CLUB ROA				
	SUMMARY ST		VARINA, NC	PROVIDER'S PLAN OF	CORRECTION	(195)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
D 273	Continued From pa	age 36	D 273				
	the resident neede -The resident woul medication usually -Some staff reported that the resident have night before she w 2017.	ade aware by the facility that d a GI consult. Id have heartburn but her helped with those symptoms. ed to the family member later ad really bad heartburn the ras sent to the hospital in June dent #3's health care provider					
	notes and progress documentation of a done for Resident Interview with a ma at 4:50 p.m. revea	s notes revealed no a speech therapy consult being #3. edication aide (MA) on 11/15/1 led Resident #3 received a egular liquids and had no					
	(PCÅ) on 11/15/17 -Resident #3 requi except eating. -Resident #3 usua regular liquids and swallowing.	w with a personal care aide ' at 5:52 p.m. revealed: ired assistance with everything Ily received regular diet with I did not have problems					
	p.m. revealed Res problems swallow Interview with a thi revealed: -She was the Resi when Resident #3 -If there was a refe	acond MA on 11/15/17 at 6:55 sident #3 did not have any ing her foods or liquids. ird MA on 11/15/17 at 1:59 p.m ident Care Coordinator (RCC) resided at the facility. erral on the hospital discharge ould give the paperwork to the er					
tision of L		was responsible for making the					

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STATEMENT OF DEFICIENCIES AND PLAND F CORRECTION       (X) PROVIDER OUR DEPRESAL IDENTIFICATION NUMBER: HALD43024       (PC) DATE SURVEY A BUILDING: HALD43024       (PC)	Division	of Health Service Re	egulation				
NME OF PROVIDER OR SUPPLIER     STREET ADDRESS, GTY, STATE, ZP CODE       SENTER'S REST HOME       STREET ADDRESS, GTY, STATE, ZP CODE       SENTER'S REST HOME       COULDAY VARINA, NC 27528       PROVIDER OR SUPPLIER       SENTER'S REST HOME       DOUGHTY STATEMENT OF CORRECTION FLOCULARY VARINA, NC 27528       PROVIDER'S TABLEM TO FORMATION       DOUGHTY STATEMENT OF CORRECTION FLOCULARY VARINA, NC 27528       DOUGHTY REST CONTRACTOR MUST BE PROVIDERS IN AM OF CORRECTION FLOCULARY VARINA, NC 27528       DOUGHTY REST CONTRACTOR PROVIDERS IN AM OF CORRECTION FLOCULARY VARINA, NC 27528       DOUGHTY REST CONTRACTOR PROVIDERS IN AM OF CORRECTION FLOCULARY VARINA, NC 27528       DOUGHTY REST CONTRACTOR PROVIDERS IN AM OF CORRECTION FLOCULARY VARINA, NC 27528       DOUGHTY REST CONTRACTOR PROVIDER TO THE ADDRESS OF TO REGULARY VARINA, NC 27528       DOUGHTY REST CONTRACTOR PROVIDER TO THE ADDRESS OF TO REGULARY VARINA, NC 27528       DOUGHTY REST CONTRACTOR PROVIDER TO THE ADDRESS OF TO REGULARY VARINA, NC 27528       DOUGHTY REST CONTRACTOR PROVIDER TO THE ADDRESS OF TO REGULARY VARINA, NC 27528       DOUGHTY REST CONTRACTOR PROVIDER TO THE ADDRESS OF TO REGULARY VARINA, NC 27528       DOUGHTY REST CONTRACTOR PROVIDER TO THE ADDRESS OF TO REGULARY VARINA, NC 27528        DOUGHTY REST CONTRACTOR P							
HAL043024     B.WM     11/16/2017       NAME OF PROVIDER OR SUPPLIEW     STREET ADDRESS, CITY, STATE, ZP CODE     40 RAWLS CLUB ROAD FUQUAY VARINA, NC 27528       (X) ID PREFIX     SUMMARY STATEMENT OF DEFICIENCIES (ECO DEFICIENCY NOT THE PRECEDE WTALL RECUMPTORY ON LIGE DESTIFYING INFORMATION)     D PREFIX (ECO DESTIFYING INFORMATION)     PD PREFIX (ECO DESTIFYING INFORMATION)     D PREFIX (ECO DESTIFYING INFORMATION) <t< td=""><td>ANDIDAN</td><td>OF CORRECTION</td><td>IDENTIFICATION NOMBER.</td><td>A. BUILDING:</td><td></td><td>COM</td><td>LLILD</td></t<>	ANDIDAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COM	LLILD
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZP CODE       SENTER'S REST HOME       CAULD ROAD       PROVIDER'S PLAN OF CORRECTION       CAULD     ECACH OFFICIENCY MUST BE PRECEDED BY FULL       PREFIX     CEACH OFFICIENCY MUST BE PRECEDED BY FULL       PREFIX     CACH CORRECTIVE ACTION       REQUERTION FOR DEDICIENCES     D       PREFIX     CACH CORRECTION       PREFIX     CACH CORRECTION       PREFIX     CACH CORRECTION       CAULD CORRECTION     D       PREFIX     CACH CORRECTION       COULD CORRECTION     CACH CORRECTION       COULD CORRECTION     CACH CORRECTION       CAULD CORRECTION     CACH CORRECTION       COULD CORRECTION     CACH CORRECTION       COULD CORRECTION     CACH CORRECTION       CAULD CORRECTION     CACH CORRECTION       CAULD CORRECTION     CACH CORRECTION       COULD CORRECTION     CACH CORRECTION       CAULD CORRECTION     CAULD CORRECTION       CAULD CORRECTION     CAULD CORRECTION       CAULD CORRECTION     CAULD CORRECTION			HAL042024	B. WING			
30 Add Average State Stat						1 101	0/2017
Stem Field Res Res Hold         FUQUAY VARINA, NC 27626           [Y4] ID PREFIX TAG         SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PREADED BY FULL RESULTIONY ON LISE DEPITITIVING INFORMATION)         D PREFIX TAG         D PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCIES ACTION SHOULD BE DEFICIENCY         D PREFIX TAG           D 273         Continued From page 37 -She did not recall seeing the instructions for speech thrapy consult for Resident #3, -The resident's meats were usually chopped and she received regular liquids, not thickened. -The RCC or the MA on duty were responsible for clarifying an orders or instructions if different from current plan of care.         D 273           Interview with the Assistant Rehabilitation provider on 111/517 at 11:50. m, revealed: -She recalled having an open claim for Resident #3 but she could not recall the date. -The open claim could have been from years before. -She did not know if anyone from their rehabilitation services or from the facility called to find out about the open claim. -They would not have been able to provide any services to the responsible for notifying the PCP. -She would search for further information regarding the ST. -The solut find thave to get an order for ST from the PCP. -She could not find a billing form for Resident #3 for ST.	NAME OF	PROVIDER OR SUPPLIER					
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Division of Health Service Regulation STATE FORM

6899

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY	
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		HAL043024	B. WING		11/1	6/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, ST	TATE, ZIP CODE			
SENTER	S REST HOME		ARINA, NC				
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	about the ST refer 3. Review of Resid documentation of being done for Res	being notified by the facility ral. dent #3's labwork revealed no a CBC (complete blood count) sident #3 as ordered on the summary on 03/23/17.					
	1:59 p.m. revealed -She was the Resi when Resident #3 -The RCC would h setting up the labw -She did not recall Resident #3 becau	ident Care Coordinator (RCC) resided at the facility. have been responsible for work for the CBC to get done. If a CBC was done for use she did not recall seeing r a CBC to be done on the		a			
	care provider (PCI revealed: -She no longer wo who serviced the f -She was the PCF #3 lived at the faci -She did not have	for Resident #3 when Resident					

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	or contraction		A. BUILDING;				
		HAL043024	B. WING			C 11/16/2017	
AME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
ENTER	DEDT LIONE	40 RAWL	CLUB ROAD	)			
SENTER	'S REST HOME	FUQUAY	VARINA, NC	27526			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
D 273	Continued From pa	age 39	D 273				
	member on 11/13/ -The resident went and was supposed -It was never done. -She did not under: B. Review of a visit provider (PCP) dat revealed: -The resident told the left side. -The resident's heat she had stiffness the of the neck. -The PCP ordered evaluate and treat -The PCP ordered Review of Resident notes and progress documentation the treated by PT as o Interview with a meat at 11:35 a.m. reveat- She used to be the (RCC) and she wat physical therapy worksident #3 would sleeping in her rec- -She recalled the re- physical therapy boresident received at -The resident only for "a short time" at	stand why it was not done. t note by the primary care ed 03/30/17 for Resident #3 the PCP her neck hurt on the ad was tilted to the right and to the muscles on the left side physical therapy (PT) to for neck pain and stiffness. a follow-up in one month. It #3's health care provider s notes revealed no resident was evaluated and rdered on 03/30/17. edication aide (MA) on 11/16/17 aled: e Resident Care Coordinator is responsible for coordinating hen she was the RCC. d complain of neck pain after liner. resident having an order for ut she did not remember if the any physical therapy services. complained of pain in her neck and then the resident stopped					
	complaining about -She could not rec	it. all any timeframes related to c pain or when physical therapy			2		

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	T OF DEFICIENCIES OF CORRECTION	egulation (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY
	of outfite field		A. BUILDING:	and the second		
		HAL043024	B. WING		11/1	6/2017
	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
SENTER	S REST HOME		CLUB ROAL			
			ARINA, NC			1
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
D 273	Continued From pa	age 40	D 273			
	(ARD) for the facilit provider on 11/15/ -She recalled havin #3 but she could nu- -The open claim co before. -She did not know rehabilitation service find out about the ou- They would not has services to the resiscial was closed. -Their process would and the facility would the PCP.	ould have been from years if anyone from their ces or from the facility called to				
	1:13 p.m. revealed -She found an inita purposes for Resid PT. -This form was red resident receiving -The resident woul there was an open -She did not know follow-up on the P	ail billing form for insurance dent #3 in their paperwork for quired to be filled out prior to a services. Id not have received PT since				
	#3 for the rehab pu -The therapy requi- -It was requested -The PCP practice physician.	ested was PT.				

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE : COMPL	SURVEY
	OF BORREO HUN	IDENTIFICATION NUMBER;	A. BUILDING:	·	COMPL	
		HAL043024	B. WING		C 11/1	6/2017
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SENTER	'S REST HOME	40 RAWLS	S CLUB ROA	D		
SENTER	S REST HOME	FUQUAY	VARINA, NC	27526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y 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)	DBE	(X5) COMPLETE DATE
D 273	Continued From pa	age 41	D 273			
		authorization was blank.				
	incuration of prior e	autonzadon was blank.				
		t #3's progress notes revealed:			_	
		umentation the rehabiliation acted to follow-up on the PT				
	order.	acted to rollow-up on the F. I				
		umentation the PCP was				
	notified the residen as ordered.	t did not receive PT services				
	as ordered.					
	C. Review of resid	ent care notes for Resident #3				
	revealed:					
		me noted): The resident had tonight". The resident's family				
		and the family member				
	"didn't want me to s					
		me noted): The resident was ked her. Emergency Medical				
		as called 6:30 a.m. She went				
	to the hospital. Sta	aff talked to the resident's				
	family member.					
	Review of an EMS	report dated 06/06/17 for				
	Resident #3 reveal	ed:				
1		s received at 7:56 a.m., EMS				
	the resident at the	7:59 a.m., and EMS arrived to facility at 8:11 a.m.				
	-The chief complain	nt was nausea / vomiting with a				
	duration of 10 hour					
	with complaints of	d the resident was up all night nausea / vomiting				
		d they thought the resident				
		his morning but they saw she				
		while sitting in her chair. ed for the resident to be seen at				
		m (ER) for further evaluation.				
	-The resident state	d she had been vomiting for	1			
		er stomach was upset.				
		no other complaints. noted to have a normal				
	the restautit has					



TATEMEN	of Health Service Re T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY
	of our contraction	DENTIFICATION NOMBER	A. BUILDING:			
		HAL043024	B. WING			C 16/2017
AME OF F	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, ST	ATE, ZIP CODE		
SENTER	S REST HOME		S CLUB ROAD			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
D 273	Continued From pa	age 42	D 273			
	the resident had no palpation of the ab					
		transported as non-emergent ı) to a local hospital.				
	Resident #3 dated	al admission record for 06/06/17 revealed:				
	and vomiting on 06 -The assessment r acidosis, atrial fibri	evaluated in the ER for nausea 6/06/17. noted vomiting, diarrhea, lactic llation, elevated troponin, 2 diabetes mellitus, and				
		s was a combination of ausea/vomiting, atrial				
	rdated 06/08/17 re	al death record for Resident #3 vealed: erall prognosis was poor and it				
		n the family and the resident measures only.				
	11/15/17 at 4:38 p. -About 2 days prio	r to Resident #3 going to the				
	heartburn.	17, the resident complained o the medication aides on duty bich MAs)	T			
	-It was unusual for heartburn.	the resident to complain of ing when the resident went to				
	the hospital in Jun					
	on 11/15/17 at 10:	w with a medication aide (MA) 40 p.m. revealed: MA on third shift the night of				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY	
						С	
		HAL043024	B. WING		11/	16/2017	
AME OF F	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, ST	ATE, ZIP CODE			
ENTER	S REST HOME		ARINA, NC				
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
D 273	Continued From pa	age 43	D 273				
	-Resident #3 vomi MA first got to the 06/05/17. -The resident said -Around 12:00 mid second time and it dinner". -It appeared to hav -There was no blo -A little vomit got of she changed the r she vomited becau the sick feeling if y -The MA called Re (health care power 12:30 a.m.", but st time. -The MA told the far resident vomiting a good. -The family memb had been going an thought the reside -The MA told the far	In the resident's bed sheets so esident's sheets. esident would feel better after use it sometimes helped with rou could vomit. esident #3's family member of attorney) "sometime after ne could not recall the exact amily member about the and the resident did not feel er told the MA a stomach bug ound and the family member nt had it. amily member that the resident		·			
	said she felt like s -The family memb said that all the tin -The MA could tell and she wanted to hospital. -The family memb go to the hospital the resident to the -The family memb posted but the fam to call back at a ca -The resident did	he "was going to die". er told the MA that the resident ne. the resident did not feel good send the resident out to the er did not want the resident to because no one could go with hospital. er told the MA to keep her nily member did not ask the MA					

Division	of Health Service Re	equiation			FURIN	AFFROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
		HAL043024	B. WING		C 11/10	6/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SENTED	'S REST HOME	40 RAWL	S CLUB ROA	D		
SENTER	S REST HOME	FUQUAY	VARINA, NC	27526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y 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)	LD BE	(X5) COMPLETE DATE
D 273	Continued From pa	ge 44	D 273			
D 273	and it was more like -The resident did not that night. -She did not receive shift from the family -The facility's proce the family of conce and get approval fr a resident to the hor -She reported to th on 06/06/17 that Rev vomiting. -The first shift MA rev the resident out to -The facility's proce resident to the hos or if vomiting. -They now call the resident to the hos or of the PCAs to vomiting. -She could smell the resident's room. -The vomit smelled chunks of food in it -She could not reca -The third shift MA had vomited throug dying". -Third shift staff represented resident's family modid not want the re- -She told the first staff.	a "clear phlegm". a "clear phlegm". b vomit anymore on third shift a any other calls during third y member. adure at that time was to notify rns or issues with residents om the family member to send aspital. a MA coming on first shift duty esident #3 had been sick and reported she was going to send the hospital. adure now was to send a pital if they had a fever, a fall, RCC first when sending a pital. edication aide (MA) on 11/15/17 ed: as a first shift MA on 06/06/17. to the facility about 5:50 a.m., Id her Resident #3 was the vomit before she got to the all the color of the vomit. and PCA reported the resident ghout the night and said "I'm borted they called the ember but the family member sident sent to the hospital. hift PCA to stay with the				
	resident and the M					

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Division	of Health Service Re	egulation			1 011111	
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE S COMPL	
		HAL043024	B. WING		C 11/16	/2017
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE		
SENTER	'S REST HOME		CLUB ROA			
SENTER	S REST HOME	FUQUAY	VARINA, NC	27526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y 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)	LD BE	(X5) COMPLETE DATE
D 273	Continued From pa	ge 45	D 273			
	want the resident s -Then the resident's check on the resident Telephone interview	s family member called to ent. v with a personal care aide				
	(PCA) on 11/15/17 -She worked as a F -When she got to w she went to Reside said she was not fe vomit. -She got the trash a resident vomited. -Then, the resident -The vomit was bla like a "blood smell" -The resident said going to die. -She reported it to thought the MA call -The resident's fam spoke with the MA. -The resident was -She worked on first	at 5:52 p.m. revealed: PCA on first shift on 06/06/17, work at 6:00 a.m. on 06/06/17, ant #3's room and the resident beling well and she needed to can for the resident and the estarted vomiting "a lot". ck and had a strange smell, she was sick and she was the MA on duty and she led 911. hily member also called and				
Disistence	1:59 p.m. revealed -She was the Resid when Resident #3 -She was not work to the hospital in Ju -The first shift MA of the RCC at the tim -The first shift MA of been throwing up a family member but resident sent to the	dent Care Coordinator (RCC) resided at the facility. ing when Resident #3 was sent une 2017. called her because she was e. reported that Resident #3 had ill night and they called the the family did not want the				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		HAL043024	B. WING			6/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
OFNITED	C DECT LIONE	40 RAWLS	CLUB ROA	D		
SENTER	'S REST HOME	FUQUAY	ARINA, NC	27526		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 273	Continued From pa	age 46	D 273			
	waiting for EMS to -The resident was because she was of -The first shift MA if "nasty". -Third shift should hospital since she -At that time, the pro- before sending the -But if a family had resident sent to the sometimes call 917 -Resident #3 was s	arrive. sent to the hospital on first shift diabetic and she kept vomiting. reported the vomit looked have sent the resident to the				
Division of H	6:55 p.m. revealed -She was not work Resident #3 was s -Resident #3 had r vomiting, heartburn -The resident alwa chocolate. -The resident's fan want the resident s -She called the fan to let her know the had called 911 (co -The family member already on the way did not want the re Telephone intervier care provider (PCF revealed: -She no longer wo who serviced the fan -She could not spe	ing in June 2017 when ent to the hospital. hever complained to her about n, or indigestion. ys asked for coffee and hilly member did not usually sent out to the hospital. hilly member on one occasion resident had fallen and the MA uld not recall date). er asked the MA if EMS was because the family member sident sent to the hospital. w with Resident #3's primary P) on 11/15/17 at 5:41 p.m. rked with the primary practice acility. eak to the incident when o the hospital in June 2017.				

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**Division of Health Service Regulation** 

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3) DATE COMP	LETED
		HAL043024	B. WING	C	6/2017
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	
SENTER	S REST HOME		S CLUB ROA		
			VARINA, NC		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	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 APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
D 273	Continued From pa	age 47	D 273		
	Telephone interview member on 11/13/ -In June 2017, the for 10 hours and st delay in sending th -The resident died in June 2017. -A MA called her or 06/06/17 between reported the reside -The MA reported to vomit and they clear	w with Resident #3's family 17 at 4:30 p.m. revealed: resident was vomiting bowel he was concerned about the e resident to the hospital. of sepsis while in the hospital he time on third shift on 1:00 a.m. and 3:00 a.m. and nt had vomited twice. here were peaches in the aned the resident and she was			
	minutes and call he -The MA never call -She tried to call th answered until abo -She talked with th the resident was sh to send her out. -She agreed to sen hospital.	ed her back. e facility back but no one out 6:00 a.m 6:30 a.m. e first shift MA who reported ill vomiting and she was going ad the resident to a local			×
	she had a stomach -Some staff report that the resident ha night before she w -Within 12 hours o	the resident to vomit unless n virus. ed to the family member later ad really bad heartburn the as sent to the hospital. f being at the hospital, sepsis dent went into renal failure.			
D 282	10A NCAC 13F .09 Service	904(a)(1) Nutrition and Food	D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service	
	(a) Food Procurem Homes: (1) The kitchen, dii	204 Nutrition and Food Service tent and Safety in Adult Care ning and food storage areas erly and protected from		Facility will assure that the kitchen, dining and food storage areas are clean, orderly and protected from contamination.	1/2/18

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STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	URVEY ETED
		HAL043024	B. WING		C 11/10	6/2017
AME OF	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY,	STATE, ZIP CODE		
ENTER	'S REST HOME		CLUB RO			
			ARINA, NO			
(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 APPE DEFICIENCY)	ULD BE	(X5) Complet Date
D 282	Continued From pa	age 48	D 282	Continued from page 48		
	contamination.	at as ouidenced by		Facility has impletmented new "Da and "Cleaning Schedule" for dietar		
	Based on observat failed to assure the dining area, was ke	et as evidenced by: tion and interviews, the facility e kitchen area, as well as the ept clean as evidenced by dirt rashing sink, black stains		Dietary Staff have been in-service daily checklist and cleaning sched		
	underneath the wir and dust on the PV the kitchen, greasy crumbs from previo	ndow air conditioning unit, dirt /C water pipes running around / build up on the oven and ous snack service on dining		Facility will utilize Maintenance we system to notify Maintenance com (BMS) of any and all repairs need dietary department.	pany	
	next meal. The fin Observations durir at 10:58am reveal -There was greasy	ng the kitchen tour on 11/14/17 ed: y build-up on the sides of the		Facility will use work order reques Dietary staff have been inserviced completing work order request for Completed forms will be turned in ED will enter work order request in system.	l on ms. to ED.	
	hand-washing sink	the edge of the wall above the	1	Dietary staff have been in-service to complete "work order request", forms and the importance of comp	location of	
	-The window ledge conditioner was sp substance. -The white PVC w interior of the kitch black material. -There were orang	a below the window mounted air plattered with a black ater pipes running around the ien were dusty with clumps of ge cracker crumbs on dining at with silverware and napkins		Dietary Manager/ED or designee conduct weekly inspections of kito area to ensure compliance with cl schedule and work order request.	hen/dietary eaning	
	11:15am revealed -The floors of the l mopped after each -The dining tables	kitchen were swept and			×	
vision of H	Interview with the lealth Service Regulatior	Kitchen Manager on 11/14/17				

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL043024	B. WING	***	11/1	6/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
SENTER	'S REST HOME		S CLUB ROA VARINA, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
D 282	at 11:19am reveals -The kitchen staff of schedule. -He voiced undersineeded cleaning. -He would put in a washing sink re-car cleaning easier. -The orange crumines snack crackers se -He would see that were cleaned and silverware. Observation of the revealed the stove Interview with the bat at 8:40am revealed -He had found a clues used in the past. -The Kitchen Mana Manager had sche update the cleanin -The updated cleanin -The updated cleanin -The Manager had sche update the cleaning -The Manager had sche -The Manag	ed: did not have a deep cleaning tanding of the areas that work order to have the hand bulked which would make os on the table were from the rved at 10:00am on 11/14/17. It the dining tables with crumbs re-set with clean napkins and kitchen on 11/15/17 at 8:25am had been cleaned. Kitchen Manager on 11/15/17 d: eaning schedule that had been ager and the Business Office eduled a time to review and		10A NCAC 13F. 0909 Reside		
	An adult care hom all residents guara Declaration of Res	e shall assure that the rights of nteed under G.S. 131D-21, idents' Rights, are maintained sed without hindrance.		Facility will assure that the rig are guarenteed under G.S. 1 Delcaration of Residents' Rig maintained and may be exerc hindrance.	31D-21, hts are	s 12/16/17
	This Rule is not m	et as evidenced by:				

Division	of Health Service Re	egulation			
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL043024	B. WING		C 11/16/2017
	PROVIDER OR SUPPLIER	STREETAD	DRESS. CITY.	STATE, ZIP CODE	
			S CLUB ROA		
SENTER	'S REST HOME		VARINA, NC		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
D 338	Continued From pa	age 50	D 338	Continued from page 50	
	TYPE A1 VIOLATIC Based on observat reviews, the facility interventions, that we primary care provide facility's falls mana sampled residents, the facility as high of experienced multip #6). The findings are: Interview with the F Support Specialist 12:50 p.m. reveale -The facility had a lith that any resident we had greater than of -Staff were to comp falls. -A falls risk worksh completed on all re- -The falls manager reports monthly. Interview with the F a.m. revealed: -She came to the f assessing resident -The facility's falls f implemented for an one fall. -Based upon the R management prog	DN ions, interviews and record failed to implement effective were ordered by the residents' der or in accordance with the gement program, for 3 of 3 who had been identified by risk for falls and had le falls with injuries (#4, #5, Registered Nurse/Clinical (RN/CSS) on 11/14/17 at d: Falls Management Program ras admitted to if the resident		<ul> <li>Facility has completed a chart aud primary care provider orders and in per its Falls Management program impletation of orders/interventions</li> <li>Facility has completed/ updated Fall Risk Assessments per its Falls Management Program for all reside</li> <li>All Chair/Bed alarms have been aud facility Quickmar system.</li> <li>Medication Aides will check qshift alarm placement and correct operation daily times one mandomly there after.</li> <li>Facility ED/RCC/MCM and/or Designee will monited all interventions to ensure ongoing complaince.</li> <li>Facility staff have completed the for in-services:</li> <li>Resident Rights</li> <li>Special Needs Resident Safety Falls Preventation and Dementia All newly hired staff will receive tra areas prior to providing care</li> </ul>	nterventions to assure ents. dded to to assure ation. ignee will and assure nonth, then w company pr/observe
	than once.			*	
Division		RN/CSS on 11/16/17 at 8:15		l ;	
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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			C
		HAL043024	B. WING			6/2017
AME OF F	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, S	TATE, ZIP CODE		
ENTER	S REST HOME	40 RAWLS	CLUB ROA	D		
		FUQUAY \	ARINA, NC	27526		
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLE DATE
D 338	Continued From pa	age 51	D 338			
	a.m. revealed:		2			
	-As a result of the	previous survey (in July 2017), alls was placed on 30 minute				
	-If the resident had	another fall, after the 30 e implemented, the resident minute checks				
	Review of the Fall -The form was to b Manager, Nurse of determine if there factor that could po -The resident was gait, level of consc medications and h	Risk Worksheet revealed: e completed by a Care Executive Director to was a medical or physical ossibly contribute to falls. scored in six areas, including iousness, mobility, diagnosis,				
	form revealed: -The team met ond previous month's f -The team consists Care Manager, Nu Supervisor. -All Incident report resident records w meetings. -The form included fall, shift and injure -There were quest completed the 72 h been prevented an medication change	ed of the Executive Director, rse (if applicable) and one s for the previous month and ere to be brought to the I the resident's name, date of ed area. ions that asked if staff nour report, could the fall have ad were there any recent es previous to fall.				
	-The last item on t team would impler type of fall again.	he form included steps the nent to assist in preventing this lent #4's current FL-2 dated				

Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE : COMPI	LETED
		HAL043024	B. WING			6/2017
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
ENTER	S REST HOME	40 RAWL	S CLUB ROA	D		
	3 REST HOME	FUQUAY	VARINA, NC	27526		
(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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 338	Continued From pa	age 52	D 338		· · · · · · · · · · · · · · · · · · ·	
						-
	06/08/17 revealed:					
		ed Alzheimer's, dementia,				
	paranola, vertigo a					
		constantly disoriented,				
	ambulatory and inc	continent of bowel and bladder.				
	Deview of Devider		1 1			
		t #4's Resident Register	1 1			
		sion from another adult care	1 1			
	facility on 3/4/14					
	Based on observat	tions report reviews and	1 1			
		tions, record reviews, and nt #4 was not interviewable.				
	interviews, Reside	ni #4 was not interviewable.				
	Review of Residen	t #4's Resident Service Plan	1 1			
	(care plan) dated 9		1 1			
		a history of wandering.				
		bility for ambulation.	1 1			
		erence to the use of any	1			
	assistive device for					
		ontinence of bowel and bladder.	1 1		•	
- 1		endent on staff for bathing,	·			
		ting and required limited	1 1			
1	assistance for tran		1			
		t provisions for Resident #4	1			
		utions due to vertigo.				
×		-				
	Observation of Res	sident #4's room on 11/13/17 at	t			
	11:05 a.m. reveale	d:				
	-The resident was	not in the room.				
	-There were two P	ersonal Care Aides (PCAs) in				
	the room.					
		or to a bed alarm laying on the				
	side dresser.					
	-The sensor's batte	ery was dead.				
		ed alarm on the bed.				
		out two bed alarms from the				
		sser drawer; one with the				
	sensor and one wi	thout the sensor.				
	Intentious with - Dr	N an 11/10/17 -1 11/10				
	alth Service Regulation	CA on 11/13/17 at 11:10 a.m.				

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Division of Health Service Regulation (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: C B. WING HAL043024 11/16/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 40 RAWLS CLUB ROAD SENTER'S REST HOME FUQUAY VARINA, NC 27526 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) D 338 Continued From page 53 D 338 revealed: -The PCA noted that the alarm laying on the bedside table had a dead battery. -The PCA was going to plug it into the bed pad but could not locate the pad. -The PCA found an extra pad in the drawer but noted the battery was dead. Review of an Incident/Accident Report dated 06/27/17 revealed: -The incident occurred at 7:15 a.m. in the hallway. -The resident was walking down the hall and tripped over her feet and fell on her left arm. -The resident was taken to the Emergency Room (ER) and the Primary Care Provider (PCP) was notified at 7:15 a.m. -The status of Resident #4 after the ER visit was documented as "fracture of distal end of humerus; follow-up care orthopedics; returned to facility." Review of Care Notes for Resident #4 revealed there was no staff documentation related to the fall on 6/27/17. Review of a Physician Face to Face Encounter form dated 7/6/17 for Resident #4 revealed: -The PCP saw Resident #4 for routine follow up. -The PCP noted to keep arm elevated and follow-up in one month. Review of an Incident/Accident Report dated 07/13/17 revealed: -The incident occurred at 5:40 p.m. -The location of the incident was not documented. -The resident got up from the couch, started walking, lost her balance and fell. -The resident had a bloody nose. -The resident was taken to the ER and the Division of Health Service Regulation

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	of Health Service Re T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	
			A. BUILDING.	ter	0	
		HAL043024	B, WING			6/2017
AME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
ENTER	S REST HOME		S CLUB ROAI		×	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLE DATE
D 338	Continued From pa	age 54	D 338			
	Primary Care Prov	der (PCP) was notified at 6:05				
	p.m.			10 A		
		dent #4 after the ER visit was jury of head; contusion;				
	follow-up with prim					
		and for Decident #4 dated				
	7/13/17 revealed:	eport for Resident #4 dated			5 <u>a</u>	1994) 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 - 1997 -
	-Resident #4 was a					
		nead was completed and soft tissue hematoma over the				
		A computed tomography scan				
	is a three-dimensio	nal image often used to assist				
		orrhage or stroke when				Ì
	scanning the head	cervical spine was completed				
		ed no acute process.				
		tes for Resident #4 for 7/13/17	1 1			
	revealed that Resid for a fall and hitting	lent #4 was sent to the hospita her head.				
		ian Face to Face Encounter				
		for Resident #4 revealed: sident #4 for follow-up of fall.				
		uising over the right side of her				
	face and a soft cas	t on her left arm.				
	-The PCP noted to follow-up in one mage	keep arm elevated and				
		aff reported no issues.				
	Review of an Incid	ent/Accident Report dated				
	07/29/17 revealed:	×				
	-The incident occu hallway.	rred at 8:40 p.m. in the				
		isting the resident to her room				
	and the resident lo	st her balance in the hallway.				
		taken to the ER and the ider (PCP) was notified at 8:55				
	p.m.	ider (FOF) was notified at 6:55	1			

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STATEMEN	of Health Service R T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDING:			-
		HAL043024	B. WING			C 16/2017
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
SENTER	'S REST HOME		S CLUB ROAI VARINA, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
D 338	Continued From pa	age 55	D 338			
	documented as "In	ident #4 after the ER visit was itraoral laceration without with PCP on next visit."				
		otes for Resident #4 for 7/29/17 dent #4 was sent to hospital for				
	form dated 8/10/17 -The PCP saw Rea at night. -The PCP noted the to leave facility due and risk for fails.	cian Face to Face Encounter 7 for Resident #4 revealed: sident #4 for breathing difficulty nat resident requires 1+ assist e to her altered mental status lan for physical therapy to for mobility.				
	dated 8/25/17 reve -Resident #5 had s -She was confuse -The resident's mo	shuffling gait. d. bbility was limited to wheelchair. ed a total of 14 points, which				
	10/6/17 revealed: -The incident occur hallway. -The resident stoo started to walk and -The resident was Primary Care Prov p.m. -The status of Res	lent/Accident Report dated urred at 6:25 p.m. in the d up from the wheelchair and d lost her balance. taken to the ER and the vider (PCP) was notified at 6:30 sident #4 after the ER visit was all; follow-up with PCP."				
	Review of an ER r 10/6/17 revealed: ealth Service Regulatior	eport for Resident #4 dated				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
		HAL043024	B. WING		C 11/18	5/2017
NAME OF	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	DEAT LIQUE	40 RAWLS	S CLUB ROA	D		
ENIER	'S REST HOME	FUQUAY	VARINA, NC	27526		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLE DATE
D 338	Continued From pa	age 56	D 338			
	-Resident #4 was s	-				
	-An x-ray of the pel	lvis was completed and results examination of the pelvis and				
	Review of Care Notes for Resident #4 review of care Notes for Resident #4 review there was no staff documentation related fall on 10/6/17.					
	form dated 10/9/17 -The PCP saw Res -The PCP noted th assist to leave faci -The PCP noted th semi electric hospi -The PCP noted th alarm and would or risk for falls.	tian Face to Face Encounter for Resident #4 revealed: sident #4 for a fall follow-up. at resident requires 24/7 1+ lity due to her dementia. at staff reported resident has a tal bed and a floor mattress. at resident is lacking a chair rder one to further reduce the		•		
	Review of physicia an order for a chai	n's orders for 10/9/17 revealed r alarm.				
	form dated 10/16/1 -The PCP saw Res -The PCP noted th difficulty to care for due to weakness a displayed by the re -The PCP noted th hospice services d related to dementia	at resident would benefit from ue to advancing symptoms a. at resident requires 24/7 1+				
	a.m. revealed: -Resident was lying	sident #4 on 11/14/17 at 9:45 g in her bed singing. mat beside the bed.				

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Division	of Health Service R	egulation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		HAL043024	B. WING			C 16/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SENTED	'S REST HOME	40 RAWLS	CLUB ROA	D		
SENTER	S REST NOME	FUQUAY	ARINA, NC	27526		
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 338	Continued From pa	age 57	D 338			
	-There was no cha	ir alarm in the wheelchair.				
	a.m. revealed: -The resident was fed lunch by a PCA	sident #4 on 11/14/17 at 11:50 sitting in her wheelchair being A in the dining room. Not have a chair alarm in her				
	revealed: -Resident #4 "does	on 11/14/17 at 11:55 a.m. s not have a chair alarm". own Resident #4 to have a				
	and the Clinical Su 11/14/17 at 12:25 p -Neither staff mem #4 had an order fo -They were not sur alarm was overloo -Neither staff mem having a chair alar -The AIC explained was written it would Pharmacy, and if it	ber was aware that Resident r a chair alarm. re why the order for the chair ked. ber recalled Resident #4 ever m. d the process for once an order d be faxed immediately to the r's for durable medical build check to see if it's in-house				
	revealed: -The CSS found and the bed or the chain -The CSS would provide wheelchair immedian Interview with anoth p.m. revealed:	her PCA on 11/14/17 at 5;45 en a chair alarm on Resident				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		LETED
		HAL043024	B. WING			6/2017
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
SENTER	'S REST HOME	40 RAWL	S CLUB ROA	D		
SCINILIX	3 REST HOME	FUQUAY	VARINA, NC	27526		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETI DATE
D 338	Continued From pa	age 58	D 338			
	#4's wheelchair.					
		er chair for the first time				
		A on 11/15/17 at 1:55 p.m.				
	revealed:		1 1			
		ed a chair alarm for Resident / her to have one ordered.				
		to walk but now she has to stay	,			
		ind we have to watch her				
	closely".					
	Interview with Med	ication Aide/ Supervisor (MA/S)				
	on 11:15/17 at 2;00					
		n Resident #4 to ever have a				1
	bed alarm or chair					
	-Resident #4 has h	hat Resident #4 had a chair				
	alarm today.					
		ident #4's primary care provide	r l			
		at 4:00 p.m. revealed:				
	-Resident #4 was a	at risk for falls. lacking a chair alarm so he				
		ther ensure reduction of falls				
	risk.					
		that Resident #4 did not have				
	a chair alarm.	o have a chair alarm at all				
	times when in the					
	Interview with Res	ident #4's family member on				
	11/16/17 at 10:15 a	a.m. revealed:				
		ntly and doesn't get to see				
	-He had concerns	t for a few times per year. with all of her falls and having				
	to be sent to the E	D.				
	-He did not voice h	is concerns to the facility staff.				1
	-He was not aware	that the physician had ordered	1			
	a chair alarm for he ealth Service Regulation					

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Division	of Health Service Re	agulation					
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL		
		HAL043024	B. WING		ON SHOULD BE COMPI IE APPROPRIATE DAT		
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
		40 RAWLS	CLUB ROA	D			
SENTER	S REST HOME	FUQUAY	VARINA, NC	27526			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
D 338	Continued From pa	age 59	D 338				
	-He thought she ha	ad a bed alarm					
	the thought one ha						
_							
-		ent #6's current FL-2 dated					
· · · ·	01/06/17 revealed:						
		ed dementia, cerebrovascular artery disease and intracranial					
	hemorrhage.	artery disease and intractanial					
	-The resident was	semi-ambulatory.					
	-He was intermitter	ntly confused.					
		incontinent of bowel and					
	bladder.						
		ders included Aspirin 325mg lood thinner and nonsteroidal					
		nedication used to reduce the					
		and reduce fever, pain and					
	inflammation.)						
	Review of Residen revealed:	t #6's Resident Register					
		admitted to the facility on					
	-He required assist living and the use of	ance with all activities of daily					
	-Resident #6's mer	mory was documented as					
	forgetful.						
	Review of Residen	t #6's Resident Service				1	
ic .		ed 03/02/17 revealed:					
		history of wandering.				· · ·	
		y with an assistive device,					
	bladder.	daily incontinence of bowel and		с. 			
		s disoriented, forgetful and					
	needed reminders.						
		red extensive staff assistance					
		ing, toileting and transferring.					
	Pouriou of an In-Id	ont/Appident Depart dated					
	07/03/17 revealed:	ent/Accident Report dated			20		
Division of H	ealth Service Regulation	· · · · ·					

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Division	of Health	Service	Regulation	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMPI	ETED	
		HAL043024	B. WING	NG		C 11/16/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
SENTER	'S REST HOME		S CLUB ROA				
		Martin Martin Contractor Contractor	VARINA, NC				
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLET DATE	
D 338	-The incident occur bathroom. -The resident bump side of the wall goil -He had a skin tear -The resident was room (ER) or seen (PCP). Review of a note to Registered Nurse ( -Resident #6 contir -The resident stood seatbelt, stepped fr and down to the floc left elbow that had -The RN requested and a seatbelt rest release. -The PCP respond 07/06/17." Review of a Physic form dated 07/06/1 -The PCP saw Rest wound care. -Staff reported to th getting up from his falling; the resident wa -The resident had elbows. -The PCP ordered resident's elbows,	rred at 5:30 a.m. in the ped his left elbow on the left ng into the bathroom. r to his left elbow. not taken to the emergency by the Primary Care Provider the PCP from the facility's (RN) on 07/05/17 revealed: hued to be at risk for falls. d up after unhooking his orward, fell against the wall por; he had a skin tear on his	D 338				
vision of H	form dated 07/13/1	tian Face to Face Encounter 7 for Resident #6 revealed: sident #6 for a bruise on his					

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TATEMEN	of Health Service Re T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	SURVEY
		HAL043024	B. WING		C 11/16/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
ENTER	S REST HOME		S CLUB ROAD			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
D 338		age 61	D 338			
	failen recently. -The PCP noted th ordered, but neithe -The PCP also note ordered, but was n of the PCP's visit. -The PCP noted th ordered to be place removed at night, be the time of the PCP Review of an emer	the PCP that the resident had at wound care had been or arm had a dressing applied. ed that a chair alarm had been ot on Resident #6 at the time at elbow protectors were ed on in the morning and but were not on the resident at P's visit. orgency room (ER) report for 07/19/17 revealed:				
	-The resident was right lateral eyebro unwitnessed, mech -Resident #6 recein laceration that were days.	seen for facial laceration to the w, closed head injury and nanical ground-level fall. ved sutures to the facial e ordered to be removed in ten				
	the facility revealed completed for the f Review of Care No	Accident reports provided by there was no incident report fall that occurred on 07/19/17. Intes for Resident #6 revealed documentation related to the			201 201	
	fall on 07/19/17. Review of a Physic form dated 07/20/1 -The PCP saw Res -The resident fell th laceration to the rig -The PCP noted th string was too long all the way forward the chair for the ala	cian Face to Face Encounter 7 for Resident #6 revealed: sident #6 for follow-up to a fall. ne night before and sustained a ght side of his forehead. e chair alarm was on, but the r; the resident was able to bend and would need to fall out of				

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Division	of Health Service Re	egulation				
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE ( COMPL	
			B. WING		C	; 6/2017
		HAL043024	D. Millo		11/1	0/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
SENTER	'S REST HOME		S CLUB ROA VARINA, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 338	Continued From pa	ige 62	D 338			
D 338	educated staff on the -The PCP ordered laceration and to en- chair alarm was shalarmed before the Review of Care No 07/22/17 revealed: -The first entry had however, staff docu "currently" had bruin right buttocks. -A second entry was documented the re- on the mat in his re- over and did not set Review of Incident/ the facility revealed completed for the facility revealed facility reve	he proper length. daily wound care to the hsure that the string on the ortened to make sure the chair resident fell out of the chair. tes for Resident #6 dated no time documented; umented that the resident sing on his right back side and as written at 10:00 p.m.; staff sident was found on the floor bom. Staff looked the resident se bruising at that time. Accident reports provided by there was no incident report all that occurred on 07/22/17. 17 at 12:35 p.m. with a IA), who documented the Care 7 revealed: ow about Resident #6's falls; king when the resident's falls eard about his falls from other with the same MA on 11/14/17 aled: I her written Care Note dated along information to the next				
	had she witnessed -Resident #6 would	an incident with Resident #6. I often roll from the bed or be o get up from a fall; "he'd fall				

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Division	of Health Service Re	egulation				
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		HAL043024	B. WING	107-0-	C 11/16/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CENTER	C DEST LONE		CLUB ROA			
SENTER	'S REST HOME	FUQUAY	VARINA, NC	27526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 338	Continued From pa	age 63	D 338			
	softly."					
	Review of Care No 07/23/17 revealed: -There was no time entry; staff docume the hospital for a fa facility at 1:15 a. m -There was a secon documented; staff trying to get up and to fight staff. Review of an ER re 07/23/17 revealed acute contusion to Review of Incident/ the facility revealed completed for the f Interview on 11/15/ who documented ti revealed: -Resident #6 was "	nd entry with no time documented the resident was a walk around, and was trying eport for Resident #6 dated Resident #6 was seen for the right flank area. Accident reports provided by a there was no incident report all that occurred on 07/23/17.				
	checks in place at	one time due to his falls, m that would alarm if he				
	moved at all; the M long time, so she w time, but it worked -The MA was not s Incident/Accident F	IA had not worked 3rd shift in a vas not sure if it worked all the when she was on duty, ure why there was no Report for Resident #6's fall on en a long time ago, so the				
Division of Li	Review of a Fall M form for Resident # -The resident fell o	anagement Team Meeting f6 dated 07/23/17 revealed: n 2nd shift and sustained no site not specified).				

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STATEMEN	of Health Service R T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE COMP	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		HAL043024	B. WING			C 6/2017
	PROVIDER OR SUPPLIER		DRESS, CITY, ST	ATE. ZIP CODE		
	NOVIDER ON OUT LIER		S CLUB ROAD			
SENTER	'S REST HOME		VARINA, NC			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	DATE
D 338	Continued From p	age 64	D 338			
1.1	-Documentation re	evealed "the fail could not have				
	been prevented."					
		recent medication changes,				
	included ear drops					
		plemented to prevent falls was wax build-up, which could				
	affect balance."	wax build-up, which could				
	unou bulanos.					
	Review of Care No	otes for Resident #6 revealed				
		mentation regarding staff				
	monitoring for ear	wax build-up.	1 1			
	Deview of Devider					
		nt #6's Increased Supervision Check Lists revealed:				
		hecks were implemented on				
		.m. for Resident #6,				
		es checks were discontinued on				
		.m. when the resident was last				
		aing observed in the hallway.				
		ecks were documented on				
	0//24/17 from 2:00	0 p.m 10:00 p.m. when ast observed in his bedroom;				1
		fifteen minute checks	1			
	documented after					
		hecks were documented on				
		.m. and continued through				
	08/01/17 at 5:45 a	.m.				
		lent/Accident Report dated			×	
	08/14/17 revealed	-	1			1
	resident's bedroon	rred at 4:30 p.m. in the				
		found on the floor at his	1			
	bedroom door on					
	-There was a "red	spot" documented on the				
	resident's head, in	dicating the location of the				
	injury.					
		taken to the ER and a				
	The statue of Poor	with the PCP at 4:40 p.m. sident #6 after ER visit was				
inion of L	ealth Service Regulation					

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TATEMEN	of Health Service Reprint of Deficiencies	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDING:			-
		HAL043024	B. WING		1	C 16/2017
	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
ENTER	S REST HOME		LS CLUB ROAD			
			VARINA, NC			1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 338	Continued From pa	age 65	D 338			
		ut on 15 minute checks, fall ow-up with PCP on 08/17/17."				
	Review of an ER re	eport for Resident #6 dated				
÷	08/14/17 revealed:					
	-Resident #6 was s	seen for a fall, head was completed and				
	results revealed no	acute process. (A computed				
		s a three-dimensional image				
	stroke when scann	at in diagnosing hemorrhage or ning the head).				
	Review of a Fall M	anagement Team Meeting				
	form for Resident	#6 dated 08/14/17 revealed:				
		n 2nd shift and had no injuries. t have been prevented" was				
-	documented.	have been prevented was				
		lemented revealed "PT				
	(physical therapy)	referral pending."				
		t #6's Care Notes revealed				
	physical therapy ev weeks later, on 08	valuated Resident #6 two /29/17.				
-		cian Face to Face Encounter				
		7 for Resident #6 revealed: sident #6 for follow-up to				
	hospital visit for a f					
	-Staff reported that	t the resident was in bed and				
		oor behind the door. Ie resident had a chair and bec				
	alarm available, as	well as a floor mat.				
		for staff to ensure the bed and	1			
	chair alarms were	utilized.				
		t #6's Increased Supervision				
	and Accountability	Check Lists revealed: hecks were implemented on	1			
		m. and continued until				
	08/24/17 at 5:45 p. ealth Service Regulation	.m.				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		PLETED
		HAL043024	B, WING		C 11/16/2017	
NAME OF F	ROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, ST	ATE, ZIP CODE		
SENTER	'S REST HOME		S CLUB ROAL			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 338	-On 08/18/17, from documented Resid -The fifteen minute again on 08/26/17 until 08/27/17 at 4:- Review of an Incide 08/18/17 revealed: -The incident occur was documented). -Resident #6 got of floor, hitting his hea -A laceration was of injury. -The resident was medical services (If Review of an ER re 08/18/17 revealed: -The resident was scalp and minor hea -Resident #6 receive laceration. Review of a Fall Mit form for Resident #4	12:30 p.m4:30 p.m., staff ent #6 was at the hospital. checks were implemented at 6:00 a.m. and continued 45 p.m. ent/Accident Report dated rred in the hallway (no time ut of wheelchair and fell on the ad. locumented as the resulting taken to the ER by emergency EMS) at 12:15 p.m. eport for Resident #6 dated seen for laceration of occipital ead injury. ved staples to the scalp				
	laceration. -There was docum could have been p string on the chair -The only step imp	n 1st shift and sustained a entation indicating the fall revented if there was a "shorte alarm." lemented to prevent falls was 'm for proper functioning."	r .			
	administration reco August 2017 revea -There was no entr alarm.	y on the July e-MAR for a chai puter-generated entry on the	r			

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TATEMEN	of Health Service Re T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		CONSTRUCTION		SURVEY	
	UT BUILLED HOLD		A. BUILDING: _	A. A.M.		-	
		HAL043024	B. WING			C 11/16/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE			
SENTER	'S REST HOME		S CLUB ROAD				
		FUQUAY	VARINA, NC	27526		_	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HEAPPROPRIATE	(X5) COMPLET DATE	
D 338	Continued From pa	age 67	D 338				
	placement every s 08/30/17. -There was docum	chair/bed alarm, check for hift; the original order date was nentation the chair/bed alarm of 3 shifts on 08/30/17 and all					
		at #6's Care Notes revealed no t staff were checking the chair unctioning.					
	Assessment for Re revealed: -Resident #6 had a -He was confused. -The resident's mo -Resident #6 score indicated a high ris -Pre-printed docum worksheet reveale monitored for 72 h immediate evaluat	bility was limited. ed a total of 17 points, which sk for falls. nentation at the bottom of the d the resident was to be ours after a fall, including ion for the reason for fall.					
	Physical Therapy f -Physical Therapy 08/29/17. -The physical therapy of 6 visits; the last -Physical therapy v exercises and acti -The resident partia assistance from th one-step comman -The therapist doc transfers and when -On 09/16/17, the extra time looking	cipated better with hands-on e therapist, and also followed					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY
			A. BUILDING:			С
		HAL043024	B. WING			16/2017
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
SENTER	S REST HOME	40 RAW	LS CLUB ROAT	D		
BENTER	OREDITIONE	FUQUA	VARINA, NC	27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
D 338	Continued From pa	age 68	D 338			
	"making him great	er fall risk due to slipping."				
	Review of a Physic	cian Face to Face Encounter				
		17 for Resident #6 revealed:				
		sident #6 for hospital follow-up	.			
		he resident had a fall and tion to the head; stitches had				
		the site was almost healed.				
		a referral for Physical Therapy	/			
		eat for frequent falls, and for				
5	staff to ensure cha	air and bed alarms were utilized	d.			
	Review of Resider	nt #6's Increased Supervision				
	and Accountability	Check Lists revealed:				
		ecks were initiated on 08/29/17	7			
		topped at 1:45 p.m. e checks resumed on 08/30/17	1			
		topped at 5:45 a.m. on				
	08/31/17.					
		08/31/17, Resident #6 was on cks until 09/01/17 at 5:45 a.m.				
	Review of Resider 09/09/17 revealed	nt #6's Care Notes dated				
		e documented for the entry.				
	the ER on 1st shift	nted the resident was sent to t for a fall.				
	Review on an Incid 09/09/17 revealed	dent/Accident Report dated				
		irred at 2:00 p.m. in the				
		found on the floor face up whe	n			
	staff was checking	halls.				
	-No injury was doo					1
	2:15 p.m.	taken to the ER via EMS at				
		aport for Davidant 40 datad		18.		
	00/00/17 revealed	eport for Resident #6 dated the resident was seen for a				1

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TATEMEN	of Health Service Re T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY
	or connection	IDENTIFICATION NOMBER	A. BUILDING:			
		HAL043024	B. WING	алан алан алан алан алан алан алан алан	Transfer and the second s	C 16/2017
AME OF P	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, ST	TATE, ZIP CODE		
ENTER	S REST HOME		LS CLUB ROA			
	CIR MADY OT		VARINA, NC		CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HEAPPROPRIATE	(X5) COMPLE DATE
D 338	Continued From pa	age 69	D 338			
	fall.					
	Interview on 11/15	/17 at 4:25 p.m. with a third				
		ited the Care Notes dated				
	09/09/17 revealed:					
		nostly on 3rd shift; the MA did lent falling when she was				
	working.	-				
		d the documentation on the 9/09/17; the MA could not				
		but she thought the personal				
		ound Resident #6 on the floor				
		ng rounds. The PCA nor the Ma sident fell or not, so the MA	A			
	sent the resident to	o the hospital for evaluation.				
	-He had bed and c	hair alarms, and they worked. A would check the alarms to				
	make sure they we	ere working.				
		as on fifteen minute checks for				
	falls (unable to rec	an dates).				
		lanagement Team Meeting				
		#6 dated 09/09/17 revealed: n 2nd shift; no injury was				1
	documented.					
	-Documentation in been prevented.	dicated the fall could not have				
	-The only step to p	prevent falls included"				
	increasing one on	one activities."				
	Review of the Care	e Notes for Resident #6				
		s no documentation that staff				
	Resident #6.	one on one activities for				
	Review of Residen	nt #6's Increased Supervision				
	and Accountability	Check Lists revealed:				
		vere initiated on 09/09/17 at tinued until 5:45 a.m. on				
	09/10/17.	unded undi 5.45 a.m. on	1			1

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	SURVEY	
	of bonneonion		A. BUILDING; _				
		HAL043024	B. WING			C 11/16/2017	
AME OF F	PROVIDER OR SUPPLIER	STREETAL	DDRESS, CITY, ST	ATE, ZIP CODE			
ENTER	S REST HOME		S CLUB ROAL				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	HEAPPROPRIATE	DATE	
D 338	Continued From pa	age 70	D 338				
	p.m. and continued -Fifteen minute ch 09/12/17 at 6:45 a	resumed on 09/10/17 at 2:00 d until 09/11/17 at 10:00 p.m. ecks were initiated again on .m. and continued until 5:45 they resumed at 10:00 p.m. on shift.					
	09/12/17 at 10:00	otes for Resident #6 dated a.m. revealed the staff esident's "thumb was red, Il occurred."					
	the facility revealed	Accident reports provided by d there was no incident report fall that occurred on 09/12/17.		<i>a</i>			
	Resident Care Co documented the C revealed: -She worked as th	/17 at 2:10 p.m. with the former ordinator (RCC)/MA, who are Note dated 09/12/17 e RCC, but was currently a MA a "faller;" he was always trying					
	to get up. -She was not sure Resident #6; she w referring to came t second fall on 09/	about the note on 09/12/17 for vondered if the injury she was from a prior fall and not from a			14		
	wheelchair; he als -Someone had to requested the sea wheelchair.	o had a floor mat by his bed. sit with him, and his family t belt be placed in his and bed alarms at the same					
	time.						
	09/14/17 revealed -There was no tim regarding the incid	e or location documented					

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HAL043024     B. WING     11/*       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     11/*       SENTER'S REST HOME     40 RAWLS CLUB ROAD     10       FUQUAY VARINA, NC 27526     10     PROVIDER'S PLAN OF CORRECTION       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
SENTER'S REST HOME     40 RAWLS CLUB ROAD FUQUAY VARINA, NC 27526       (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)	6/2017
SENTER'S REST HOME         FUQUAY VARINA, NC         27526           (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)	
(X4) ID         SUMMARY STATEMENT OF DEFICIENCIES         ID         PROVIDER'S PLAN OF CORRECTION           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE ACTION SHOULD BE           TAG         REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCED TO THE APPROPRIATE	
PREFIX       (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX       (EACH CORRECTIVE ACTION SHOULD BE         TAG       REGULATORY OR LSC IDENTIFYING INFORMATION)       TAG       CROSS-REFERENCED TO THE APPROPRIATE	(X5)
D 338 Continued From page 71 D 338	(X5) COMPLETE DATE
she was walking on North Hall and noticed Resident #6 on the floor on his knees; the PCA	
got the Executive Director (ED), who checked the resident for bruises.	
-There was no injury documented. -The resident was not taken to the ER nor was the PCP notified.	
Review of an Incident/Accident Report dated 09/18/17 revealed: -The incident occurred at 5:15 a.m. in the resident's bedroom.	
-Resident #6 was laying on his back on the floor. -The resident was not alone at the time of the incident. -A skin tear to the back of the resident's head was	
the documented injury. -Resident #6 was taken to the ER via EMS.	
Review of Resident #6's Care Notes dated 09/18/17 revealed:	
-There were no entries documented by third shift staff. -The RN/CSS documented an entry at 8:00 a.m.	
that Resident #6 was sent to the ER at 5:30 a.m. for fall and head injury. The RN/CSS had spoken	
with the 3rd shift Supervisor, who reported that the PCA had been in the resident's room for a 30 minute check; the PCA left to get linen and upon	
return, found Resident #6 lying on his fall mat with bleeding noted at the back of his head. The Supervisor stated the fall mat and bed/chair	
alarm were in place. -The RN/CSS documented a second entry at 9:45 a.m. on 09/18/17 that she had directed staff to	
rearrange the resident's room so that the night stand was not near the bed as it was possible the resident's head struck it prior to him landing on the floor mat.	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COM	SURVEY
	or contraction		A. BUILDING;			
		HAL043024	B. WING			C 16/2017
NAME OF F	ROVIDER OR SUPPLIER	STREETAD	DRESS, CITY, ST	TATE, ZIP CODE		
ENTER	'S REST HOME	40 RAWL	S CLUB ROAL	Q		
BENTER	3 REST HOME	FUQUAY	VARINA, NC	27526		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT 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 THE APPROPRIATE	(X5) COMPLET DATE
D 338	Continued From pa	age 72	D 338	A.L		
	Review of a Fall Ma form for Resident # -Resident #6 fell or injury to the back o -Documentation ind been prevented. -The only step implincluded "checking functioning." Review of Residen 2017 revealed: -There was a comp September e-MAR placement every sl -There was docum was checked on al and 09/23/17-09/24 -There was docum the hospital from 0 away on 09/29/17. Review of Residen there was no docu checking the chair functioning. Review of a hospit Resident #6 dated -Resident #6 had a the facility were ch -The resident had back of the head w -A CT scan of the h	anagement Team Meeting 6 dated 09/18/17 revealed: h 3rd shift and sustained an f his head. dicated the fall could have lemented to prevent falls chair alarm for proper t #6's MAR for September buter-generated entry on the for chair/bed alarm, check for hift. entation the chair/bed alarm I shifts from 09/01/17-09/17/17 8/17. entation Resident #6 was in 9/18/17-09/22/17, and passed t #6's Care Notes revealed mentation that staff were or bed alarm for proper al discharge summary for 09/22/17 revealed: a mechanical fall while staff at anging the resident's linen. a small open wound to the vith some bleeding. head revealed an acute hronic ischemic changes.				
	-The resident's dis intracranial hemorr	charge diagnosis was acute hage. to receive comfort care and				

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TATEMEN	of Health Service Re	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		SURVEY	
IND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
		HAL043024	B. WING			C 11/16/2017	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DRESS, CITY, ST	TATE, ZIP CODE			
			S CLUB ROA				
SENTER	'S REST HOME		VARINA, NC				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	E APPROPRIATE	COMPLE	
D 338	Continued From pa	age 73	D 338	A defense of the second se			
	Telephone interviev	w on 11/15/17 at 10:10 p.m.					
		was working on 09/18/17					
<u>, 11 - 1</u>	when Resident #6	fell, revealed:					
- I	-He recalled the fa		1				
),		ft change, and the PCA went in				1	
		om to check on him; he bather	1 1				
	Resident #6.						
		t of the room to get a change o					
		cart that was located near the					
	resident's room in	the naliway. still in bed when the PCA went					
	out of theroom.	still in bed when the PCA went					
		ent #6's room was on, so he					
		was time to get up for the day					
		ent back into the resident's					
·		he floor; his body was on the					
	floor mat, but his h		1				
	-Resident #6's hea	d must have hit the night	1				
		vas right next to the bed.					
		eding, so the PCA did not move	9				
		#6; the resident was awake					
	and talking.						
	-The PCA got the I	viA. a bed alarm; he did not recall					
	the alarm not work						
		he remembered hearing the					
		norning while he was out of the					
	room.						
	-The resident had	to put "a certain amount of					
	weight on the bed	to make the alarm sound."					
	Telephone interview	w on 11/15/17 at 10:20 p.m.					
		he MA who was working when					
		09/18/17 revealed:					
	-The MA primarily						
		ident #6 fell (unable to recall					
	date), the MA had	gone to his room; the MA could	1				
		went to Resident #6's room,					
		d turned the light on.					
	-The MA left the ro ealth Service Regulation	om for something (the MA did					

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TATEMEN	of Health Service Re T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE COMP	SURVEY
		HAL043024	B. WING		C 11/16/2017	
AME OF	PROVIDER OR SUPPLIER	STREET A	DRESS, CITY, S	TATE, ZIP CODE		
			S CLUB ROA			
SENTER	'S REST HOME		VARINA, NC			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	DATE
D 338	Continued From pa	age 74	D 338			
	not recall why she	left Resident #6's room) and				
		ck in, he was on the floor.	1 1			
1		with her at the time she went	1 1			
	to Resident #6's ro					
		ad was injured and she told the				
		king that they needed to send				
	Resident #6 to the					
		call if Resident #6 had a bed				
		rd the alarm sounding from his				1
	room during that sl					
		Resident #6 just rolled out of	1 1			
	bed.					
	-By the time her sh	nift ended, Resident #6 had not				
	left the facility.					
		Incident/Accident report.				
		me from working her shift, she				
		n management that she				
		the Incident/Accident report				
		; the MA could not remember				
		ed to change, but she thought i				
	had something to a	do with a "name or something."				
		RN/CSS on 11/15/17 at 6:40				
	p.m. revealed:	ot have an order for a fall mat;				
		facility's fall management				
	program,	radinty a rain management				
		on 15 minute checks; the CSS				
		n 30 minute checks, but the				
	frequency was incl	reased to 15 minutes due to the	e l			
	number of falls Re	sident #6 was having.				
	-The RN/CSS com	pleted the Fall Risk Workshee	t			
		ted 08/25/17 and the team				1
		ts for several falls that				
	Resident #6 had.					
		umented the fall on 09/18/17				
		revented had a new bed/chair				
	alarm been obtain					
	-when the RN/CS	S arrived at the facility on the				
	ealth Service Regulation	17, it was 6:15 a.m.; "something				

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Division	of Health	Service	Regulation	
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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		GOWPI	EIED
		HAL043024	B. WING		C 11/1	6/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
			CLUB ROA			
SENTER	'S REST HOME		VARINA, NC			
(14) 10	SI MAMARY STA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTI	ON	IVE
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETE DATE
D 338	Continued From pa	age 75	D 338			
		early that morning."				
	when I got here that	e bed alarm was working				
	when I got here the	a day.				
	Review of Hospice	Service Narratives for				
	Resident #6 reveal					1
	-Resident #6 was a	admitted to hospice care on				
-	09/22/17 at 2:50 p.	m.				
		ninimally responsive on				
	09/25/17.					
		ed away on 09/29/17 at 12:53				
	p.m.					
	Attorney (POA) on revealed: -Resident #6 was a constantly trying to -He fell at home pr had a brain bleed; worse. -He figured out how chair alarm was in -The POA was awa resident had while -The staff always of was a fall, because -With the last fall, of and he fell. -The POA understo to change him and -The resident was thought it was time -Resident #6 had a	ior to coming to the facility, and his Dementia had gotten w to take his shirt off when the place. are of the number of falls the at the facility. ontacted the POA when there e EMS was notified. on 9/18/17, Resident #6 got up bod the staff went in his room it was early in the morning. very routine, and probably for him to make his bed. a puncture wound on the back scan revealed several bleeds.				
	three-dimensional	image often used to assist in				
	diagnosing hemorr the head).	hage or stroke when scanning				
		hink there was any staff in the				
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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:			PLETED	
		HAL043024	B. WING		11/	11/16/2017	
NAME OF F	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, S	TATE, ZIP CODE			
SENTED	S REST HOME	40 RAW	LS CLUB ROA	D			
SENTER	S REST HOME	FUQUAY	VARINA, NC	27526			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLETE DATE	
D 338	Continued From pa	age 76	D 338				
	room when the fall	occurred.					
	revealed:	ident on 11/15/17 at 6:09 p.m.					
	a second s	m was near Resident #6's.					
		om his wheelchair one time aff were not watching him.					
	-Most of the time, F	Resident #6 fell at night.					
		r heard Resident #6's bed					
	alarm go off.						
	Interview with a fift	h MA on 11/16/17 at 9:30 a.m.					
	revealed:						
	-Resident #6 had a						
	-Resident #6 was u	dents had bed alarms as well,					
		ir alarms too, it was usually th					
	same alarm.						
		esident #6 used the same					
	alarm for the chair	and bed. r come to work and found his					
		ed or not on, but she had		*			
		found his chair alarm not					
	hooked to him.						
		male PCA was working when					
		e last time, and the PCA had oom to get something when					
	Resident #6 fell.	som to get something when					
	-The MA did not kn	ow if the bed alarm was on or					
		, the PCA should have heard i	t.				
		much to set off those bed					
	much to cause the	alarm to sound "					
		m was close to the nurse's					
		where the linen cart was					
	usually kept in the been easily heard.	hallway; the alarm would have					
	Interview with a se p.m. revealed:	cond PCA on 11/15/17 at 4:45					

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Division	of Health Service Re	egulation				
STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	
			D. MILLO		C	
		HAL043024	B. WING	and the second sec	11/1	6/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	TATE, ZIP CODE		
SENTER	'S REST HOME	40 RAWLS	CLUB ROA	D		
JENTER		FUQUAY	ARINA, NC	27526		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETE DATE
D 338	Continued From pa	age 77	D 338			
	-Resident #6 had fi -He could walk, but would get out of be help. -The PCA did not k occurred. Telephone interview at 5:55 p.m. reveal -Resident #6 had a never found the be came into work. -The PCA did not w but if she did, she breakfast and the a would go off. Telephone interview	alls; he was a "busybody." t needed assistance and he ed or out of the chair without mow about the last fall that w with a third PCA on 11/15/17				
Division of H	Resident #6 on 11/ -The PCP/NP reca up on his own and -He did not like to I -He had bed and c his wheelchair that -The PCP/NP rem Physical Therapy a recall the specific t -As far as the PCP her when Resident I wouldn't know it, -The PCP/NP coul when she visited F was not attached; her notes regardin not working at the not be 100% sure, months ago."	<ul> <li>(15/17 at 5:40 p.m. revealed:</li> <li>Illed that Resident #6 could get fell frequently.</li> <li>be told to stay in bed.</li> <li>hair alarms, and a seatbelt in</li> <li>the could unlatch.</li> <li>embered Resident #6 received at one time, but was unable to imeframe.</li> <li>//NP knew, the staff were telling t #6 fell; "if they did not tell me, I guess."</li> <li>d not recall a specific time Resident #6 and his chair alarm she no longer had access to g the resident since she was provider's office, so she could "It may have been several</li> </ul>				

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TATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY
IND PDAIN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COM	LETED
		HAL043024	B. WING			C 16/2017
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
			S CLUB ROAL			
SENTER	'S REST HOME		VARINA, NC			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF O		(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	DATE
D 338	Continued From pa	age 78	D 338			
	Resident #6 experi	enced nine falls from				
		Five of the nine falls resulted				
		ired transportation to the				
		or medical evaluation. The				
		mat on the floor next to his bed				
		are Provider ordered a chair				
		Fifteen minute checks were rious times, with the first time				
		The resident fell five additiona	d			
		a bed alarm was ordered on	'			
		therapy evaluated Resident #6				
		aw the resident for a total of six				
		e resident continued to have				
		iled to implement effective				
		event Resident #6's falls, who				
		to frequently get out of bed or	'			
		17, Resident #6 fell in his ng left alone by staff, and				
		njury, resulting in an				
		hage for which hospice				
		ed, and the resident passed				
		ater. Based on interviews, it				
	could not be deterr	nined if the resident's bed				
-	alarm was on and t	functioning properly. Staff				
		7 could not recall if they heard				
		nd when the resident got out of				
		ot be determined if an				
		sident #6's room and other een completed and if				
		een implemented as a result.				
		son implomented as a result.				
	3. Review of Resid	ent #5's current FL-2 dated				
	1/12/17 revealed:		1 1			
		ed Alzheimer's/dementia,				
	bipolar, edema, ver	nous stasis, lipidosis,				
		rrent dermatitis, history of				
	fungal infections					
		constantly disoriented,				
	bladder.	and incontinent to bowel and				
	Maduci.					1

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If continuation sheet 79 of 103

STATEMEN	of Health Service R T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE COM	SURVEY	
	or connection		A. BUILDING:		0		
		HAL043024	B. WING			C 11/16/2017	
	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, ST	ATE, ZIP CODE			
SENTER	'S REST HOME		S CLUB ROA				
		· · · ·	VARINA, NC	27526			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE	
D 338	Continued From p	age 79	D 338				
	Review of Resider revealed an admis	nt #5's Resident Register ssion date of 3/10/99.					
	(care plan) dated 9 -Resident #5 had verbally and physi -He was non-amb for locomotion. -He had daily inco -He was always di	a history of wandering, was					
	bathing, dressing, Review of Resider Coordinator's note (PCP) and the fac revealed the resid	nsive staff assistance with toileting and transferring. In #5's Resident Care as to the Primary Care Provider ility's Incident/Accident Reports ent experienced four falls and pruise to the right hip from					
	form for Resident -Resident #5 fell of -It was not noted if injuries from the fa -It was documented prevented by "mod- -Steps implemented	f the resident sustained any					
	dated 8/25/17 rev -Resident #5 had -He was confused	a shuffling gait.					

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STATEMEN	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A CONTRACTOR OF A CONTRACTOR O	CONSTRUCTION	(X3) DATE COM	SURVEY
			A. BUILDING:			•
		HAL043024	B. WING			C 16/2017
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
ENTER	'S REST HOME		S CLUB ROAD			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	HE APPROPRIATE	DATE
D 338	Continued From pa	age 80	D 338		- <u>188 805 - 5</u>	
	-Resident #5 score indicated high risk	d a total of 12 points, which for falls.				
	Review of note date	ed 10/20/17 from the Resident				
	Care Coordinator (	RCC) faxed to the PCP				
		est (previous) fall out of bed, no e orders for a hospital bed, fall				
	mat and bed alarm					
		n note dated 10/23/17 revealed vrite face-to-face today".				
	Review of a Physic	ian Face to Face Encounter				
		7 for Resident #5 revealed:				
		sident #5 for a fall follow-up. e resident "has no precautions				
	in place".					
		edical decision "ordering a fall tric (SE) hospital bed with bed				
		afety and reduced falls risk."				
		ne SE hospital bed is				
	warranted due to p weakness and adv	atient's significant muscle anced dementia.				
	-The PCP noted th	e resident requires 2+ assist				
	for transfers and po	ositioning in bed.				
		n orders dated 10/23/17				
	revealed: -Semi electric hose	ital bed with guard rails.				
	-Guard rails for saf	ety and falls prevention, not for	.			
	restraining. -Fall mat.					
	Observation of Res	sident #5 on 11/13/17 at 12:00				
	p.m. revealed:					
		sitting in a wheelchair in the hair alarm draped over the				
	back of the wheelc					
	-Ace bandages we	re noted on both of his lower				
later of the	extremities. ealth Service Regulation	the design of the section of the sec				

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	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		SURVEY
	•		A. BUILDING:			C
		HAL043024	B. WING			6/2017
AME OF	PROVIDER OR SUPPLIER	STREETAD	DRESS, CITY, ST	ATE, ZIP CODE		
ENTER	'S REST HOME		S CLUB ROAL			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	<b>HEAPPROPRIATE</b>	DATE
D 338	Continued From pa	age 81	D 338			
		gernails were long and had a ance underneath each nail. calm.				
	Observation of Rep. p.m. revealed:	sident #5 on 11/13/17 at 5:05				
	-Resident #5 was s had been served h	seated in the dining room and is supper meal. picking at the inside of both				
	ears. -He was quiet and residents seated a	not interacting with the other t the table,				
	p.m. revealed:	sident #5 on 11/14/17 at 12:00				
	dining room being Aide).	sitting in a wheelchair in the fed by a PCA (Personal Care draped over the back of the				
	wheelchair.					
	p.m. revealed:	sident #5 on 11/14/17 at 5:30 in the staff office sitting in				
	wheelchair and wa noises and words -A PCA reported "t	as agitated and shouting out that were not understandable. the resident was agitated in the dining room, so we took				
	-Staff members ga ate.	ave him some cookies that he				
	calm sitting in whe	minutes later, Resident #5 was elchair (with chair alarm fice with several staff				e.
	a.m. revealed:	sident #5 on 11/15/17 at 10:15 yelling and cursing. as beeping.				

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Division	of Health Service Re	egulation				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMP	SURVEY
		HAL043024	B. WING		C 16/2017	
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, SI	TATE, ZIP CODE	4	
OENTED	DEST LIONE		S CLUB ROAL			
SENTER	S REST HOME	FUQUAY	VARINA, NC	27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL GULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 338	Continued From pa	age 82	D 338			
	-Staff were pushing wheelchair, to his r	g the resident, who was in his oom.				
	Observation on 11	15/17 at 3:00 p.m. of Resident				
	#5's room revealed	1:				
	-The resident was	not in the room. uard rails and there were no				
		nywhere in the room.				
		mat beside the bed.				
	Interview with Resi	dent #5's PCP on 11/15/17 at				
	4:00 p.m. revealed	:				
		at risk for falls and was total				
	care assist. -He did not conside	er the guard rails a restraint for				
	the resident.					
		ility to pull himself up is very				
	laying position".	not sit up on the bed from a				
	-He last visited Res	sident #5 on 11/16/17 and was				
	not sure if he saw bed.	guard rails on the resident's				
		that the guard rails were not				
	on the bed.					
		ard rails on 10/23/17 and #5 to have them installed				
	immediately.					
		A on 11/15/17 at 4:45 p.m.				
	revealed:	manal ages from us the se				
	Resident #5.	ersonal care frequently on				
	-Resident #5 had a	a wheelchair alarm but she has				
	not seen him ever					
	+5's bed.	en any guard rails on Resident				
	Observation of Res	sident #5 on 11/15/17 from				
	7:00 p.m 7:10 p.r					
Division of H	-The resident was ealth Service Regulation	lying in his bed; there were no				

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Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE COMP	SURVEY
		HAL043024	B. WING			6/2017
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
SENTER	S REST HOME		CLUB ROA			
		······································	ARINA, NC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
D 338	Continued From pa	ge 83	D 338			
	guard rails on the b	bed				
	•	as located next to the head of				
	the resident's bed.					
		nearly rolling out of the bed; his				
		half way off the bed, and his	1			
	head was partially					
		that Resident #5 needed MA came to the resident's				
	room and reposition					
	Internation with the F	200 and the Olinical Summart				
		RCC and the Clinical Support n 11/15/17 at 7:35 p.m.				
	revealed:	1 11/10/17 at 7.35 p.m.				
	i o i o chi o chi	aware of the order for				
	Resident #5's guar					
	-The RCC was not	aware that guard rails were				
	allowed in the facili					
		ontact the PCP for clarification.		2		
		hysician orders was the RCC order and have the Supervisor				1
		R and then the RCC would sign				
	off before it's imple					
	Attempted interview	w with Resident #5's family				
		17 at 11:30 a.m. was				
	unsuccessful; mes	sage was left to return call.				
	Interview with the V	/ice President of Clinical				
	Services on 11/15/	17 at 8:00 p.m. revealed:				
		e that Resident #5 had an				
	order for guard rail					
	-They would contai	ct the PCP for clarification.				
		sident #5's room on 11/15/17 at				
	9:40 p.m. revealed					1
		d been moved and turned so ing next to the resident's bed; it				
	was several feet av					
	-The bed rails were					
		P. P				

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Division of Health Service Regulation

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: C HAL043024 B. WING C NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	2017
	CTRACK CONTRACTOR
SENTER'S REST HOME 40 RAWLS CLUB ROAD FUQUAY VARINA, NC 27526	
	(X5) COMPLETE DATE
D 338       Continued From page 84       D 338         Observation on 11/16/17 at 9:05 a.m. of Resident #5's room revealed: -The resident was not in the room. -The bed had guard rails on each side that were half side rails.       D 338         Interview with the Administrator in Charge on 11/16/17 at 9:45 a.m. revealed: -The PCP was called and the guard rail order was clarified and rewritten on 11/16/17. -The restraint assessment and care plan was completed on 11/16/17. -The guard rails were put on Resident #5's bed on evening of 11/15/17.         Interview with the CSS on 11/16/17 at 10:25 a.m. revealed that Resident #5's POA gave consent for guard rails.         Interview with the RN/CSS on 11/16/17 at 8:15 a.m. revealed: -She was aware of how Resident #5 responded when the chair alam sounded.         -There had been no other interventions implemented or evaluated to consider as an alterative to the chair alam.         -There NACSS knew that the PCP had discussed the level of care for Resident #5, and placement was being sought at a skilled nursing facility.         Based on observations, interviews and record reviews, Resident #5, had experienced four fails and was on the facility's Fail Management Program. The facility had implemented interventions for the resident, including a floor mat at a chair alam, which was not ordered by	

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Division of Health Service Regulation (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: C B. WING 11/16/2017 HAL043024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 40 RAWLS CLUB ROAD SENTER'S REST HOME FUQUAY VARINA, NC 27526 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) D 338 D 338 Continued From page 85 the PCP. The PCP had ordered guard rails, which were not implemented by the facility until 11/15/17, when staff had to be contacted as the resident was observed to be nearly halfway off the bed. The resident was also observed to become agitated when the chair alarm sounded each time during the survey. No other interventions had been implemented by the facility. The facility's failure to provide the services necessary to maintain the residents' physical and mental health by not implementing interventions identified by the facility's fall management program and/or as ordered by the primary care provider for three sampled residents, who had a history of falls, resulting in Resident #6 sustaining a fatal head injury with intracranial hemorrhage; and resulting in Resident #5 being observed nearly halfway off the bed and staff had to be notified of the resident's urgent need to be repositioned on the bed. This noncompliance constitutes a Type A1 Violation for serious physical harm and serious neglect. Review of the facility's Plan of Protection dated 11/15/17 revealed: -The night stand has been moved away from the head of the bed until side rails arrive in approximately 9 minutes from now per estimated time of arrival. (9:27 p.m.-Side rails here and being applied to bed.) -All bed/chair alarms will be checked every shift and documented to ensure in place and operating properly. -Will continue to follow company falls management program. -Executive Director (ED) or designee will monitor/observe all interventions to ensure ongoing compliance. Division of Health Service Regulation

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY
			A. BUILDING:		С
	•	HAL043024	B. WING		11/16/2017
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
SENTER	S REST HOME	40 RAWL	S CLUB RO	AD	
		FUQUAY	VARINA, NC	27526	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E DAT
D 338	Continued From p	age 86	D 338		
		ON DATE FOR THIS TYPE A1 L NOT EXCEED DECEMBER			
D 358	10A NCAC 13F .1 Administration	004(a) Medication	D 358	10A NCAC 13F .1004(a) Medication Administration	
	<ul> <li>(a) An adult care preparation and ad prescription and n by staff are in accord (1) orders by a lic which are maintain</li> </ul>	004 Medication Administration home shall assure that the dministration of medications, on-prescription, and treatments ordance with: ensed prescribing practitioner ned in the resident's record; and ection and the facility's policies		<ul> <li>Facility will assure that the preparation ar administration of medications, prescriptio and non-prescription, and treatments by are in accordance with:</li> <li>(1) orders by a licensed prescribing pract</li> <li>(2) rule in this Section and the facility's policies and procedures.</li> <li>Facility has completed an audit of all phy orders against eletornic medication administration records to assure all medications and treatments are impletment as ordered.</li> </ul>	n 1/2/1 staff itione sican
	Based on observa reviews, the facility medications as or #4) sampled inclu- order for a potass decrease the dose (#3), and failure to topical antibiotic o stop date and the	net as evidenced by: tions, interviews, and record y failed to administer dered for 2 of 5 residents (#3, ding failure to implement an ium supplement (#3), failure to e of an anti-anxiety medication o discontinue the use of a intment for a skin rash after the rash had healed (#4).		Facility Medicaiton Aides, ED and RCC/M have been in-serviced on implementation orders Facility ED/RCC/MCM or designee will conduct weekly med cart and medication administration record audits times one m then randomly there after to assure all physician orders are implemented correct	n of onth, itly.
	revealed diagnose	dent #3's FL-2 dated 09/01/16 s included Alzheimer's s, hypertension, anemia, and		to ensure all ordered medicaitons are on and availble for administration. ED or des will monitor weekly to ensure on going compliance	hand
	A. Review of hos	oital emergency room discharge			

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If continuation sheet 87 of 103

Division	of Health Service Re	egulation				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE COMP	SURVEY
			DOILDING.		0	, ,
	*	HAL043024	B. WING			6/2017
NAME OF F	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
SENTER	S REST HOME		CLUB ROA			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 358	Continued From pa	nge 87	D 358			
D 358	forms dated 03/29/ -The resident was a low potassium. -One of the resident was discontinued. -There was a press ER 20mEq daily and dispensed with no ra- a potassium supple of potassium.) Review of a visit no provider (PCP) data revealed: -The PCP noted the for low blood sugar -The PCP noted the for low blood sugar -The PCP discontind diabetic medication -The PCP ordered 10mEq take 1 table scheduled to be add -The original date of 03/30/17. -Potassium Chlorid as administered on Review of Residen revealed: -There was an entr 20mEq take 1 table scheduled to be add -There was an entr 20mEq take 1 table scheduled to be add -There was an entr	17 for Resident #3 revealed: seen for low blood sugar and at's oral diabetic medications cription for Potassium Chloride d 10 tablets were to be refills. (Potassium Chloride is ement used to treat low levels bete by the primary care ed 03/30/17 for Resident #3 e resident went to the hospital and low potassium. nued one of the resident's oral hs. Potassium Chloride ER et daily. t #3's March 2017 medication ord (MAR) revealed: by for Potassium Chloride ER et every day and it was liministered at 8:00 a.m. of the order was noted to be le ER 20mEq was documented for 0 03/31/17. t #3's April 2017 MAR by for Potassium Chloride ER et every day and it was liministered at 8:00 a.m.				
	as administered da 04/30/17.	le ER 20mEq was documented aily at 8:00 a.m. from 04/01/17 -				
Division of H	-There was no entr	ry for Potassium Chloride ER		· • • • • • • • • • • • • • • • • • • •		

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	of Health Service Re IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY
	or borneo non	DENTIONATION NONDER	A. BUILDING: _			C
		HAL043024	B. WING			6/2017
	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
SENTER	'S REST HOME		S CLUB ROAL			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	DATE
D 358	Continued From pa	age 88	D 358			
	10mEq as ordered	on 03/30/17.				
	Review of Residen	t #3's May 2017 MAR				
	revealed:					
		ry for Potassium Chloride ER et every day and it was				
	scheduled to be ac	iministered at 8:00 a.m.				
		te ER 20mEq was documented				
	05/31/17.	aily at 8:00 a.m. from 05/01/17				1
	-There was no entr	ry for Potassium Chloride ER				
	10mEq as ordered	on 03/30/17.				
	Review of Residen	t #3's June 2017 MAR				
		ry for Potassium Chloride ER				
	20mEq take 1 table	et every day and it was				
		dministered at 8:00 a.m. de ER 20mEq was documente	d			
	as administered da 06/05/17.	aily at 8:00 a.m. from 06/01/17	-			
		ry for Potassium Chloride ER				
	10mEq as ordered	l on 03/30/17. loride ER was documented as				1
1.1		6/07/17 - 06/08/17 due to				
	resident being in th	ne hospital.				
		cy dispensing records dated				
		7 for Resident #3 revealed: hloride ER 20mEg tablets were				
	dispensed on 03/3					
	-There was no othe	er Potassium Chloride ER				
	tablets dispensed	for the resident.				
		w with a pharmacist at the				
	revealed:	on 11/16/17 at 9:35 a.m.				
		e pharmacy received for				
		e for Resident #3 was the he hospital dated 03/30/17.				

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If continuation sheet 89 of 103

T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				SURVEY
of bonneonon		A. BUILDING:			
5 ° '	HAL043024	B. WING			C 16/2017
ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
S DEST HOME					
		VARINA, NC			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO T	ION SHOULD BE	(X5) COMPLET DATE
Continued From pa	ge 89	D 358			
-The prescription di Potassium Chloride only 10 tablets were -They only dispense the prescription. -They never receive Chloride 10mEq an -No Potassium was pharmacy because for billing purposes Review of a lab rep Resident #3 reveale level was 3.6 (refer Interview with two r 11/16/17 at 11:10 a -If a medication wa they were suppose in the facility. -If not in the back-u to notify the RCC o -If a medication wa supposed to docum administered on the -They could not exp Potassium Chloride administered for ow have been none av Interview with the A on 11/16/17 at 10:4 -She was not sure of #3's Potassium Chloride action was the facility of facility.	ated 03/30/17 was for a R 20mEq 1 tablet daily and a ordered with no refills. ed 10 tablets as indicated on ad an order for Potassium id never dispensed any. a dispensed by the back-up it would show in their records ort dated 04/27/17 for ed the resident's potassium ence range 3.6 - 5.1). medication aides (MAs) on .m. revealed: s not in the medication cart, d to check the back-up supply up supply, they were supposed r the pharmacy. s not administered, they were nent why it was not a MARs. Dain why Resident #3's a was documented as rer 2 months when there would railable to administer. administrator-in-Charge (AIC) 15 a.m. revealed: what happened with Resident loride because she did not when Resident #3 lived at the				
	T OF DEFICIENCIES OF CORRECTION ROVIDER OR SUPPLIER S REST HOME SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa -The prescription di Potassium Chloride only 10 tablets were -They only dispense the prescription. -They never receive Chloride 10mEq an -No Potassium was pharmacy because for billing purposes Review of a lab rep Resident #3 reveal level was 3.6 (refer Interview with two r 11/16/17 at 11:10 a -If a medication wa they were suppose in the facility. -If not in the back-u to notify the RCC o -If a medication wa supposed to docum administered on the -They could not exp Potassium Chloride administered for ow have been none av Interview with the A on 11/16/17 at 10:4 -She was not sure of #3's Potassium Chloride administered for ow have been none av	TOF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         DF CORRECTION       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:       IDENTIFICATION NUMBER:         IDENTIFICATION NUMBER:       IDENTIFICATION NUMBER:         ROVIDER OR SUPPLIER       STREET AD         S REST HOME       40 RAWL FUQUAY         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 89         -The prescription dated 03/30/17 was for Potassium Chloride ER 20mEq 1 tablet daily and only 10 tablets were ordered with no refills.         -They only dispensed 10 tablets as indicated on the prescription.         -They never received an order for Potassium Chloride 10mEq and never dispensed any.         -No Potassium was dispensed by the back-up pharmacy because it would show in their records for billing purposes.         Review of a lab report dated 04/27/17 for Resident #3 revealed the resident's potassium level was 3.6 (reference range 3.6 - 5.1).         Interview with two medication aides (MAs) on 11/16/17 at 11:10 a.m. revealed: -If a medication was not in the medication cart, they were supposed to check the back-up supply in the facility.         -If not in the back-up supply, they were supposed to notify the RCC or the pharmacy.         -If a medication was not administered, they were supposed to document why it was not administered on the MARs.         -They could not explain why Resident #3's Potassium Chloride was documented as administered f	TOF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE         DF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA       (X2) MULTIPLE         ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, S         S REST HOME       STREET ADDRESS, CITY, S         S REST HOME       SUMMARY STATEMENT OF DEFICIENCIES       ID         (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       D         7 The prescription dated 03/30/17 was for       Potassium Chloride ER 20mEq 1 tablet daily and only 10 tablets were ordered with no refills.         - They never received an order for Potassium       Chloride 10mEq and never dispensed any.       -No Potassium was dispensed by the back-up pharmacy because it would show in their records for billing purposes.         Review of a lab report dated 04/27/17 for       Resident #3 revealed the resident's potassium level was 3.6 (reference range 3.6 - 5.1).         Interview with two medication aides (MAs) on 11/16/17 at 11:10 a.m. revealed: -1f a medication was not administered, they were supposed to check the back-up supply in the facility.         -If a medication was not administered, they were supposed to document why it was not administered on the MARs.         -They could not explain why Resident #3's Potassium Chloride was documented as administered for over 2 months when there would have been none available to administer.         Interview with the Administrator-in-Charge (AIC) on 11/16/17 at 10:45 a.m. revealed: -She was not sure what happened with Resident #3's Potassium Chloride bec	TOF DEFICIENCIES       (X1) PROVIDER/SUPPLER/CLIA       (X2) MULTIPLE CONSTRUCTION         A BUILDING:       HAL043024       B. WING         ROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         S REST HOME       40 RAWLS CLUB ROAD         FUQUAT VARINA, NC 27525       PROVIDER/SPLAN OF ICENCIES         SUMMARY STATEMENT OF DEFICIENCIES       ID         IREGULATORY OR LSC IDENTIFYING INFORMATION       DEFICIENCY VARINA, NC 27525         Continued From page 89       D 358         -The prescription dated 03/30/17 was for       Potassium Chioride ER 20mEq 1 tablet daily and only 10 tablets were ordered with no refills.         -They only dispensed 10 tablets as indicated on the prescription.       D 358         -The probasium Chioride ER 20mEq 1 tablet daily and only 10 tablets were ordered with no refills.       Choride 10mEq and never dispensed any.         -No Potassium was dispensed by the back-up pharmacy because it would show in their records for billing purposes.       Review of a lab report dated 04/27/17 for         Resident #3 revealed the resident's potassium level was 3.6 (reference range 3.6 - 5.1).       Interview with two medication aides (MAs) on 11/16/17 at 11:10 a.m. revealed:         -If a medication was not in the medication cart, they were supposed to check the back-up supply in the facility.       Find in the back-up supply, they were supposed to notify the RCC or the pharmacy.         -If a medication was not administered, they wore supposed to	OF CORRECTION     IDENTIFICATION NUMBER:     A BUILDING:     COM       HAL043024     B. WING     11//       ROVIDER OR SUPPLIER     STREET ADDREES, CITY, STATE, ZIP CODE     40 RAWLS CLUB ROAD       S REST HOME     FUQUAY VARINA, NC 27628     PROVIDER'S PLAN OF CORRECTION SHOULD BE       SUMMARY STATEMENT OF DEFICIENCES (REACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)     ID PREFX     PROVIDER'S PLAN OF CORRECTION (REACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       Continued From page 89     D 358       -The prescription dated 03/30/17 was for Potassium Chioride ER 20mEq 1 tablet daily and only 10 tablets were ordered with no refills. -They only dispensed 10 tablets as indicated on the prescription. -They oney cause it would show in their records for billing purposes.     D 358       Review of a tab report dated 04/27/17 for Resident % revealed the resident's potassium level was 3.6 (reference range 3.6 - 6.1).     Interview with two medication aides (MAs) on 11/16/17 at 11:10 a.m. revealed: -1f an endication was not in the medication cart, they were supposed to check the back-up supply in the facility. -1f a medication was not administered, they were supposed to document why it was not administered for over 2 months when there would have been none available to administer.       Interview with the Administrator-in-Charge (AIC) on 11/16/17 at 10:45 a.m. revealed: -1f a medication was not administer.       Interview with the Administrator-in-Charge (AIC) on 11/16/17 at 10:45 a.m. revealed: -5he was not sure what happened with Resident d3's Potassium Chioride because she did not work at the facility.

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	
			A. DUILDING.			C
		HAL043024	B, WIŅG		11/1	6/2017
IAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ENTER	S REST HOME		S CLUB ROAL			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION		(X5) COMPLE
TAG		LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO TH DEFICIENCY	<b>EAPPROPRIATE</b>	DATE
D 358	Continued From p	age 90	D 358			
		w with Resident #3's primary P) on 11/15/17 at 5:41 p.m.				
	revealed:					
	-She no longer wo that serviced the fa	rked with the primary practice				
		access to Resident #3's				
	records.	t #3's PCP when the resident				
	resided at the facil	lity.				
		all any details about the ions, including the Potassium	1			
	Chloride.					
	Review of hospital 06/06/17 revealed	records for Resident #3 dated				
	-The resident was	evaluated in the emergency				
		sea and vomiting on 06/06/17. possible viral gastroenteritis				
	-The resident's po	tassium level at the hospital on				
	-The resident expi	(reference range 3.5 - 5.0). ired on 06/08/17.				
-		ident #3's FL-2 dated 09/01/16				
		for Clorazepate 3.75mg 1 (Clorazepate is a controlled				
		or anxiety and/or agitation.)				
		cian's order from the primary				
		P) dated 02/09/17 for Resident der for Clorazepate 3.75mg				
	twice daily.					
		om Resident #3's mental health	1			
-		ated 03/22/17 revealed: ler to discontinue Clorazepate				
	3.75mg twice a da	iy.				
	take 1 tablet daily.	order for Clorazepate 3.75mg				

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TATEMEN	of Health Service R T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	SURVEY
		HAL043024	B. WING			C 16/2017
AME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
ENTER	'S REST HOME		S CLUB ROAL			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
D 358	03/23/17 for Resider continue taking Ck Review of Resider sheet dated and si revealed an order tablet twice a day. Review of clarifica #3's PCP on 03/30 03/29/17 revealed 3.75mg 1 tablet da Review of Resider administration reco -There was an ent twice daily and it w administered at 8: 03/01/17 - 03/17/1 -Staff documented hospital from 03/1 -There was an ent a day entered on 0 03/23/17 with non- There was a third twice a day at 8:00 documented as ac 03/31/17. Telephone intervie primary pharmacy	al discharge summary dated lent #3 revealed an order to orazepate 3.75mg twice daily. It #3's signed physician's order igned by the PCP on 03/30/17 for Clorazepate 3.75mg 1 tion orders signed by Resident 0/17 for the hospital orders from an order for Clorazepate aily at 8:00 a.m. It #3's March 2017 medication ord (MAR) revealed: ry for Clorazepate 3.75mg vas documented as 00 a.m. and 8:00 p.m. from 7 (8:00 a.m.). I the resident was in the	D 358	DEFICIENCY		
	to decrease Clora: 03/23/17. -They received the	ceived the order dated 03/22/17 zepate to once daily on a hospital discharge summary an order for Clorazepate 3.75mg				

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If continuation sheet 92 of 103

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		SURVEY
	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
		HAL043024	B. WING			C 16/2017
AME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE		
ENTER	'S REST HOME	40 RAWL	S CLUB ROAD	0		
	S REST HOME	FUQUAY	VARINA, NC	27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
D 358	Continued From pa	age 92	D 358			
	Resident #3 reveal	r by the PCP dated 04/27/17 fo led an order for Clorazepate et (3.75mg) twice a day.	r	*		
	revealed:	t #3's April 2017 MAR				
	twice daily and it w	ry for Clorazepate 3.75mg as documented as 00 a.m. and 8:00 p.m. from 7 (8:00 a.m.)				
	-There was an ent ½ tablet (3.75mg) documented as ad	ry for Clorazepate 7.5mg take twice daily and it was ministered at 8:00 a.m. and				
	8:00 p.m. from 04/ Review of a visit no for Resident #3 rev	ote dated 04/26/17 by the MHP				
	-The resident was during the day.	very sleepy and slept a lot				
	decreased to once medications but it the MAR.	a day due to duplicate did not appear to happen per				
	-She would verify w make a new order.	with the RCC and may need to				
	05/24/17 revealed	om Resident #3's MHP dated an order for Clorazepate t daily for 5 days, then stop.				
	revealed:	nt #3's May 2017 MAR				
	1/2 tablet (3.75mg)	ry for Clorazepate 7.5mg take twice daily and it was Iministered at 8:00 a.m. and 01/17 - 05/24/17.				
	-There was an ent tablet daily for 5 da	ry for Clorazepate 7.5mg 1 ays and it was documented as 05/26/17 - 05/30/17.				

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Division of Health Service Regulation

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION		SURVEY
		HAL043024	B. WING	and a state of the		C 16/2017
NAME OF I	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, ST	TATE, ZIP CODE		
			S CLUB ROAL			
SENTER	'S REST HOME		VARINA, NC			
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From pa	age 93	D 358			
	Review of Residen	t #3's June 2017 MAR no entry for Clorazepate on				
	Resident #3's Clora 05/30/17 revealed:	rolled substance (CS) log for azepate dated 03/01/17 - ng was documented as				
	administered twice 03/16/17. -Clorazepate 3.75n	daily from 03/01/17 - ng was documented as on 03/17/17 (resident in				
	hospital when seco -The resident was 03/23/17.	ond dose was due). in the hospital from 03/17/17 -				
	administered twice 04/10/17.	ng was documented as daily from 03/24/17 -				
	administered once hospital when seco -Clorazepate 3.75n	ng was documented as on 04/11/17 (resident was in ond dose was due). ng was documented as daily from 04/12/17 -				
	04/27/17. -Clorazepate 7.5m	g ½ tablet (3.75mg) was				
	-Clorazepate 7.5m	ministered once on 04/28/17. g ½ tablet (3.75mg) was ministered twice daily from 7.				
	documented as ad (resident in hospital	g ½ tablet (3.75mg) was ministered once on 05/20/17 al when second dose due).				
	documented as ad 05/21/17 - 05/24/11					

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STATEMEN	of Health Service R TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDING:			C
	1. 1. Way of Male 1. 1. 1.	HAL043024	B. WING			6/2017
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ENTER	'S REST HOME		S CLUB ROA			
			VARINA, NC	and the second		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
D 358	Continued From p	age 94	D 358			
	Review of pharma Resident #3 revea -Sixty Clorazepate dispensed on 02/0 -Sixty Clorazepate dispensed on 03/1 -Thirty Clorazepate on 04/27/17. -Five Clorazepate on 05/25/17. Interview with a m 6:55 p.m. revealed -She recalled then Resident #3's Clor recall the details o -Resident #3 was -Resident #3 was too sleepy to her k Telephone intervie care provider (PC revealed: -She no longer wo that serviced the f -She did not have records.	every dispensing records for led: a 3.75mg tablets were by/17. b 3.75mg tablets were c 7.5mg tablets were dispensed c 7.5mg tablets were dispensed c 7.5mg tablets were dispensed c 8 c 11/15/17 at c 9 was a medication error with razepate but she could not of the time or the error. very agitated and combative. not having problems with being cnowledge. ew with Resident #3's primary P) on 11/15/17 at 5:41 p.m. orked with the primary practice access to Resident #3's				
	resided at the faci -She could not rec	it #3's PCP when the resident lity. call any details about the tions, including the Clorazepate.				
		h practice that provided services is no longer in business.]	5			
	06/06/17 revealed -The resident was room (ER) for nau	evaluated in the emergency isea and vomiting on 06/06/17. possible viral gastroenteritis		90 - 7214		

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STATEMEN	of Health Service Re T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	SURVEY
	or connection	DENTI IOANON NOMBER.	A. BUILDING:			
		HAL043024	B, WING			C 6/2017
NAME OF I	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
ENTED	'S REST HOME	40 RAWL	S CLUB ROA	D		
SENTER	S REST HOME	FUQUAY	VARINA, NC	27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
D 358	Continued From pa	age 95	D 358			1
	and lactic acidosis.					
	-The resident expir					
		dent #4's current FL-2 dated				
		diagnoses included ntia, paranoia, vertigo and				
	depression.	nua, paranola, venigo and				
	asprootion.					
		t #4's Resident Register				
		sion from another adult care				
	facility on 3/4/14					
	Based on observat	tions, record reviews, and				
	interviews, Resider	nt #4 was not interviewable.				
	Review of a physic	ian's order for Resident #4				
		aled Mupirocin 2% ointment;				
	apply thin layer to r	rash on left side nostril area				
	three times per day	y for 5 days.				
	Review of Residen	t #4's electronic Medication				
		cords (eMAR) for October 2017	.			
	revealed:					
		ry for Mupirocin 2% ointment				
	area three times a	o rash on left side of nostril day for 5 days				
		tment was documented as				
		0/10/17 two doses and on				
	10/11-10/31/17 thr	ee doses each day.		6		
	Review of Residen	nt #4's electronic Medication				
	Administration Rec	cords (eMAR) for November				
	2017 revealed:					
		ry for Mupirocin 2% ointment o rash on left side of nostril				
	area three times a					
	-To the right of the	entry, there was "D/C'd"				
	(discontinued) enter					
		tment was documented as 1/1-11/5/17 and 11/7-11/8 three				
sion of H	ealth Service Regulation			12.444		

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TATEMEN	of Health Service Re T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	(X3) DATE COMP	SURVEY
	or contraction		A. BUILDING:			
		HAL043024	B. WING			C 6/2017
AME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
ENTER	'S REST HOME		S CLUB ROA			
	S REST HOME	FUQUAY	VARINA, NC	27526		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
D 358	Continued From pa	age 96	D 358			
D 358 Continued From page 96 doses each day. -On 11/6/17 it was documented that the 8:00 a.m. dose was not administered due to "medication not in facility". The other 2 doses were documented as administered that day at 2:00 p.m. and 8:00 p.m. -On 11/6/17 it was documented that the 8:00 a.m. and 2:00 p.m. doses were not administered due to "medication not in facility". The other dose was documented as administered that day at 8:00 p.m. -On 11/10/17 it was documented that the 8:00 a.m. dose was not administered due to "medication discontinued". The other 2 doses had no initials on the eMAR for that day at 2:00 p.m. and 8:00 p.m. -The remainder of the month showed no initials on the eMAR for any days.						
	the medication car Review of Consult	ant Pharmacist Progress Notes ast quarterly review was				
	a.m. revealed: -Resident was in w with other resident	not have any redness, rash or				
	at 11:00 a.m. reve -She gave the Mu documented for O	pirocin 2% ointment as ctober and November, luse it was in the medication //AR".	7			

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY	
					с	
	HAL043024	B. WING			16/2017	
ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
S REST HOME						
	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)	
		PREFIX	CROSS-REFERENCED TO	THE APPROPRIATE	COMPLE	
Continued From pa	ge 97	D 358				
11/8/2017 because eMAR. -She did not give it in the cart. -The facility proces still on the eMAR a the timeframe for w would be reported to Coordinator (RCC) the medication to the Interview with the M (MA/S) on 11/16/17	it was in the cart and on the on 11/9/17 because it was not s was if the medication was nd in the medication cart past which it was ordered, then it to the Resident Care to verify the order and return he pharmacy if needed. Medication Aide/Supervisor Y at 11:05 a.m. revealed:					
the eMAR and in the timeframe for which validate the order w provider's order an pharmacy if application update the eMAR.	he medication cart past the h it was ordered, would be to with the Pharmacy and d return the medication to able and inform the RCC to					
a.m. revealed: -She gave the Mup 11/7/2017 because eMAR. -She documented in did not give it on 11 the cart and she vai be discontinued aft -The process to fol the eMAR and in the timeframe for which validate the order a to the pharmacy if a	irocin 2% ointment on it was in the cart and on the medication discontinued and 1/10/17 because it was not in lidated the medication was to er 5 days. low if medication was still on he medication cart past the h it was ordered, was to and send the medication back applicable.					
	(EACH DEFICIENCY REGULATORY OR L Continued From participants) -She gave the Mup 11/8/2017 because eMAR. -She did not give it in the cart. -The facility process still on the eMAR at the timeframe for wind Coordinator (RCC) the medication to the Interview with the M (MA/S) on 11/16/17 -The process to fol the eMAR and in the timeframe for which validate the order w provider's order an pharmacy if application update the eMAR. Interview with anoth a.m. revealed: -She gave the Mup 11/7/2017 because eMAR. -She documented 1 did not give it on 11 the cart and she vat be discontinued aft -The process to fol the eMAR and in the timeframe for which validate the order at to the pharmacy if a Interview with the A 11/16/17 at 11:15 at	OF CORRECTION       IDENTIFICATION NUMBER:         HAL043024         PROVIDER OR SUPPLIER       STREET AI         S REST HOME       40 RAWL FUQUAY         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)         Continued From page 97         -She gave the Mupirocin 2% ointment on 11/8/2017 because it was in the cart and on the eMAR.         -She did not give it on 11/9/17 because it was not in the cart.         -The facility process was if the medication was still on the eMAR and in the medication cart past the timeframe for which it was ordered, then it would be reported to the Resident Care Coordinator (RCC) to verify the order and return the medication to the pharmacy if needed.         Interview with the Medication Aide/Supervisor (MA/S) on 11/16/17 at 11:05 a.m. revealed: -The process to follow if a medication was still on the eMAR and in the medication cart past the timeframe for which it was ordered, would be to validate the order with the Pharmacy and provider's order and return the medication to pharmacy if applicable and inform the RCC to update the eMAR.         Interview with another MA/S on 11/16/17 at 11:10 a.m. revealed: -She gave the Mupirocin 2% ointment on 11/7/2017 because it was in the cart and on the eMAR.         -She documented medication discontinued and did not give it on 11/10/17 because it was not in the cart and she validated the medication was to be discontinued after 5 days.         -The process to follow if medication was still on the eMAR and in the medication cart past the timeframe for which it was ordered, was to validate the order and send the	OF CORRECTION       IDENTIFICATION NUMBER:       A. BUILDING:         HAL043024       B. WING         PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, ST         S REST HOME       40 RAWLS CLUB ROAL FUQUAY VARINA, NC         SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 97       D 358         -She gave the Mupirocin 2% ointment on 11/8/2017 because it was in the cart and on the eMAR.       D 358         -The facility process was if the medication was still on the eMAR and in the medication cart past the timeframe for which it was ordered, then it would be reported to the Resident Care Coordinator (RCC) to verify the order and return the medication to the pharmacy if needed.         Interview with the Medication Aide/Supervisor (MA/S) on 11/16/17 at 11:05 a.m. revealed: -The process to follow if a medication was still on the eMAR and in the medication was still on the eMAR and in the medication cart past the timeframe for which it was ordered, would be to validate the order with the Pharmacy and provider's order and return the medication to pharmacy if applicable and inform the RCC to update the eMAR.         Interview with another MA/S on 11/16/17 at 11:10 a.m. revealed: -She gave the Mupirocin 2% ointment on 11/7/2017 because it was in the cart and on the eMAR. -She documented medication discontinued and did not give it on 11/10/17 because it was not in the cart and she validated the medication was to be discontinued after 5 days. -The process to follow if medication was to be discontinued after 5 days. -The process to follow if medication was to be discontinue	OF CORRECTION     IDENTIFICATION NUMBER:     A. BUILDING:       HAL043024     B. WING       *ROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       S REST HOME     40 RAWLS CLUB ROAD       SUMMARY STATEMENT OF DEFICIENCIES     D       (EACH DEFICIENCY MUST BE PRECEDED BO BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     D       Continued From page 97     D 358       -She gave the Mupirocin 2% ointment on 11/8/2017 because it was in the cart and on the eMAR.     D 358       -She did not give it on 11/9/17 because it was not in the cart.     D 358       -The facility process was if the medication was still on the eMAR and in the medication cart past the timeframe for which it was ordered, then it would be reported to the Resident Care Coordinator (RCC) to verify the order and return the medication to the pharmacy if needed.       Interview with the Medication Alde/Supervisor (MAVS) on 11/16/17 at 11:05 a.m. revealed: -The process to follow if a medication was still on the eMAR and in the medication was still on the eMAR and inform the RCC to update the order with the Pharmacy and provider's order and return the medication to pharmacy if applicable and inform the RCC to update the eMAR.       Interview with another MAVS on 11/16/17 at 11:10 a.m. revealed: -She gave the Mupirocin 2% ointment on 11/17/2017 because it was in the cart and on the eMAR.       -She documented medication discontinued and did not give it on 11/10/17 because it was not in the cart and she validated the medication was to be discontinued after 5 days.       -The process to follow if medication was still on the eMAR and in the medication wa	OF CORRECTION     IDENTIFICATION NUMBER     A BUILDING:     111/       HAL043024     B. WING     111/       ROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     9       S REST HOME     40 RAWLS CLUB ROAD     PROVIDER'S PLAN OF CORRECTION       RESUMMARY STATEMENT OF DEFICIENCES     ID     PREFX       REACH OFFICIENCY MUST RE PRECEDED BY FULL     ID     PREFX       RESULATORY OR LSC IDENTIFYING INFORMATION)     ID     SS       -She give the Mupirocin 2% ointment on     11///2017 because it was in the cart and on the edMAR.     -She did not give it on 11/9/17 because it was not in the cart.       -The facility process was if the medication was still on the edMAR and in the medication cart past the timeframe for which it was ordered, then it would be reported to the Resident Care     Coordinator (RCC) to verify the order and return the medication to the pharmacy if needed.       Interview with the Medication Aide/Supervisor     (MAS) on 11/16/17 at 11:05 a.m. revealed:     -The process to follow if a medication vas still on the edMAR.       -She did no the medication to the pharmacy if applicable and inform the RCC to update the order and return the medication to the pharmacy if applicable and inform the RCC to update the edMAR.     -She documented medication as till on the edication as the cart and on the edMAR.       -She did could be availed at the medication was to be discontinued after 5 days.     -The process to follow if medication was to be discontinued after 6 days.       -The process to follow if medication was to the tim	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING:       (X3) DATE SURVEY COMPLETED         NAME OF PROVIDER OR SUPPLIER       HAL043024       B. WING       C 11/16/2017         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE       C 11/16/2017         SENTER'S REST HOME       40 RAWLS CLUB ROAD FUQUAY VARINA, NC 27526       VARINA, NC 27526         (X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION SHOULD BE COMPLETED       (S5 COMPLETED	) ETE
A. BUILDING:	) ETE
HAL043024     B. WING     11/16/2017       NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     11/16/2017       SENTER'S REST HOME     40 RAWLS CLUB ROAD     10       FUQUAY VARINA, NC 27526     FUQUAY VARINA, NC 27526     10       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CORRECTION     (X5       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION SHOULD BE     COMPL       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)     TAG     CROSS-REFERENCED TO THE APPROPRIATE     DAT	) ETE
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       SENTER'S REST HOME     40 RAWLS CLUB ROAD       FUQUAY VARINA, NC 27526       (X4) ID     SUMMARY STATEMENT OF DEFICIENCIES       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL       PREFIX     (EACH DEFICIENCY MUST BE PRECEDED BY FULL       TAG     REGULATORY OR LSC IDENTIFYING INFORMATION)	) ETE
40 RAWLS CLUB ROAD FUQUAY VARINA, NC 27526         (X4) ID PREFIX       SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG       ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPL       COMPL DAT	
SENTER'S REST HOME         FUQUAY VARINA, NC         27526           (X4) ID         SUMMARY STATEMENT OF DEFICIENCIES         ID         PROVIDER'S PLAN OF CORRECTION         (X5           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE ACTION SHOULD BE         COMPL           TAG         REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCED TO THE APPROPRIATE         DAT	
FUQUAY VARINA, NC         27526           (X4) ID         SUMMARY STATEMENT OF DEFICIENCIES         ID         PROVIDER'S PLAN OF CORRECTION         (X5)           PREFIX         (EACH DEFICIENCY MUST BE PRECEDED BY FULL         PREFIX         (EACH CORRECTIVE ACTION SHOULD BE         COMPL           TAG         REGULATORY OR LSC IDENTIFYING INFORMATION)         TAG         CROSS-REFERENCED TO THE APPROPRIATE         DAT	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DAT	
DEFICIENCY)	
D 358 Continued From page 98 D 358	
ointment was not given as ordered to Resident #5.	
-The process to follow if medication was still on	
the eMAR and in the medication cart past the	
timeframe for which it was ordered, was to	
validate the order, fax it to the pharmacy and they	
would enter the update in Quick MAR. The RCC would validate the order, approve and sign off	
before the change was implemented.	
D 451 10A NCAC 13F .1212(a) Reporting of Accidents D 451 10 A NCAC 13F .1212(a) Reporting of 1/2/18	4
and Incidents Accidents and Incidents	
10A NCAC 13F .1212 Reporting of Accidents and	
Incidents Facility will notify the county department of	
(a) An adult care home shall notify the county soical services of any accident or incident resulting in injury to a resident which requires	
department of social services of any accident or referral for emergency medical evaluation,	
accident or incident resulting in injury to a hospitalization , or medical treatment other than first aid.	
resident requiring referral for emergency medical	
evaluation, hospitalization, or medical treatment Facility care staff have been in-service on	
other than first aid. accident/incident reporting. Facility has impletmented a wall folder,	
which is located in the med room, were	
This Rule is not met as evidenced by: staff are to place completed accident/incident	
Based on record reviews and interviews the Accident/Incident folder will be checked daily	
facility failed to notify the county department of by ED/RCC/MCM or designee for completed	
social services of incidents requiring referral for reports.	
emergency medical evaluation for 1 of 7 residents Facility ED/RCC/MCM or designee will be responible to ensure reports are faxed to	
county DSS within required time frames.	
Review of Resident #6's current FL-2 dated Facility will maintain all faxed reports with	
01/06/17 revealed: attached confirmation of fax in a binder located in the ED office.	
-Diagnoses included dementia, cerebrovascular	
accident, coronary artery disease and intracranial hemorrhage.	
-The resident was semi-ambulatory and	
intermittently confused.	
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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	E SURVEY
			A. BUILDING		С
		HAL043024	B. WING		16/2017
AME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE	
SENTER	'S REST HOME		S CLUB ROAL		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF	 (X5) COMPLET
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T DEFICIENC	DATE
D 451	Continued From p	age 99	D 451	1	
	Review of an eme	rgency room (ER) report for			
		07/19/17 revealed: seen for facial laceration to the			
		bw, closed head injury and			
	unwitnessed, mec	hanical ground-level fall.			
		ived sutures to the facial re ordered to be removed in ten			
	days.	le ordered to be removed in terr			
		t/Accident reports provided by			
		d there was no incident report fall that occurred on 07/19/17.			
		otes for Resident #6 revealed from staff dated 07/19/17.			
		report for Resident #6 dated Resident #6 was seen for			
	acute contusion to	the right flank area.			
		t/Accident reports provided by			
		d there was no incident report fall that occurred on 07/23/17.			
	Review of Care No 07/23/17 revealed	otes for Resident #6 dated			
		e documented by the first entry;			
		Resident #6 was sent to the The resident returned to the			
		and entry with no time			
	documented or sta	aff signature; staff documented			
	the resident was the and was trying to the second s	rying to get up and walk around, fight staff.			
		6/17 at 4:50 p.m. with the			
	entry on 07/23/17	MA), who documented the first in the Care Notes for Resident			
	#6 revealed:	ted Incident/Accident reports			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
	•	HAL043024	B. WING			C 16/2017
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
ENTER	S REST HOME		S CLUB ROAL			
(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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
D 451	Continued From pa	age 100 he Executive Director (ED) or	D 451			
	Resident Care Coo -Incident/Accident any incident, espec					
	Incident/Accident F	ure why there was no Report for Resident #6's fall on en a long time ago, so the een misplaced.				
	Coordinator (RCC) revealed:	ormer Resident Care on 11/15/17 at 2:10 p.m. reports were done by the				
	MAs/Supervisors; t RCC or ED. -The former RCC u	then, they turned them in to the used to fax the reports to the	e			
	(DSS), but she was now.	tment of Social Services s not sure who was doing that ys complete a report with a fal				
	or injury to a reside -She was not sure Resident #6; she w	ent. about the note on 09/12/17 for vondered if the injury she was rom a prior fall and not from				
	4:25 p.m. revealed	cond shift MA on 11/15/17 at : dent report was completed for				
	-The Incident/Accid	dent report was given to the were there at the time of the				
	Support Specialist revealed:	Registered Nurse/Clinical on 11/15/17 at 6:40 p.m. ed the Incident/Accident				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING		с	
		HAL043024	B. WING			6/2017
AME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
ENTER	S REST HOME		CLUB RO			
(X4) ID SUMMARY STATEN		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	COMPLE
D 451	Continued From p	age 101	D 451			
	resident.					
		ed if the resident needed to be				
		I for evaluation unless the RCC ement staff was at the facility	4).			
		at the time of the incident.				
		-Once the Incident/Accident reports were				
	completed, a nurs sending to DSS.	e reviewed them prior to				
	sending to Doo.					
	Telephone interview with the local DSS Social					
		1/16/17 at 12:30 p.m. revealed:				
		received Incident/Accident ent #6 for 08/14/17, 09/09/17				
	and 09/18/17.					
	-She had not received 2017.	ived any reports prior to August				
D914	G.S. 131D-21(4)	Declaration of Residents' Rights	D914	G.S. 131d-21(4)Declaration of Resid	ent Rights	
		claration of Residents' Rights		Facility will assure that every residen	t has the	
		all have the following rights:		following rights: 4. To be free of mental and physical	abusa	12/16/1
	neglect, and explo	ental and physical abuse, itation.		neglect and exploitation.	abuse,	
	This Rule is not m	net as evidenced by:		Facility has completed a chart audit of	ofall	
	Based on observa	tions, record reviews, and		primary care provider orders and interper its Fall Management Program to	ensure	
		ility failed to assure the services		implementation of orders/intervention		
	mental health.	tain the residents' physical and		Equility has completed/undeted Fall	Diele	
				Facility has completed/updated Fall I Assessments on all residents per its		
	The findings are:		à	Management Program.		
	1 Based on obsor	vations, interviews and record		Fall Risk Assessments will be comple quarterly on all residents.	eled/updated	2
		y failed to implement effective		All new admissions will have a Fall R		
	interventions, that	were ordered by the residents'		Assessment completed at admission	•	
		der or in accordance with the				
		agement program, for 3 of 3 , who had been identified by				
		risk for falls and had	1			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	BURVEY
		e)	A, BUILDING:		c	
		HAL043024	B. WING		11/10	5/2017
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
ENTER	S REST HOME		VARINA, NO			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE		
D914	Continued From pa	age 102	D914	Continued From page 102		
experienced multiple falls with injuries (#4, #5, #6). [Refer to Tag D338, 10A NCAC 13F. 0909 Resident Rights (Type A1 Violation)].			All orders for bed/chair alarms ha to facility Quickmar system. Medication Aides will check qshit alarm placement and correct ope	ft to assure		
				Facility staff have completed the In-services/trainings: Resident Rights Falls Prevention and Dementia All newly hired staff will receive t areas prior to providing care.		
				Facility ED/RCC/MCM or design chair/bed alarm placement and a operation daily times one month, there after.	assure correct	
				Facility will continue to follow con Management Program.	mpany Falls	
				Facility ED or Designee will mon all interventions to ensure ongoin		
				Facility ED will conduct quaterly meeting to including review of R	Quality Assurancesident Rights	ce
				7		
				y ,		
				3 7		
	ealth Service Regulation				7.24	