DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/13/2011 FORM APPROVED OMB NO. 0938-0391

<u> CENTER</u>	S FUR MEDICARE &	MEDICAID SERVICES				T CIVID INC	. 0000-0001
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	ULTIPLI LDING	E CONSTRUCTION	(X3) DATE SUR COMPLETI	
		345491	B. WI	IG		12/0	1/2011
	ROVIDER OR SUPPLIER N RIDGE NURSING AND	REHABILITATION CENTER		210	ET ADDRESS, CITY, STATE, ZIP CODE D FOXHALL ROAD EWPORT, NC 28570		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 279 SS=D	A facility must use the to develop, review and comprehensive plan. The facility must develop and for each resident objectives and timetal medical, nursing, and needs that are identificated assessment. The care plan must do to be furnished to attaining heat practicable pipsychosocial well-being \$483.25; and any serble required under \$4 due to the resident's \$483.10, including the under \$483.10(b)(4). This REQUIREMENT by: Based on observation interviews, the facility interventions to ensure tubing was not touch residents in a low beinclude: 1. Resident # 28 was diagnoses of urinary annual Minimum Datain 10/20/11, Resident # and incontinent of both and incontinent of	e results of the assessment de revise the resident's of care. elop a comprehensive care that includes measurable bles to meet a resident's mental and psychosocial ied in the comprehensive escribe the services that are ain or maintain the resident's hysical, mental, and ng as required under vices that would otherwise 83.25 but are not provided exercise of rights under e right to refuse treatment is not met as evidenced ons, record review, and staff failed to care plan re a urinary catheter bag and ing the floor for 1 of 1 of 1 of 1 of 1 of 1 of 1	F	279	Croatan Ridge Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quarty of care of residents. The plan of correction is submitted as a written allegation compliance.	ne f t e ali- e	12/29/4
ABOB ĄT ORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE			IIIE		v,

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

If continuation sheet Page 1 of 7

Facility ID: 960414

PRINTED: 12/13/2011 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLEYED	
		345491	B. WN	ıG		12/0	1/2011
	OVIDER OR SUPPLIER	D REHABILITATION CENTER		21	EET ADDRESS, CITY, STATE, ZIP CODE 10 FOXHALL ROAD IEWPORT, NC 28570		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 279	was present. On 11/30/11 at 10: observed in bed. It highest position so sweep under the bit to the lowest positi. On 11/30/11 10:23 observed for a treat Resident # 28's be an intervention to prompleted the treat catheter bag and to floor. An observation marevealed the catheter bag and tubing is some was not on the floor. During an interview Nursing Assistant of the bed frame with the floor. I don't know the bed frame with the bed frame with the bed after houseked bed. Nurse # 1 stated some was not on the floor. I don't know the bed after houseked bed. Nurse # 1 stated some was not on the floor. I don't know the bed after houseked bed. Nurse # 1 stated some was not on the floor. I don't know the bed after houseked bed. Nurse # 1 stated some was not on the floor. I don't know the bed after houseked bed. Nurse # 1 stated some was not on the floor. I don't know the bed after houseked bed. Nurse # 1 stated some was not on the floor. I don't know the bed after houseked bed. Nurse # 1 stated some was not on the floor. I don't know the bed on the bed on the bed on the bed on the floor.	15 AM, Resident # 28 was The bed was raised to the housekeeping staff could ed. The bed was then lowered on by Nurse # 1. AM, Resident # 28 was timent change with Nurse # 1. d was in the lowest position as prevent falls. Nurse # 1 timent and left the room. The ubing were noted lying on the de on 11/30/11 at 11:29 AM ter bag and tubing remained ov on 11/30/11 at 11:37 AM, (NA) # 2 stated, "The catheter supposed to be off the floor. ent # 28) this morning, the bag or. I had clamped it to the end there it would not touch the	F	279	Croatan Ridge Nursing ar Rehabilitation Center's response to this Statement Deficiencies does not detagreement with the Statement of Deficiencies nor does it constitute an admision that any deficiency i accurate. Further, Croata Ridge Nursing and Rehabitation Center reserves the right to refute any of the ficiencies on this Statement of Deficiencies through Informal Dispute Resolution formal appeal procedure and/or any other administive or legal proceeding. F 279 Resident #28 had urinary catheter bag re-adjusted ensure that the bag and ingiding did not touch the floot the DON on 11/30/11. Tintervention was also Care	e- of note e- nis- s an illi- e de- ent n- n, stra- t to tub- or by his	12/29/11
	catheter bag and t				intervention was also Ca	re	

Facility ID: 960414

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPL LDING	LE CONSTRUCTION	(X3) DATE SI COMPLE	
		345491	B. WIN	IG		12/	01/2011
	OVIDER OR SUPPLIER	REHABILITATION CENTER		21	EET ADDRESS, CITY, STATE, ZIP CODE 10 FOXHALL ROAD EWPORT, NC 28570		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 279 F 441 SS=D	A review of Resident 8/1/11 revealed the consules of risk for inferinfections. Care place changing the cathete protocol, emptying the shift, monitoring / recodrainage tubing was device/strap, and monurinary tract infection place to ensure the cokept of the floor where position. During an interview of Director of Nursing (I expectation that Restubing would be off the care plan. "For (Restubing would have to be specially be below the bladder should be on the care 483.65 INFECTION CONTRACTION CO	# 28's urinary care plan of are plan addressed the ction and urinary tract an interventions were: r per physician order and e bag at the end of each ording output, ensuring secured with an anchoring nitoring for symptoms of a . No interventions were in atheter bag and tubing were in the bed was in the lowest on 11/30/11 at 3:36 PM, the DON) stated it was her ident # 28's catheter bag and he floor, and included on the ident # 28) the care plan ecific because the bag should and he's on a low bed. It is plan." CONTROL, PREVENT Ablish and maintain an gram designed to provide a mfortable environment and evelopment and transmission ion. Program ablish an Infection Control		279	Planned in the resident medical record by the DON/MDS nurse on 11/30/11. All other residents in the cility with urinary catheter bags at tubing were not touch floor by the DON on 11/30/11. These reside Care Plans were also reviewed and an interve was added to keep the nary catheter bag and from touching the floot the DON/MDS nurse of 11/30/11.	he fa- eters e that and ing the ents e- ntion e uri- tubing	12/29/11

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345491	B. WING		12/01/2011
	ROVIDER OR SUPPLIER N RIDGE NURSING AND I	REHABILITATION CENTER	21	EET ADDRESS, CITY, STATE, ZIP CODE 0 FOXHALL ROAD EWPORT, NC 28570	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
			F 279	ing staff to keep urinar catheter bags and tubin from touching the floor the DON, completed or 12/21/11. Administration nurses will monitor/aucresidents to include residents to include residents to include residents and tubin are kept from touching floor using a monitoring daily X 1 week, then we 4, then monthly X 3. As istrative nurse will follow on any potential concerupon identification. As view of all residents Camplans with urinary cathet to ensure that intervent to keep the catheter bag tubing from touching flow place by DON/MDS comed on 11/30/11. Care powill be audited on an onling basis to ensure intertions for drainage bags at tubing not touching the are addressed	y ng by n ive dit all sident ers to ing the g tool, ekly X dmin- w up ns e- e ters ion g and or in uplet- lans igo- ven- and
		A. Carlotte			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 12/13/2011 FORM APPROVED OMB NO. 0938-0391

If continuation sheet Page 3 of 7

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO	<u>), 0938-0391 </u>
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		•	B. WI				
		345491	D. 4411	·—		12/0	1/2011
NAME OF PR	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CROATA	N RIDGE NURSING AND	REHABILITATION CENTER		ı	OXHALL ROAD PORT, NC 28570		<u>.</u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
			F	279	The executive QI commit		12/29/11
				-	will meet to review audits identify and address concerns and/or trends and t	-	
					follow up as necessary to		
		•			determine the frequency		
	•				and/or need for continue	đ	
	ŧ				monitoring, weekly X 4, th	nen	
					monthly X 3 then quarter	ly.	
		,			en e	e.	
							-
			- .				
	• •			1			
				ŕ			
		l _e :	L*	,		+	

Facility ID: 960414

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345491	B. WNG	<u></u>	12/0	01/2011
	ROVIDER OR SUPPLIER N RIDGE NURSING AND	REHABILITATION CENTER	21	EET ADDRESS, CITY, STATE, ZIP CODE 0 FOXHALL ROAD EWPORT, NC 28570		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 441	actions related to infection (b) Preventing Spread (1) When the Infection determines that a respreyent the spread of isolate the resident. (2) The facility must promunicable disease from direct contact will trar (3) The facility must rhands after each direct hand washing is indicted professional practice. (c) Linens Personnel must hand transport linens so as infection. This REQUIREMENT by: Based on observation interviews, the facility catheter bag and tubing 1 of 1 residents (Resinclude: 1. On 11/30/11 at 10 observed in bed. The highest position so here	d of Infection In Control Program ident needs isolation to infection, the facility must brothibit employees with a se or infected skin lesions ith residents or their food, if insmit the disease. equire staff to wash their ct resident contact for which sated by accepted le, store, process and to prevent the spread of is not met as evidenced ns, record review, and staff failed to ensure a urinary ing did not touch the floor for ident # 28). Findings 15 AM, Resident # 28 was be bed was raised to the busekeeping staff could The bed was then lowered	F 441	F 441 Resident #28 had urin catheter bag re-adjust ensure that the bag at ing did not touch the the DON, completed of 11/30/11. All other residents in cility with urinary cawere audited to ensurinary catheter bag tubing were not tout floor by the DON co on 11/30/11.	ted to and tub-floor by on the fa-theters ure that is and ching the	12/29/1

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345491	B. WNG		12/01/2011	
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	:	STREET ADDRESS, CITY, STATE, ZIP CODE 210 FOXHALL ROAD NEWPORT, NC 28570		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION	
F 441 F 464 SS=D	On 11/30/11 10:23 A observed for a treatm Resident # 28's bed on Nurse # 1 completed room. The catheter is lying on the floor. An observation made revealed the catheter on the floor. During an interview on Nursing Assistant (Nabag and tubing is sur When I left (Resident was not on the floor. of the bed frame whe floor. I don't know will be to the bed after housekeepided. Nurse # 1 stated she catheter bag and tubing lowered the bed or don't will lowered the bed or don't will lowered the bed or don't seen it there. During an interview on Director of Nursing (Dexpectation that Residubing would be off the even though a low be # 28, the bed should catheter bag and tubic catheter bag and tubic desired in the page 1.	M, Resident # 28 was ent change with Nurse # 1. was in the lowest position. The treatment and left the bag and tubing were noted on 11/30/11 at 11:29 AM bag and tubing remained on 11/30/11 at 11:37 AM, A) # 2 stated, "The catheter posed to be off the floor. # 28) this morning, the bag I had clamped it to the end re it would not touch the no moved it." In 11/30/11 at 11:53 AM, had lowered Resident # 28's ng staff swept under the dishe was not aware the ng was on the floor after she aring the treatment change. would never have left the ng on the floor'if she had In 11/30/11 at 3:36 PM, the DON) stated it was her dent # 28's catheter bag and the floor. The DON stated it was required for Resident be raised enough for the	F 4	ing staff to keep urinary catheter bags and tubin from touching the floor the DON, completed on 12/21/11. Administrative nurses will monitor/auctoresidents to include residents to include residents to include residents and tubin are kept from touching the floor using a monitoring daily X 1 week, then week 4, then monthly X 3. Admistrative nurse will follow on any potential concern upon identification. The executive QI commit will meet to review audit identify and address concerns and/or trends and follow up as necessary to determine the frequency and/or need for continue monitoring, weekly X 4, the monthly X 3 then quarters.	g by /e lit all ident ers to ng the tool, ekly X nin- / up s tee s to d nen	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		345491	B. WING		12/	01/2011
	ROVIDER OR SUPPLIER N RIDGE NURSING AND	REHABILITATION CENTER		REET ADDRESS, CITY, STATE, ZIP CODI 210 FOXHALL ROAD NEWPORT, NC 28570		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 464	Continued From page	• 5	F 464	4		
ļ	These rooms must be ventilated, with nonsm	noking areas identified; be and have sufficient space		F 464	•	12/29/11
	by: Based on observation interview and record recor	eview, the facility failed to appropriate height for 1 of 1		Resident #14 was pro with a table that was priate for residents h while in dining room times by DON on 11,	s appro- height hat meal	124"
	01/02/10 with cumulat Intracerebral Hemorrh Disease, Osteoporosis Dysphagia. The resid recent MDS (minimum as having short and lo and as being impaired	ent was coded on the most n data set) dated 01/05/11 ong term memory problems t in the decision making the resident was coded as		All residents were reto ensure that table(sappropriate for all reto No other issues/concurred by DON/administrative 11/29/11.	s) was esidents. cerns	
	lunch meal sitting at ta Resident #14 was sitting chin was observed to latop. Resident #14 was green peas on her fork mouth some of the pea- sitting with another res	erved on 11/29/11 at the able with other residents. ng in her wheel chair. Her be at a level with the table is observed to put some and as she lifted it to her as fell off. A staff member sident suggested that spoon. When the resident				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345491	B. WNG_		12/01/2011
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		REET ADDRESS, CITY, STATE, ZIP CODE 210 FOXHALL ROAD NEWPORT, NC 28570	, ,20112011
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION
F 464	get it away from the to her mouth to eat the observed to reach for and she had to lift the and then bring it near taking a sip of the teat taking an interview with 11/29/11 at 12:50 PM seems to be to short for the table her. We used to have (dining room). I don't buring an interview with the company of the table her.	nad to raise the spoon up to able and then bring it down he peas. Resident #14 was the glass with the tea in it e glass up with both hands to her lap (lower) before a. With nurse aide #1 on the it was revealed " she an over bed table in here the know where it went."	F 46	Table was placed in dining room for resident(s) use to include resident #14 to en sure that resident has a tathat is height appropriate use during mealtimes. Placement of this table we remain in the dining room and appropriate table heifor all residents to include resident #14 will be monitored by the DON/administrative staff daily utilizing a QI tool.	o lulur lu
	on 12/01/11 at 12:15 table is too high for he table in there. " The facility failied to e table was at an appro	with the Director of Nursing PM it was revealed " the er, we used to have a lower ensure that a dining room priate height for a resident. The ethat a resident had a mealtime.		The executive QI commodified will meet to review auditentify and address of cerns and/or trends at follow up as necessary determine the frequent and/or need for continuous monitoring, weekly X monthly X 3 and then terly.	idits to on- nd to y to ncy nued 4, then

		AND HUMAN SERVICES				JAPPROVEJ . 0938-039
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	ILTIPLE CONSTRUCTION DING 01 - MAIN BUILDING 01	(X3) DATE S	
		345491	B. WING	·	CONSTRUC 12/1	5/2011
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER	*	STREET ADDRESS, CITY, STATE, ZIF 210 FOXHALL ROAD NEWPORT, NC 28570		· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(FACH 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 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X6) COMPLETION DATE
Building construct of the following. 19.3.5.1 This STANDARD 42 CFR 483.70(By observation on the following non-compliant, swere penetration that does not merating, near room NFPA 101 LIFE SEED.		FETY CODE STANDARD	K 0°	Croatan Ridge Nurs Rehabilitation Cent acknowledges rece Statement of Defic and proposes this correction to the e findings is factually and in order to ma compliance with a	er lipt of the lencies plan of xtent of correct intain pplicable as of	1/29/12
A				The plan of correct submitted as a wrallegation of comp	tion is itten	(X6) DATE
BORATOR	Y DIRECTOR'S OR PROVI	DERVSUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE	30.11	(X6) DATE
Llun	y Sproul	Annuntraten an asterisk (*) denotes a deficiency while			30-11	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

1 PRINTED (12/19/2014)

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDING	E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SI COMPLE	
	•	345491	B. WING		12/1	5/2011
		AND REHABILITATION CENTER	210 NE	ET ADDRESS, CITY, STATE, ZIP CODE D FOXHALL ROAD WPORT, NC 28570 PROVIDER'S PLAN OF CORREC	etion.	(35)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X6) COMPLETIO DATE
K 052 SS=F	This STANDARD 42 CFR 483.70(a) By observation on noon the following non-compliant, spe clean utility room, i and latch tightly in NFPA 101 LIFE SA A fire alarm system installed, tested, an with NFPA 70 Nati 72. The system ha and testing program	is not met as evidenced by: 12/15/11 at approximately corridor door was beific findings include; door to be near room 400, did not close	K 018	Croatan Ridge Nursing a Rehabilitation Center's response to this Statem of Deficiencies does not denote agreement with Statement of Deficienci nor does it constitute at admission that any deficiency is accurate. Further, Croatan Ridge Nursing and Rehabilitat Center reserves the right refute any of the deficient on this Statement of Deficiencies through Informal Dispute Resolution formal appeal procedur and/or any other administrative or legal proceeding.	ent the es ion at to encies	1/291
	42 CFR 483.70(a) By observation on noon, during the in facility fire alarm sy multiple componer component, when line failure, located not send a trouble annunciator next to	is not met as evidenced by: 12/15/11 at approximately spection and testing of the vetem, that consisted of the automatic dialer placed in trouble from phone in the mechanical room, did signal to the remote the main fire alarm control e nurses station. The		K 012 On 12/15/2011 Mainte Director caulked around identified ceiling attic accesses, #6 and #7 accesses, #6 and #7 accessed that did not meet the required fire resistance rating, using fire retard caulking (3M) fire barries sealant with 4 hour rations.	d esses dant er	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION 6 01 - MAIN BUILDING 01	(X3) DATE S COMPL	BURVEY ETED
		345491	B. WING		12/	15/2011
	PROVIDER OR SUPPLIER	AND REHABILITATION CENTER	21	EET ADDRESS, CITY, STATE, ZIP CODE 0 FOXHALL ROAD EWPORT, NC 28570		
(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 CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
K 052 K 062 SS≃F	mechanical room, component was lot signal, however, the the main fire alarm nurses station, should be main communication. There was not a visual communication. The sequired automatic continuously maint	where the automatic dialer cated, gave an audible trouble e remote annunciator next to control panel, located at the wed no power to the unit. sual and audible signal at the ons area. AFETY CODE STANDARD c sprinkler systems are ained in reliable operating	K 052	All other ceiling attic accesses in facility wer checked by the mainte director to assure the required fire resistance rating was met. On 12/30/2011 Hillco, will inspect and make additional corrections,	enance e Inc.	1/291.
K 067 SS≔E	periodically. 19.7 25, 9.7.5 This STANDARD 42 CFR 483.70(a) By observation and approximately noor was non-compliant there was a gallon documentation fror "system needs flus states "check to se indicate that the sy system shall be proaccordance with Nanspection, Testing water-based fire properties. Heating, ventilating with the provisions in accordance with	FETY CODE STANDARD , and air conditioning comply of section 9.2 and are installed	K 067	necessary, to #6 and # ceiling attic access to a compliance. All other attic accesses in facility be inspected and corremade, if necessary, to fire resistance rating. Maintenance Director audit all ceiling attic ac in facility utilizing a QI monitoring tool weekl weeks and then month months to assure ceiling accesses remain within fire resistance rating.	7 issure ceiling y will ections meet will ccesses y x 4 nly x 3 ng attic	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	345491		A. BUILDIN B. WING	G 01 - MAIN BUILDING 01	12/15/2011	
	PROVIDER OR SUPPLIER AN RIDGE NURSING A	AND REHABILITATION CENTER	2.	EET ADDRESS, CITY, STATE, ZIP CODE 10 FOXHALL ROAD EWPORT, NC 28570		
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCEO TO THE AF DEFICIENCY)	HOULD BE COMPLETION	
K 067	42 CFR 483.70(a) By observation on 1 noon the following I conditioning (HVAC specific findings inc 401 and the adjace during the survey. If the unit was tied is down upon fire alar	s not met as evidenced by: 12/15/11 at approximately neating, ventilating, and air 2) system was non-compliant, lude; unit #7 that feeds room not corridor was not functioning to could also not be concluded not the fire alarm for shut activation.	K 067	The executive QI commodile will meet to review audentify and address concerns and/or trend to determine the frequency and/or need for conting monitoring, weekly x 4 weeks, then monthly a months. K 018 On 12/16/2011 maintent director adjusted the door jam hinges and door later door found by surveyor the did not close and latch time its frame, near room 4 to meet compliance. Maintenance Director the inspected and corrected other doors in the facility assure door jam hinges a door latches are function correctly and in compliant with Life Safety Code Standards.	dits to	

PRINTED: 12/19/2011 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BU	LDING	E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE S COMPL	SURVEY ETED
345491			B. VVII	,		12/	15/2011
,	PROVIDER OR SUPPLIER AN RIDGE NURSING	AND REHABILITATION CENTER		210	T ADDRESS, CITY, STATE, ZIP CODE FOXHALL ROAD NPORT, NC 28570		,
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETI DATE
	Building construction of the following. 18 19.3.5.1 This STANDARD If 42 CFR 483.70(a) By observation on noon the following non-compliant, spewere penetrations at that does not meet rating, near room 4 NFPA 101 LIFE SAD Doors protecting corequired enclosures hazardous areas ar those constructed of wood, or capable of minutes. Doors in sequired to resist the no impediment to the are provided with a the door closed. Duare permitted. 19	12/15/11 at approximately building construction type was cific findings include; there around the ceiling attic access the required fire resistance 00. FETY CODE STANDARD In the control openings in other than a control openings in other than a control openings, exits, or the substantial doors, such as in 1% inch solid-bonded core in resisting fire for at least 20 sprinklered buildings are only the passage of smoke. There is the closing of the doors. Doors means suitable for keeping attendoors meeting 19.3.6.3.6.3. Tohibited by CMS regulations illities.			On 12/30/2011 Hillco, Incinspected and made additional corrections to door Jam hinges and door latches found not to be in compliance with the Life Safety Code Standard. Maintenance Director will audit all door Jam hinges door latches utilizing a QI monitoring tool weekly x weeks and then monthly months to assure door Jahinges and door latches a functioning correctly as p Life Safety Code Standard. The executive QI committed will meet to review audits identity and address concerns and/or trends a to determine the frequent and/or need for continue monitoring, weekly x 4 weeks and then monthly months.	r n ll and 4 x 3 m er l. tee s to nd ccy d	Ibali2

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 09EU21

Facility ID: 980414

If continuation sheet Page 4-of-4-

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345491		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0 B. WING		3 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED 12/15/2011	
	PROVIDER OR SUPPLIER AN RIDGE NURSING	AND REHABILITATION CENTER		21	EET ADDRESS, CITY, STATE, ZIP CODE 0 FOXHALL ROAD EWPORT, NC 28570		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	XIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	COMPLETION DATE
K 052 SS=F	This STANDARD I 42 CFR 483.70(a) By observation on noon the following of non-compliant, spec clean utility room, n and latch tightly in it NFPA 101 LIFE SA A fire alarm system installed, tested, an with NFPA 70 Natio 72. The system has and testing program	s not met as evidenced by: 2/15/11 at approximately corridor door was cific findings include; door to ear room 400, did not close	_		K 052 On 12/15/2011 Hillco, Inc. was notified that during the Life Safety Inspection and testing of the facility fire alarm system that consisted of multiple components was not functioning as it should have. On 12/22/2011 Charles Taylor Electric replaced battery system and new annuccuator board to correct the malfunction of the fire alarm system. He then tested fire alarm system to assure it was functioning properly. Maintenance Director will		Sadir
	This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 12/15/11 at approximately noon, during the inspection and testing of the facility fire alarm system, that consisted of multiple components, the automatic dialer component, when placed in trouble from phone line failure, located in the mechanical room, did not send a trouble signal to the remote annunciator next to the main fire alarm control panel located at the nurses station. The				assure functioning prodaily x 2 weeks, then weeks and then mox 3 months to assure final alarm system function properly to meet the Leafety Code Standard.	veekly onthly ire ing ife	

PRINTED: 12/19/2011 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 01 B. WING 345491 . - :-12/15/2011 NAME OF PROVIDER OR SUPPLIER . STREET ADDRESS, CITY, STATE, ZIP CODE 210 FOXHALL ROAD CROATAN RIDGE NURSING AND REHABILITATION CENTER NEWPORT, NC 28570 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION -(X6) COMPLETION DATE ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) K 052 | Continued From page 2 The executive QI committee mechanical room, where the automatic dialer will meet to review audits to component was located, gave an audible trouble Identify and address signal, however, the remote annunciator next to the main fire alarm control panel, located at the concerns and/or trends and nurses station, showed no power to the unit. to follow up as necessary to There was not a visual and audible signal at the determine the frequency main communications area. NFPA 101 LIFE SAFETY CODE STANDARD K 062 and/or need for continued SS=F monitoring, weekly x 4 Required automatic sprinkler systems are weeks and then monthly x 3 continuously maintained in reliable operating months. condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9, 7, 5 K 062 On 12/15/2011 Hillco Inc. This STANDARD is not met as evidenced by: was notified records did not 42 CFR 483,70(a) indicate the automatic By observation and documentation on 12/15/11 at approximately noon the following sprinkler system sprinkler system had been was non-compliant, specific findings include; there was a gallon of sediment from 1/09, inspected and tested as documentation from 10/10 indicated that the required by Life Safety Code "system needs flush", documentation from 7/11 states "check to see if flushed". Records did not Standard. indicate that the system had been flushed. The system shall be properly maintained in On 12/20/11 Sunland Fire accordance with NFPA 25, Standard for the Protection was here to inspection, Testing, and Maintenance of inspect and test automatic water-based fire protection systems. K 067 NFPA 101 LIFE SAFETY CODE STANDARD sprinkler system. Report of SS≍E inspection was obtained. Heating, ventilating, and air conditioning comply Sunland Fire Protection, Inc. with the provisions of section 9.2 and are installed in accordance with the manufacturer's will be here week of 1/2/12 19.5.2.1, 9.2, NFPA 90A. specifications. to correct findings. 19,5.2.2 Corrections will be FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 09EU21 Facility eet Page 3-of-4 completed by 1/17/2011.

Farding 20:

7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345491		A. BU	LDIN	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE COMP		
	PROVIDER OR SUPPLIER	:	2	REET ADDRESS, CITY, STATE, ZIP CODE 10 FOXHALL ROAD IEWPORT, NC 28570			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR: (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X6) COMPLETION DATE	
K 067	Continued From page 3 This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 12/15/11 at approximately noon the following heating, ventilating, and air conditioning (HVAC) system was non-compliant, specific findings include; unit #7 that feeds room 401 and the adjacent corridor was not functioning during the survey. It could also not be concluded if the unit was tied into the fire alarm for shut down upon fire alarm activation.			Record obtained from Advanced Fire Design to confirm automatic sprinkler system has been flushed within the last five years. The system was flushed on 1/30/2009. Sunland Fire Protection will notify the Administrator or Maintenance Director when they are in the building to test sprinkler system. They will leave inspection report with the Administrator or Maintenance Director.		1/29/12	
	A CONTROL OF THE CONT			Maintenance Director we keep a log of the sprinkle inspections to assure automatic sprinkler system inspected quarterly and annually. The Administrator will monitor to assure inspections and testing completed timely.	er em is		

PRINTED; 12/19/2011 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVI	
		345491	B. WING		12/15/20	011
	PROVIDER OR SUPPLIER AN RIDGE NURSING A	ND REHABILITATION CENTER		REET ADDRESS, CITY, STATE, ZIP CODE 210 FOXHALL ROAD NEWPORT, NC 28570		<u> </u>
(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 SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE CO	(X5) MPLETION DATE
K 012 SS=D		FETY CODE STANDARD n type and helght meets one		<u>K 067</u>	1/2	29/12
		1.6.2, 19.1.6.3, 19.1.6.4,		On 12/15/2011 it was note	d	
	10.0.0.1	2:		the Life Safety Inspector		
		·		could not confirm the #7 u	1	
				was tied into the fire alarm		
j	This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 12/15/11 at approximately noon the following building construction type was non-compliant, specific findings include; there were penetrations around the ceiling attic access			system for shut down upor	1	
				fire alarm activation.		
				On 12/15/2011 Hillco Inc.		
				was notified of findings of f	17	
	that does not meet th	ne required fire resistance		unit, Maintenance Directo	l l	
K 018	rating, near room 40	0. ETY CODE STANDARD	d TD	will then check all units in		
SS=D	NEPA TOT LIFE SAF	ETY CODE STANDARD		facility to assure they are		
		ridor openings in other than		tied into the fire alarm		
1		of vertical openings, exits, or substantial doors, such as		system for shut down upon	1	
	those constructed of	1% inch solid-bonded core resisting fire for at least 20		fire alarm activation.		
	minutes. Doors in sp	ites. Doors in sprinklered buildings are only ired to resist the passage of smoke. There is		On 12/30/2011 Elite		
	no impediment to the closing of the doors. Doors			Mechancal was here to		İ
		neans sultable for keeping ch doors meeting 19.3.6.3.6		inspect unit #7 to assure it		
	are permitted. 19.3			was functioning properly.		
	•	Ellette d less OMO es avulette es		Charles Taylor Electric	-	
	Roller latenes are pro in all health care facil	hibited by CMS regulations lities.		inspected unit # 7, as well a	ıs,	
				all units in facility to assure		
				they are tied into the fire	[
				alarm system for shutdown		Ī
				upon fire alarm activation.		
HORATON	NIDWOTONIO CHI ETC.			and and an		
BORA FORY I	DIRECTOR'S OR PROVIDER	VSUPPLIER REPRESENTATIVE'S SIGNA	TURF	TITLE	(X6) DA	TE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

OCITIC	TO FOLLING DIOLINE	S MICDICAID SCRVICES				OMD M	<u>, บรุงด-บงช</u>
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IULTIPLE (LDING	CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE (COMPL	BURVEY ETED
	•	345491	8. WI	IG		12/	15/2011
	PROVIDER OR SUPPLIER AN RIDGE NURSING	AND REHABILITATION CENTER		210 FC	ADDRESS, CITY, STATE, ZIP CODE DXHALL ROAD PORT, NC 28570	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	· ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X6) COMPLETION DATE
K 018	This STANDARD is 42 CFR 483.70(a) By observation on 1 noon the following on non-compliant, speciean utility room, nand latch tightly in it NFPA 101 LIFE SA A fire alarm system installed, tested, and with NFPA 70 Natio 72. The system has	s not met as evidenced by: 2/15/11 at approximately corridor door was cific findings include; door to ear room 400, did not close is frame. FETY CODE STANDARD required for life safety is a maintained in accordance nal Electrical Code and NFPA an approved maintenance complying with applicable					1/29/1°
	42 CFR 483.70(a) By observation on 12 noon, during the inspfacility fire alarm systmultiple components component, when pkilne fallure, located in not send a trouble signal.	not met as evidenced by: 2/15/11 at approximately section and testing of the tem, that consisted of , the automatic dialer aced in trouble from phone in the mechanical room, did gnal to the remote the main fire alarm control					