DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: AUG 2 9 2012 AUG B. WNG 345072 07/26/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 📐 1839 ONSLOW DR EXTENSION 🕪 🗸 CAROLINA RIVERS NURSING AND REHABILITATION CENTER JACKSONVILLE, NC 28540 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) 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 483.10(e), 483.75(l)(4) PERSONAL F 164 Carolina Rivers Nursing and PRIVACY/CONFIDENTIALITY OF RECORDS SS=D Rehabilitation Center acknowledges receipt of the The resident has the right to personal privacy and confidentiality of his or her personal and clinical Statement of Deficiencies and records. proposes this plan of correction to the extent that the summary of Personal privacy includes accommodations, findings is factually correct and in medical treatment, written and telephone order to maintain compliance with communications, personal care, visits, and meetings of family and resident groups, but this applicable rules and provision of does not require the facility to provide a private quality care of the residents. The room for each resident. plan of correction is submitted as written allegation of compliance. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the Carolina Rivers Nursing and release of personal and clinical records to any Rehabilitation Center's response to individual outside the facility. the Statement of Deficiencies and Plan of Correction does not denote The resident's right to refuse release of personal agreement with the Statement of and clinical records does not apply when the resident is transferred to another health care Deficiencies and the Plan of institution; or record release is required by law. Correction nor does it constitute an admission that any deficiency is The facility must keep confidential all information accurate. Further, Carolina Rivers contained in the resident's records, regardless of Nursing and Rehabilitation Center the form or storage methods, except when release is required by transfer to another reserves the right to submit healthcare institution; law; third party payment documentation to refute any of the contract; or the resident. stated deficiencies on this Statement of Deficiencies through This REQUIREMENT is not met as evidenced informal dispute resolution, formal appeal procedure and/or any other Based oin observation and staff interview, the administrative or legal proceeding. facility failed to provide privacy of personal information of 2 of 13 residents (resident #41 and resident #24) during medication administration.

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.

MANA

(X6) DATE

If continuation sheet Page 1

F164

TITLE

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

CENTER	ASPOR MEDICARE &	MEDICAID SERVICES			OMB_NO. 0938-039	11
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION .	(X3) DATE SURVEY COMPLETED		
		0.45070	B. WNG_		С	
		345072			07/26/2012	
	ROVIDER OR SUPPLIER I A RIVERS NURSING ANI	PREHABILITATION CENTER		REET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DR EXTENSION JACKSONVILLE, NC 28540		
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPROPRIEM (EACH CORRECTION COR	OULD BE COMPLETION	
	2/3/2004 with cumular airway obstruction, fra peripheral vascular didementia, and cerebrate dementia, and cerebrate demential	dmitted to the facility on ive diagnosis of chronic acture and repair to left hip, sease, hypertension, reflux, al vascular accident. 1 Minimum Data Set (MDS) acterly assessment indicated term and long term and long term and severe impaired y decision making. 1 A severe impaired a decision making. 2 A severe impaired a decision making. 3 A severe impaired a decision making. 3 A severe impaired a de	F 164	a. The Medication Administration Record (Medication	were f e. and rained as of cation or Rs times to conal y with d the e for	
-	been left open with per to anyone for a total of	sonal information exposed 5 minutes. The nurse #1 tion cart at 4:08 pm and		identification of trends ar follow up as deemed nece and to determine the freq and/or need for continued	essary uency	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERSFOR MEDICARE & MEDICAID SERVICES

PRINTED; 08/07/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345072				C 07/26/2012
NAME OF PROVIDER OR SUPPLIER CAROLINA RIVERS NURSING AND REHABILITATION CENTER			s	TREET ADDRESS, CITY, STATE, ZIP COL 1839 ONSLOW DR EXTENSION JACKSONVILLE, NC 28540	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 164	Continued From pa	age 2	F 16	34	8120/12
	#2 indicated all numake sure the MA they had walked as protect the residen On 7/26/2012 at 9: Administrator revelobat all nurses cove when they had walcart. The Administrator indicates to the facility that conformation being wadministrator indicateviewed annually randomly. The Administrator agrincleding the MAR	40 am an interview with nurse reses had been instructed to R is covered or closed when way from the medication cart to t personal information. 13 am an interview with the aled her expectation had been er the MAR or keep it closed ked away from the mediation ator indicated all nurses had osure agreement on orientation overed release of resident written or verbal. The ated the discloser was and during medication audits aninistrator indicated the element covered topics being covered during a stration to protect the resident in.			
	Director of Nursing expectation that nut the MAR to protect from being expose that the nurses had orientation to the faudits periodically opersonal information. On 7/26/2012 at 9:3 Staffing Coordinate nurses that any informats revolving a re-	19 am in interview with the (DON) indicated her rese had covered or closed resident personal information of to others. The DON indicted been instructed during cility and during medication on protection of resident n. 23 am and interview with the r indicated that she had taught formation on the medication sident personal information covered when the nurse had			

M

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTER SFOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/07/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
	345072		B. WING				C 07/26/2012		
NAME OF PROVIDER OR SUPPLIER CAROLINARIVERS NURSING AND REHABILITATION CENTER				1839	TADDRESS, CITY, STATE, ZIP CO ONSLOW DR EXTENSION KSONVILLE, NC 28540	DE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIED CORRECTIVE ACTION SHOULD PROVIDER'S PLAN OF CORRECTIVE PROVIDER'S		ILD BE	(X5) COMPLETION DATE					
	coordinator indicated with the nurses during when she had done in periodically. 2. Resident #24 was 6/4/2012 with cumula convulsions, depressipersistent mental disconvulsions, depressipersistent mental disconvulsions and long term in severely impaired cog decision making. On 7/24/2012 at 4:12 #1 revealed she had smedication for resider from the medication cand exposed to other walk down the hall turn phone call at 4:13 pm During the time away housekeeper had wal. On 7/26/2012 at 8:40 #2 indicated all nurses make sure the MAR is	e medication cart. The she covered this information g orientation, annually, and nedication audits admitted to the facility on tive diagnosis of on, heart disease, reflux, order, and hypertension. 4 Minimum Data Set (MDS) ated resident #24 had short emory problems and initive skills for daily pm an observation of Nurse started to prepare at #24 and walked away art and left the MAR open is. She was observed to in the corner and answer a and returned at 4:15 pm. from the medication cart a ked by the exposed MAR.	F	164				470/12	
	Administrator revealed	am an interview with the I her expectation had been ne MAR or keep it closed							



DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/07/2012 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l' '		LE CONSTRUCTION	(X3) DATE S	
, and i CARO		.5	A. BUIL	A. BUILDING			С
		345072	B. WING	3			//26/2012
NAME OF PR	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
CAROLIM	ARIVERS NURSING AN	REHABILITATION CENTER			839 ONSLOW DR EXTENSION		
				J	ACKSONVILLE, NC 28540		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	•	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 164	Continued From page	2.7	F	164	F431		8/20/12
	,	d away from the mediation	•		a. The seven expired gre	en ton	, j
		or indicated all nurses had					
		re agreement on orientation			vacutainer tubes were		
		ered release of resident			discarded at the time	OT .	
	information being writ				discovery.		
	administrator indicate				b. All other vacutainer t	ubes were	
		d during medication audits			checked; no other exp	oired -	
	randomly. The Admin				tubes were noted.		
	non-disclosure agree			'	c. Licensed staff will be	retrained	
	including the MAR be				by the Staff Develop		
	,	ation to protect the resident			Coordinator or design		
	personal information.						
	On 7/26/2012 of 0:10	am in interview with the		'	08/20/2012 to check		
	Director of Nursing (D				expiration date of vac		
		es had covered or closed			tubes prior to use. Th		
	the MAR to protect re	sident personal information			shift Team Leader ha	s been	
	from being exposed to	o others. The DON indicted	-		retrained to check va-	cutainers	
	that the nurses had b				weekly for four week		
		ity and during medication			monthly to discard ex		
		protection of resident			}	xpireu	
	personal information.	•			items.	·1	
	A =10010010	and the analysis of the			d. The day shift Team I	Leader or	
• :		am and interview with the		:	designee will check		
		ndicated that she had taught nation on the medication			vacutainers weekly f		-
•		dent personal information			weeks, then monthly	, with	
	should have been co	vered when the nurse had		:	corrective action take		
		medication cart. The			indicated. The result		
	coordinator indicated	she covered this information		•	documented and revi		
		g orientation, annually, and			weekly for four weel		
	when she had done n				Resident Care Comm	-	
	periodically.			٠			
F 431	483.60(b), (d), (e) DR		F	431	1		\
SS=D	LABELISTORE DRUG	GS & BIOLOGICALS			follow up as deemed		
		to a ship the southern of		-	and to determine the	frequency	
	The facility must emp	loy or obtain the services of			and/or need for cont	inued	
	a licensed pharmacis	t who establishes a system			monitoring.		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERSFOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/07/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
	~	345072	B. WNG	3	C 07/26/2012
NAME OF PROJUDER OR SUPPLIER CAROLINARIVERS NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1839 ONSLOW DR EXTENSION JACKSONVILLE, NC 28540	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 431	Continued From pa	ge 5	F4	31	820112
·	controlled drugs in	t and disposition of all sufficient detail to enable an ion; and determines that drug	. :		
	records are in order	and that an account of all naintained and periodically			
	labeled in accordan professional princip appropriate accesso		A STATE OF THE STA		
	facility must store al locked compartmen	State and Federal laws, the I drugs and biologicals in is under proper temperature only authorized personnel to keys.			
	permanently affixed controlled drugs liste Comprehensive Dru Control Act of 1976 abuse, except when package drug distrib	vide separately locked, compartments for storage of ed in Schedule II of the g Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can			
	by: Based on observati facility failed to ensu items in 1of 4 storag	T is not met as evidenced on and staff interview, the re that there were no expired e areas (the office behind station.). The findings			



DEPART MENT OF HEALTH AND HUMAN SERVICES
CENTER SFOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/07/2012 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE S	(X3) DATE SURVEY COMPLETED		
345072			B. WING		07	C //26/2012	
	ROVIDER OR SUPPLIER ARIVERS NURSING AN	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 1839 ONSLOW DR EXTENSION JACKSONVILLE, NC 28540		12012012	
(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 ACTI CROSS-REFERENCED TO T DEFICIENCE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 431	Continued From page include: During an observation	on 07/25/12 at 3:45 PM of	F 43	31		BR0/12	
·	station, 7 green top va to obtain blood specin have and expiration d						
	07/25/12 at 3:50 PM it check the supply when The tubes are obtaine whenever we need to	th the Nurse Facilitator on was revealed "I would never I would draw blood. d from the Lab that we use add to the supply. I am the ation dates. These are ot be here."					
		•	·				
-							



PRINTED: 08/23/2012

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO, 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 01 "MAIN BUILDING 01 A BUILDING B, WING 08/23/2012 345072 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1839 ONSLOW DR EXTENSION CAROLINA RIVERS NURSING AND REHABILITATION CENTER JACKSONVILLE, NC 28540 PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPRIOPRIATE (XLI) COMPLETION DAYE SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) 10/07/2012 by the 11/1/12 K 000 administrator. K 000 INITIAL COMMENTS Facility Maintenance Staff This Life Safety Code(LSC) survey was will check corridor doors conducted as per The Gods of Federal Register. to include the corridor door at 42CFR 483.70(a); using the Existing Health to the oxygen storage room Care section of the LSC and its referenced publications. This building is Type V construction, and soiled utility room on one story, with a complete automatic sprinkler 600 hall weekly for four weeks then monthly for system. four months to ensure the The deficiencies determined during the survey corridor doors close with are as follows: NEPA 101 LIFE SAFETY CODE STANDARD K 029 latch and seal. The K 029 maintenance supervisor or SS≃D One hour fire rated construction (with 1/4 hour designee will also monitor fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 the fire damper to ensure it and/or 19.3.5.4 protects hazardous areas. When is in appropriate repair the approved automatic fire extinguishing system monthly with fire drill. option is used, the areas are separated from These findings will be other spaces by smoke resisting partitions and reviewed in the Safety doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed Committee meeting 48 inches from the bottom of the door are monthly for three months 19,3,2,1 permitted. and follow up as deemed necessary and to determine the frequency and/or need for continued monitoring. This STANDARD is not met as evidenced by: Based on observation on Thursday 8/23/12 at approximately 11:00 AM the following was noted. K061 1) The corridor door to the solled utility room on The line in question has 600 hall was not self closing. been determined to be a water line per Sunland Fire 42 CFR 483.70(a) K 061 NFPA 101 LIFE SAFETY CODE STANDARD K 061 Protection not a sprinkler line. No repair necessary. SS⇔D Required automatic sprinkler systems have (X6) DATE LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TILE

Any deficiency statement anding with an asteriak 0) 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 numing homes, the findings stated above are discloseble 90 days other safeguards provide sufficient protection to the patients. (See instructions.) Except for numing homes, the shawe findings and plans of correction are discloseble 14 following the date of survey whether or not a plan of correction is provided. For numing homes, the above findings and plans of correction are discloseble 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES EDICARE & MEDICAID SERVICES

PRINTED: 08/23/2012 FORM APPROVED OMB NO. 0938-0391

CATCHEAN	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIENCUA (DENTIFICATION NUMBER:	(X2) MI A. BUIL		E CONSTRU 01 - MA	IN BUILDING 01	COMPLET	
		345072	B. WIN				08/23	/2012
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		183	CKSONVII	, city, state, zip code dr extension LE, NC 28540	<u>:</u>	
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×		OVIDER'S PLAN OF CORRECTIVE ACTION SHO I CORRECTIVE ACTION SHO REFERENCED TO THE APPR DEFICIENCY)	11 II II RF 1	(XG) COMPLETION DATE
K 061	valves supervised will sound when the 72, 9,7:2.1 This STANDARD Based on observe approximately 11: 1) The is a valve sprinkler system of 600 hall that was 42 CFR 483.70(a) NFPA 101 LIFE Semoking regulation less than the following that the following t	is not met as evidenced by: ation on Thursday 8/23/12 at 00 AM the following was noted, on the branch line for the dry off of the main line in the attic on not electronically supervised. AFETY CODE STANDARD ons are adopted and include no wing provisions: ohibited in any room, ward, or ore flammable liquids, s, or oxygen is used or stored nazardous location, and such th signs that read NO SMOKING ational symbol for no smoking. attents classified as not ohibited, except when under the combustible material and safe ted in all areas where smoking is	K	066	b	A metal container of self-closing cover la placed in the appropriate of the maintenance staff. All approved smoking areas have inspected metal containers we closing cover has been retrained as indicated 10/07/2012 by the maintenance staff. Facility maintenance staff. Facility maintenance have been retrained regarding need for containers with secover devised into a shtrays can be enteredily available to a proved smoking the administrator 10/07/2012. The facility maintenance staff approved smoking areas we four weeks then rewith rounds to entered with the summer staff.	nas been lived f facility facility facility fing ed with lith self- been li as of facility fa	10/12
	(4) Metal contain devices into which	ers with self-closing cover- h ashtrays can be emptied are				metal containers closing covers at	with self-	

PRINTED: 08/23/2012 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION 01 -MAIN BUILDING 01 IDENTIFICATION NUMBER: A. BUILDING 08/23/2012 B, WING 345072 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1838 ONSLOW OR EXTENSION CAROLINA RIVERS NURSING AND REHABILITATION CENTER JACKSON/ILLE, NC 28540 FROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) DEFICIENCY) TAG maintained in approved K 066 smoking areas as indicated. Continued From page 2 K 066 readily available to all areas where smoking is These findings will be permitted. 19.7.4 reviewed in the Safety Committee meeting monthly for three months and follow up as deemed necessary and to determine This STANDARD is not met as evidenced by; the frequency and/or need Based on observation on Thursday 8/23/12 at approximately 11:00 AM the following was noted. for continued monitoring. 1) A metal container with a self-closing cover life which ashtrays can be emptied in the smoking area per paragraph 4 above was not provided. K067 The high and low level 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD K 067 combustion air inlet behind K 067 the dryer will be inspected SS≈D Heating, ventilating, and air conditioning comply and repaired by an outside with the provisions of section 9.2 and are agency as indicated as of installed in accordance with the manufacturer's 19.5.2.1, 9.2, NFPA 90A, specifications. 10/07/2012. 19.5.2.2 The high and low level combustion air inlet behind the dryer will be inspected and repaired by an outside This STANDARD is not met as evidenced by: agency as indicated as of Based on observation on Thursday 8/23/12 at approximately 11:00 AM the following was noted. 10/07/2012. 1) The high level combustion air inlet behind the c. Facility maintenance staff dryer was being used as an exhaust vent and the will be retrained to inspect lower level was not maintained clean and good the high and low level condition. combustion air inlets for proper working condition 42 CFR 483,70(a) NFPA 101 LIFE SAFETY CODE STANDARD K 144 with routine rounds by the K 144 administrator as of SS≃F Generators are inspected weekly and exercised

FORM CMS-2567(02-99) Provious Versions Obsoble

Event ID: UMV821

Facility 10: 923029 10/07/2012.

If continuation sheat Page 3 of 4



9104550325

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 08/23/2012 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	(X2) M	ULTIPL	E CONSTRUCTION	(X3) DATE SU COMPLE	RVEY TED
	of deficiencies PCORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUI	FDING	01 - MAIN BUILDING 01	Ì	
		345072	B, Wit		STAYE ZIP CO		3/2012
NAME OF PI		AND REHABILITATION CENTER		183	ET ADDRESS, CITY, STATE, ZIP CO 9 ONSLOW DR EXTENSION CKSONTILLE, NC 28540 FROVIDER'S PLAN OF CO	DERECTION	COMPLETION
(X4) ID PREFIX TAG		NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION)	PREF	XX	(FACH CORRECTIVE ACTIO (FACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	EAPPROPRIATE	DAYE
K 144	This STANDARD Based on observ approximately 11:	is not met as evidenced by: atton on Thursday 8/23/12 at 00 AM the following was noted he emergency generator the idd not function when the led from normal to emergency.		144	d. The high and lead to combustion air inspected week weeks the more three months to maintenance seem in the maintained in good condition made as indicating will be in the Safety of meeting months and for deemed necessed determine the and/or need for monitoring.	rinlet will be kly for four othly for you the facility upervisor or sure it is clean and n with repairs ated. These we reviewed Committee hly for three cllow up as sary and to frequency	
					a. The transfer s emergency ge be serviced by agency by 10, repairs made b. The generator inspected by	nerator will y an outside /07/2012 with as indicated. will be	

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

Event ID: UMV821

Fectivy ID: 92:1029

If continuellon shoot Page 4 of 4



10/7/12

with adjustments made accordingly.

- c. Facility Maintenance staff will be retrained by the administrator as of 10/07/2012 on requirements for emergency transfer of power for the generator.
- d. Facility maintenance supervisor or designee will check the generator weekly for four weeks to ensure emergency transfer of power occurs within 10sec of loss of power, then monthly thereafter. These findings will be reviewed in the Safety Committee meeting monthly for three months and follow up as deemed necessary and to determine the frequency and/or need for continued monitoring.



9104550325

DEPART	MENT OF HEALTH	AND HUMAN SERVICES		•	DEGETVEN	FORM	08/23/2012 APPROVED 0938-0391
CENTER	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES . (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MUI	LTIPLI DING	construction 0 2012	(X3) DATE S COMPL	URVEY
		345072	B. WING		COMSTRUCTION SETTION	08/2	23/2012
	ROVIDER OR SUPPLIER	AND REHABILITATION CENTER		183	T ADDRESS, CITY, STATE, ZIP CODE ONSI OW DR EXTENSION CKSONVILLE, NC 28540		
(X4) ID PREFIX TAG	SUMMARYSTA	TEMENT OF DEFICIENCIES WUST 9E PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	П	PROVIDER'S PLAN OF CORRECTIVE ACTION SH (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	เบบเม ยะ	COMPLETION (XG)
	INITIAL COMMEN	rs	K 0		Carolina Rivers Nursing and Rehabilitation Center acknowledges receipt of the		10/1/12
	conducted as per at 42CFR 483.70(at 42CFR 483.70(at 22CFR 483.	ode(LSC) survey was The Code of Federal Register (i); using the Existing Health (LSC and its referenced (utilding is Type V construction, (utilding automatic sprinkler)			Statement of Deficiencies are proposes this plan of correct the extent that the summary findings is factually correct order to maintain compliance applicable rules and provision	id ion to of and in e with on of	
K 029 \$S=D	are as follows: NFPA 101 LIFE SA One hour fire rated fire-rated doors) or extinguishing systemation 19.3.5.4 protection is used, the other spaces by sideors. Doors are	AFETY CODE STANDARD I construction (with % hour an approved automatic fire am in accordance with 8.4.1 beets hazardous areas. When matic fire extinguishing system areas are separated from moke resisting partitions and self-closing and non-rated or ctive plates that do not exceed bottom of the door are 2.1	ΚO		quality care of the residents, plan of correction is submitt written allegation of complic Carolina Rivers Nursing and Rehabilitation Center's resp the Statement of Deficiencies Plan of Correction does not agreement with the Statement Deficiencies and the Plan of Correction nor does it constituding and Rehabilitation of accurate. Further, Carolina Nursing and Rehabilitation of reserves the right to submit documentation to refute any	ed as ance. I onse to es and denote nt of itute an ey is Rivers Center	
	Based on observe approximately 11: 1) A fire damper is electrical room we conditioning unit is 2). The condent if	Is not met as evidenced by: ation on Thursday 8/23/12 at 00 AM the following was noted. Is need at the celling in the Ire the vent for the air Is located. In or to the oxygen storage room In and seal when checked.			stated deficiencies on this Statement of Deficiencies th informal dispute resolution, appeal procedure and/or any administrative or legal proce	formal other	
Name and the second	42 CFR 483.70(a)	INERRIPPLIER REPRESENTATIVE'S 910	NATURE		K029	a	- 0x6) DATE
A ACVIVI	NAMA INVAM	MULT EN BSN LN	HH	4	Administrator	<u> </u>	110012

Any deficiency statement ending with an esterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguerds provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days of 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 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 those documents are made evaluable to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 08/23/2012

FORM APPROVED

9104550325

DEPARTMENT OF HEALTH AND HUMAN SERVICES <u>OMB NO. 0938-0391</u> CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONTITRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: A, BUILDING 02 - BUILDING 02 B. WING 345072 08/23/2012 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1839 ONSI,OW DR EXTENSION CAROLINA RIVERS NURSING AND REHABILITATION CENTER JACKSONVILLE, NC 28540 PROVIDER'S PLAN OF CORRECTION COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX (INCH CORRECTIVE ACTION SHOULD BE PREFIX CRI)SS-REFERENCED TO THE APPROPRIATE TAO a. A fire damper will be placed in the electrical room were the vent for the air conditioning unit is located by an outside agency by 10/07/2012. The corridor door to the oxygen storage room and the corridor door to the soiled utility room on the 600 hall has been adjusted and is closing properly with latch and scal by facility maintenance staff as of 10/07/2012. b. All other corridors doors have been checked as of 10/07/2012 by facility maintenance staff, and are closing with latch and seal. as indicated. No other areas are identified as having issue with lack of fire damper. c. Facility maintenance staff has been retrained regarding closure of corridor doors with latch and scal, and of need for approved automatic fire extinguishing system where applicable as of