100 AUG 2 7 2012

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

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

	OF DEFICIENCIES F CORRECTION	(XI) PROVIDERSUPPLIENCUA IDENTIFICATION NUMBER:	(X2) M A. BUR		E CONSTRUCTION VIOLET	(X3) DATE SURVEY COMPLETED	
		345414	D. WAN	G		07/2	6/2012
	ROMOER OR SUPPLIER BYT REHABILITATION &	NURSING CENTER, INC		234	et address, city, state, zip code 46 Barrington Circle Lyetteville, NC 28303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI TAG		PROYNER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOW CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JD BE	COMPLETION DATE
F 157 SS=G	(INJURY/DECLINE/I A facility must immeconsult with the residence of an interested familiance dentered for an interested familiance dentered for an interested familiance dentered for a signification, a signification in heelt status in either life the clinical complications significantly (i.e., a nexisting form of treat consequences, or to treatment); or a deck the resident from the §483.12(a). The facility must also and, if known, the resident from the section of the section of the section of the section of the section. The facility must associated in §483.15 (as the resident from the section of the section.	diately inform the resident; dent's physician; and if sident's legal representative ity member when there is an e resident which results in otential for requiring physician icent change in the resident's psychosocial status (i.e., a th, mental, or psychosocial meatening conditions or so;); a need to alter triatiment eed to discontinue an iment due to adverse commence a new form of sion to transfer or discharge is facility as specified in promptly notify the resident sident's legal representative member when there is a commate assignment as si(e)(2); or a change in Federal or State law or fied in paragraph (b)(1) of	F	157	Haymount Rehabilitat and Nursing Center acknowledges receipt the Statement of Deficiency and proposities plan of correction extent that the summa findings is factually cond in order to mainta compliance with application and the provision quality care to residen The plan of correction submitted as written allegation of compliant. The below response to Statement of Deficient and the plan of correct does not denote agree with the citation by Haymount Rehabilitat and Nursing Center. Tacility reserves the right.	of ses to the ry of correct in cable n of ts. n is nce. o the cy tion ment ion he ght to	
	This REQUIREMEN' by: Based on observation	one number of the resident's or interested family member. This not met as evidenced on, interviews with staff and	***************************************		submit documentation refute the stated defici through informal appe procedures and/or othe administrative or legal proceedings.	iency eals er	
	resident, and record	reviews the facility failed to	ļ				

Any desciency statement ording with an asteriak (*) denotes a desciency which the institution may be excused from correcting provising it is determined that other selegiants purishes stated above are disclosable 90 days offer selegiants purishes stated above are disclosable 90 days offer selegiants purishes and plans of correction is provided. For musting homes, the above findings stated above are disclosable 10 days totowing the date of survey whether or not a plan of correction is provided. For musting homes, the above findings and plans of correction are disclosable 14 days totowing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to confinued program participation.

ERASUPPLIER BEPRESEMIATIVES SIGNATURE

FORM CMS-2567(02-99) Previous Vorsions Cosciete

Eventio:WSRU11

Fecilly III, 923149

If continuation sheet Page 1 of 26

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	ULTIP	LE CONSTRUCTION		UKYKI
40 MAJPLOW	PLAN OF CORRECTION IDENTIFICATION NUMBER:	- 1			(XS) DATE SURVEY COMPLETED		
	CORRECTION	(Carrier of the carrier of the carri	A.BU	LOING			
		345414	B, W\$	(G		07,	26/2012
JAME OF PRO	OVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
		· · · · · · · · · · · · · · · · · · ·		ŧ	145 BARRINGTON CIRCLE		
HAYMOUN	IT REHABILITATION & I	iursing center, inc		F/	AYETTEVILLE, NC 28303		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION]	ID PREF TAG		PROMOER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY)	HOULD BE	COMPLETIC DATE
- 1		The same of the sa					
F 157	Continued From page	•1 ·	F	157			
		f 1 of 1 sampled residents	.				
	fresident #114) about	continued complaints of			D169		1.
.	nain and discomfort in	the resident's left arm and	1		F157		1
ĺ	the dialysis access si	te resulting in continued use			Resident #114 was reass	secred for	1
}	of as needed pain me	dication.	1		pain by the DON and M		
	at we see that the same				notified of findings. (7/2		7/26/12
1	Findings include:						
				- 1	Resident #114 lefts shur	nt site was	1
	Resident #114 was a	dmitted to the facility 4/25/12		l	reassessed by the Unit		
1	and readmilled 5/25/	Her diagnoses included			Coordinator on 7/26/12.		7/26/12
1	end stage renal disea	se.	1	l		• •	
- 1	-		1		Resident #114 was reass		
1	The minimum data se	t (MDS) assessment dated			the PA for pain and effe of pain medication. (7/2		7/27/12
	5/2/12 revealed resid	ent #114 was cognitively			or pain incurcation. (72	11 12)	1/2//12
	Intact. She was not co	oded for impairment for daily			Resident was ordered ar	1	
I	decision making. She	required limited one person	1		additional PRN dose of		
I	assistance for bed me	obility, transfers, walking,			medication. (7/26/12)	=	7/26/12
1	dressing, tollet use, b	athing and personal					
- 1	hydiene. She required	i set up help only for	1	ŀ	The facility audit was co		,
1	locomotion on the uni	t and eating. She was not		i	by the DON and Admin		
	coded for pain or dial				each resident medication		
I			1		for review of PRN medi		
1	A hospital consultation	n note dated 5/17/12			Findings were document PRN Audit sheet. (8/10/		8/10/12
1	revealed resident #11	4 had an arteriovenous			t Mr Audit ancer (0/10/	,	0/10/12
ł	(AV) fistula (a surgica	il connection of an artery	1		All findings of PRN me	dication	-
1	and vein for dialysis)	placed in her left arm on	1		utilized were discussed		
1	3/5/12 due lo stage fo	our chronic kidney disease.			MD. (8/11/12)		8/11/12
1	When she was admit	led to the hospital on 5/6/12	1				1
1	her chronic kidney dis	sease had progressed into			The MD reviewed all us		
l	end stage renal disea	se and hemodialysis was			PRN medication for res		
1	recommended. The fi	istula in her left upper arm	1		and all other residents a	na made	1
1	had not majured for u	ise so a catheler was	1	'	changes as needed for e		8/11/12
1	Inserted in her chast	for dialysis. Residenl #114	1		individual resident. (8/1	1114)	0/11/12
1	was discharged to the	a facility on 6/25/12 with			Licensed nursing staff v	as in-	1
1	orders for dialysis thre	ee days a week.		-	serviced on the PRN po		1
1		•			DON and RN superviso		
- 1	A physician's order d	aled 5/26/12 read; Tylenol			medications and MD no		8/15/12
		y mouth every six hours as					1

STATEMENT OF DEFICENCES (XI) PROVIDERSUPPLIENCIA IDENTIFICATION NUMBER:		(XI) PROMOER/SUPPLIER/CLIA	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345414	B. WING		07/26	V2012
	ROVIDER OR SUPPLIER NT REHABILITATION & I	NURSING CENTER, INC	2	EET ADDRESS, CITY, STATE, ZIP CODE 346 BARRINGTON CIRCLE AYETTEVILLE, NO 28303		
(XI) 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 APPRO DEFICIENCY)	ILDBE	(XS) COMPLETION DATE
F 157	neaded. A significant change completed on 6/1/12 coded as cognitively extensive one person dressing, bathing and required one person transfers, walking, los and tolleting. She was medications as need occasional pain. She has pital procedure 6/6/12 revealed the ledemonstrated a mod (abnormal narrowing the left upper extremitack of thrill. Balloon and there was good throughout the entire or blockage. Resident to the facility on 6/6/1 instructions read; "Le clothing, blood press arm. Report or call for severe pain in left arm. A nurse's note dated #114 returned from hintact on her left upper completints of pain arm. A nurse's note on 6/7 left arm tender to touter the completints of pain arm.	MDS assessment was and resident #114 remained intact. She required a assistance for bed mobility, of personal hygiene. She limited assistance for comotion on the unit, eating a coded to use pain and to have moderate, was also coded for dialysis. In the for resident #114 dated aft arteriovenous fistulogram erate degree of stenosis of the proximal portion of the pr	F 157	Ten percent of resident charts will be audited weekly x4, then monthl x3, then quarterly x2 by DON, Unit Coordinator RN designee for notification to MD for significant changes. Ten percent of all resid receiving PRN medicat will be audited by the L and/or Unit Coordinato usage of PRN medication and notification to the These audits will be conducted weekly x4, t monthly x2, then quarterly x3, and then quarterly x3 and then as needed. Changes will be made by the QA comm as needed and appropriplan will be implement by the DON and staff where in serviced to the revised plan by the DO designee as needed.	ent ion DON or for on MD. tted for tee iittee ate ed vill	8/17/12 8/17/12 & Ongoing 8/2012 and ongoing

STATEMENT	of Deficiencies Correction .	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION .	8 PATE (EX)	
		345414	B, WING		07/	28/2012
	OVIDER OR SUPPLIER . NT REHABILITATION &	YURSING CENTER, INC	2346	I ADDRESS, CITY, STATE, ZIP CODE BARRINGTON CIRCLE ETTEVILLE, NC 28303	,	_
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUIST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROMDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	COLUMN CONTRACTION CONTRACTION
F 157	complained of "left arm medicated with Tylen Manurse's note on 6/1 complained of pain in not severe" and she was medicated with Tarm soreness. A nurse's note on 6/1 was medicated with Tarm soreness. A nurse's note on 6/2 dialysis note dated #114 complained of I medicated with Tylen A nurses note on 6/2 dialysis today came a see (physician) d/t (d pain in Lt arm access Review of the June 2 administration record #114 received Tyleno 6/11/12, 6/18/12, 6/26/12	m site pain" and she was oil. 6/12 revealed resident #114 ther "left arm fistula site but was medicated with Tylenol. 8/12 revealed resident #114 'ylenol for complaints of left 20/12 indicated resident with Tylenol for complaints 6/22/12 indicated resident with Tylenol for complaints 6/22/12 indicated resident aft arm pain and was oil. 9/12 read; "resident went to at 500pm with order to go ue to) c/o (complaints of). Monday july 2, 2012." 012 medication (MAR) revealed resident if 650 mg once a day on 5/12, 6/21/12, 6/22/12, 3/12 and 6/30/12. She mg twice a day on 6/12/12, 6/19/12. s note from the surgeon's 2 revealed resident #114's of working" There was no need to discuss the findings in possible procedure to	F 167			

OCHTED	CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO	0,0938-0391
STATEMENT	of deficiencies	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) h	IULTIP	LE CONSTRUCTION	(X3) DATE SUI COMPLET	
AND PLAN OF	CORRECTION	DEGIN DATIONS DE	A.SU	LDING			
		346414	B. WA	√G	*	07/2	6/2012
NAME OF PR	OVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
HAYMOU	NT REHABILITATION & I	Nursing Center, Inc			46 Barrington Circle Ayetteville, NC 28303		
(X4) ID PREFIX TAG	IFACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	X.	PROMDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	XAD BE	COMPLETION DATE
F 157	Continued From page	a 4	F	157			
	appointment and quo	7/2/12 indicated that furned from her doctor's led the physician assistants ras not working and there				·	
-	A nurse's note dated was medicated for co pain.	7/6/12 indicated the resident implaints of AV fistula site					
	A nurse's note on 7/1 resident #114 was m arm palñ.	1/12 and 7/13/12 revealed edicated with Tylenol for left					
		20/12 indicated resident #114 It hand and loft arm pain.					
	#114 received Tylend 7/2/12, 7/3/12, 7/5/12 7/15/12, 7/16/12, 7/1 She received Tylend	I (MAR) revealed resident of 650 mg once a day on 2, 7/6/12, 7/10/12, 7/14/12, 7/12, 7/23/12 and 7/25/12. I 650 mg twice a day on I/12, 7/13/12, 7/18/12,					
	scale classified pain 7-10 as severe. Revi revealed resident #1 pain on 7/16/12 and on 7/9/12, 7/10/12, 7 7/19/12, 7/20/12, 7/2 Pain was not assess	of Health numerical pain from 4-6 as moderate and ew of the July 2012 MAR 14 complained of severe 7/17/12 and moderate pain //1/12, 7/12/12, 7/18/12, 4/12, 7/25/12 and 7/26/12, ed and the site of the pain every time Tylenol was					

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STATEMENT	OF DEFICIENCIES F CORRECTION	(XI) PROVIDERSUPPLIENCUA IDENTIFICATION NUMBER:	1, ,	LULTIP LOING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345414	B. W/	₩		07/	26/2012	
	ROVIDER OR SUPPLIER NT REHABILITATION &	NURSING CENTER, INC		STREET ADDRESS, CITY, STATE, ZP COD 2346 BARRINGTON CIRCLE FAYET TEVILLE, NC 28303				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID Pref Tac	- 1	PROVICERS PLAN OF CORR (EACH CORRECTIVE ACTION SI GROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETION COMPLETION DATE	
F 157	Review of a facility per read; "PRN (on requestively be used as little uses a PRN medicall days or longer, the number of the physician whether remains appropriate, medications are indiced as a proper of the physician where appropriate in the physician whether emains appropriate, medications are indiced availation is needed, would be more appropriate in the proper of the properties of the proper of the pro	colley titled *PRN Orders* ast or as needed) orders as possible. If a resident on repeatedly over several ast possible. If a resident on repeatedly over several asteries at the current medication whether other or additional ated, whether any additional ated, whether a standing order priate.* M resident #114 was or room. She frowned as she and shoulder. She said her e early June when she had by fistula. She indicated she and almost every day but it M the resident was ted her left orm had hurt her fingertips daily since the ine early June. She described ling* at times and said she of for the pain due to her hat Tylenol helped iff 14 said her left arm pain ted her life. She said she felt all the time because she did to to the pain in her left hat she was left handed but her right arm to feed	F	157				

Evect ID:WSNUSS

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CL/A IDENTIFICATION NUMBER:	1.	iultipi Ld in g	E CONSTRUCTION		E SURVEY PLETED
		345414	8. WA	83	· · · · · · · · · · · · · · · · · · ·		07/26/2012
i	OMDER OR SUPPLIER NT REHABILITATION & I	JURSING CENTER, INC		23	EET ADDRESS, CITY, STATE, ZIP CODE 48 BARRINGTON CIRCLE LYETTEVILLE, NC 28303		
(X4) ID PREFIX YAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	FREE TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	CONSTETION CONSTETION
	Continued From page on the left hand was reported it was too pather left hand. She said dealt with the pain on no one had helped her continued of left arm pain and that has stated "something was not sure what has resident #114 had realmost daily but she if physician. She said a resident's left arm pain and that was often the nur #114 back from dialystesident usually completed 8. She said she because he was alread form pain and that Nurse #2 also reported complained of left har that the stated of left hard complained of left hard.	and fully closed. She alinful to make a light fist with d a lot of times she just her own because she felt er. AM nurse #1 was cated that resident #114 d and cognitively intact. e recident's left arm paln g was done to her left arm, d been done." She sald exited Tylenot for paln had never called the she had reported the not the unit supervisor but she reported it. AM nurse #2 was I she vorked second shift see who received resident sis. When asked about m pain, nurse #2 said the plained of pain around a did not notify the physician key aware of the resident's the fistula was not working, d "last week" resident #114 and numbness and said she lify the physician. Nurse #2	<u>} </u>	157	DEFICIENCY)		
	with resident #114. Si occasionally complain	she worked weekend days	,	and the section of the section were the section where the section of the section			

CENTER	S FOR MEDICARE &	MEDICAID SERVICES			·	OMB NO) <u>. 0938-0391</u>
STATEMENT	OF DEFICIENCIES F CORRECTION	(XI) PROMDER/SUPPLIENCLIA IDENTIFICATION NUMBER:	(X2) #.		LE CONSTRUCTION	(X3) DATE SU COMPLET	
		345414 ·	B, W.N	G		07/2	6/2012
ł	ROVIDER OR SUPPLIER NT REHABILITATION & I	YURSING CENTER, INC		23	eet address, city, state, zip code 349 Barrington Circle Ayetteville, nc 28303		
(X4)10 PREFIX TAG	FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROMDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO BE	(XS) COLPLETICH DATE
F 157	because resident #11 complained of left au On 7/26/12 at 1:05 Plinterviewed. She sail she had been informed pain. She said had si celled the physician a On 7/26/12 at 2:40 Plinterviewed the nursing staff to continued complaints	4 had only occasionally n pain to her. M the unit supervisor was d 7/26/12 was the first lime ad of resident #114's left arm ne known she would have	F	157			
F 164 SS=D	Interviewed. He said documentation that a notified him of resider said he expected the resident used as nee several consecutive of discuss the need for the also expected the resident who complaid 483.10(e), 483.75(i)(f) PRIVACY/CONFIDE The resident has the confidentiality of his officereds. Personal privacy inclimedical treatment, with communications, permeetings of family and provided that is a said to the communications, permeetings of family and privacy inclimedical treatment, with the communications, permeetings of family and privacy inclimedical treatment, with the communications, permeetings of family and privacy inclimedical treatment, with the communications of family and privacy inclined the communications of the communi	right to personal privacy and in her personal and clinical idea accommodations, itlen and telephone	LL.	164			

	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES	(XI) PROVIDERISUPPLIERICUA	(X2) MULTIPLE	CONSTRUCTION	B) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A BURLDING		COMPLETED
			8, WNG		
•		346414			07/26/2012
NAME OF PR	OVIDER OR SUPPLIER			T ADDRESS, CITY, STATE, ZIP CODE	•
DIVUAD	ut deux dii (TATIAN &)	NURSING CENTER, INC		BARRINGTON CIRCLE -	
IM HUOUI	41 VEHADICHOHON #1		FAY	ETTEVILLE, NC 28303	
(X4) 10	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E COMMETIN
PREFIX TAG	REGULATORY OR	LSC (DENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRE DEFICIENCY)	ATE DATE
	<u>.</u>		F 164	F164	
F 164	Continued From page		F 104	Social Worker met with reside	ent
	room for each reside	nt.		#91 regarding Resident rights	and
	Except as provided in	n paragraph (e)(3) of this		Resident safety. (7/27/12.)	7/27/12
	section, the resident	may approve or refuse the		Care plan meeting was held w	
	release of personal a	ınd clinical records to any		resident and his responsible pa	
	Individual outside the	facility.		regarding resident rights and safety by the Care plan team o	
Ì	The residents sight to	o refuse release of personal		8/2/12.	
	and clinical records of	loes not apply when the		Residents requiring assistance	-
	resident is transferre	d to another health care		were identified through the M	DS. 8/16/12
	institution; or record	release is required by law.		Department Heads will monito	nr
		Bits it all toformation		resident dignity and privacy	"
	The facility must kee	p confidential all information Jent's records, regardless of		during Weekly Round Checks	
	the form or storage of	nethods, except when		Findings will be documented the Resident and Room Audit	
	release is required by	y transfer to another		Sheet, by the Dept Head assig	ned. 8/16/12
	healthcare institution	; law; third party payment		Findings will be corrected and addressed by the Dept. Head	and on-
	contract; or the resid	ent.		immediately on rounds.	
				Licensed staff and C.N.A.'s w	ere
	This REQUIREMEN	is not met as evidenced		in-serviced on Resident Rights	s·
	by:			and Dignity by the Social Wor Dietary, Therapy, and	rker.
	Based on observation	on, interviews and facility		Housekeeping staff in-service	d by
	record review the fac	dilly failed to move 1 of 4 osident #91) dependent for		Social worker and/or their	8/16/12
	repositioning to a pri	vate area to reposition him.		Department Manager.	,
	Tobositioning to a bu	e and the second of a self of property of the second of th		Licensed staff and C.N.A.'s no	
	Findings include:	ı.		in-serviced by the Social work will be in-serviced upon return	
	and the second s	•		work by the DON or RN design	gnee. and on-
	Davidont #01 was as	imitted to the facility on		New employees (licensed nurs	going
	2/1/12. His diagnosis	included a cerebral vascular		and c.n.a.'s) will be in-service	d l
	accident (stroke) with	left sided paralysis.		upon hire during orientation a annually thereafter by the Soc	
	}.			Worker or DON.	going
	The quarterly minima	um data set assessment			
	dated 5/8/12 for resh cognitively intact. He	dent #91 revealed he was			
	cognitively intact. He	oble tot ped wopilith aud was			
	assistance of the be	after the armount and arm	1		

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•••	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
7010 22101		,		A BUE	.DING			
		346414		B, WIN	G		07/2	8/2012
	OVIDER OR SUPPLIER OF REHABILITATION & 1	iursing center, inc			2	REET ADDRESS, CITY, STATE, ZIP CODE 346 BARRINGTON CIRCLE CAYETTEVILLE, NG 28303	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Atement of deficiencies y must be preceded by full sc identifying information)		id Prefi Tag	X	PROMOER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO BE	(X5) COMPLETION DATE
F 164	Continued From page dependent on two perange of motion impalower extremities. Resident #91's care pherequired staff assidally living related to were no interventions. On 7/28/12 at 1:00 Plobserved in a high be 200 and 300 hall nursifalling. There were formembers and a visito Nursing assistant (N/member of the mainter a resident through the NA #1 walked over to his wheelchair and to reposition him. NA #1 resident #91's wheelchair and to reposition, NA #1 mover right side and pulled I pillow under his left strepositioned a pillow on 7/26/12 at 1:05 Plandar at the go to his "it can be embarrassian asked to be repositioned asked to be repos	ople for transfers. He had irment in bilateral upper and blan dated 2/6/12 identified stance for all activities of impaired mobility. There related to repositioning. If resident #91 was ck wheelchair by the 100, les station in no danger of our residents, two facility staff or in the immediate area. If the immediate			164	DEFICENCY) Documented findings from the	the ade led	8/24/12 8/2012 and on- going
		epositioned him. M NA #1 indicated she was staff that resident #91 asked						

CENTER	NTERS FOR MEDICARE & MEDICAID SERVICES	MEDICAID SERVICES			OMB NO. 0938-039		
BTATEMENT	of deficiencies	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N	ULTIPLE	CONSTRUCTION	(X3) DATE 8 COMPL	
NO PLAN OF	CORRECTION	STRICTOR TOWNS	A. BUR	LDING			
		345414	B. WIN	G		07	/26/2012
	OMDER OR SUPPLIER NT REHABILITATION &	nursing center, inc		2346	ADDRESS, CITY, STATE, ZIP CODE BARRINGTON CIRCLE ETTEVILLE, NC 28303		
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC	ATELIENT OF DEFICIENCIES Y MUST BE PRECEDED BY FUIL ESC IDENTIFYING INFORMATION)	ID PREF TAG	ix X	PROMDER'S PLAN OF CCR (EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(%) COMPLETION DATE
	moved resident #91 troom to reposition his should be reposition he their privacy and digitation before she reposition hallway. On 7/26/12 at 2:38 P indicated her expects repositioned in their thallways unless it was prevent a fail.	he sald she should have to a private area such as his m. NA #1 stated residents ad in their rooms to respect tilty and she did not think ted resident #91 in the M the Director of Nursing atton was that residents be come and not in the s an emergency situation to		164			
F 279 SS=G	to davelop, review ar comprehensive plan comprehensive plan. The facility must develope for each resident objectives and timetal medical, nursing, and needs that are identified assessment. The care plan must do be furnished to attain highest practicable playchosocial well-being \$483.25; and any set to the regulated under \$4 due to the resident's	care Plans e results of the assessment and revise the resident's of care. elop a comprehensive care that includes measurable bles to meet a resident's inental and psychosocial fied in the comprehensive		279	Resident #141 care plar updated on pain. Residents who have paidentified through the Market and the residuentified as having paidentified as having paidentifie	n were fDS. ents n will have MDS nat a care residents its will be y Pain 8/13/12). essed for nit sessment t clinical and a-serviced d by the	8/13/12 8/13/12 8/13/12

		MEDICAID SERVICES	T		The section of the se	(X3) PATE SURVEY	
	of deficiencies • Correction	(X1) PROVIDENSUPPLIENCUA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A BUILDING		COMPLETED	
	·	345414	B, WA	₩		07/7	26/2012
	OVIDER OR SUPPLIER NT REHABILITATION & 1	NURSING CENTER, INC		STREET ADDRESS, CITY, STATE, ZIP CODE 2348 BARRINGTON CIRCLE FAYETTEVILLE, NG 28303			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLO BE	(XS) COMPLETION DATE
F 279	Continued From page This REQUIREMENT by: Based on observatio and staff, and record develop a comprehen of 1 residents (residen moderate to severe p frequent use of as ner Findings include: Resident #114 was an and readmitted 6/25/4 end stage renai disea The minimum data se 5/2/12 revealed reside intact. She required it assistance for bed mo dressing, toilet use, by hygiene. She required focomotion on the unit coded for pain or dialy A significant change & completed on 6/1/12 a coded as cognitively in extensive one person dressing, bathing and person limited assista locomotion on the unit was coded to use pair needed basis and to h pain. She was also co	is not met as evidenced in, interviews with resident reviews the facility failed to esive care plan for pain for 1 int #114) with identified ain in her left arm and eded pain medications. dmitted to the facility 4/25/12 2: Her diagnoses included see. I (MDS) assessment dated ant #114 was cognitively mitted one person ability, transfers, walking, athing and personal I set up help only for I and eating. She was not resident #114 remained intact. She required assistance for bed mobility, personal hygiene and one nce for transfers, walking, a eating and toileting. She medications on an as lave moderate, occasional		279	DEFICIENCY) Licensed nurses not in-servi	iced by bove ON on y of ed to IDS en i ges med ittee rill be	8/16/12 8/2012 and On- going
	not include pain.	•					

	CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	0.0938-039 <u>1</u>
CENTERS FOR MEDICAR STATEMENT OF DEFICIENCIES			(X1) PROVIDER/SUPPLIER/CLIA	· (X2) እ	ULTI	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
M	YD PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A.8U	LON	G	COMPLE	(EU
			346414 ·	8.WI	lG		07/2	8/2012
Ţ	NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
	HAYMOU	YT REHABILITATION &	nursing center, inc		i	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303		
-	(X4)10 Prefix Tag	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	, ID PREF TAC		PROMDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD 8E	DATE COMPETION (X9)
TOTAL STATE OF THE PROPERTY OF		Continued From page A physiclan's order of 650 milligrams (mg) I needed. Review of the May 20 administration record #114 received Tyleno 5/28/12, 5/27/12, 5/2 5/31/12. She received 5/28/12. Review of the June 2 administration record #114 received Tyleno 6/11/12, 6/18/12, 6/2 6/25/12, 6/26/12, 6/2 received Tylenol 650 8/13/12, 6/15/12 and Review of the July 20 administration record #114 received Tylenol 7/21/12, 7/3/12, 7/5/12 7/15/12, 7/16/12, 7/11/12, 7/16/12 7/15/12, 7/16/12, 7/11/12, 7/12/12 7/19/12, 7/11/12, 7/12/12 7/19/12, 7/10/12, 12 On 7/26/12 at 8:50 Al	ated 5/25/12 read; Tylenol by mouth every six hours as of 2012 medication (MAR) revealed resident of 5/29/12, 5/30/12 and of 17/20/12, 5/30/12 and of 17/20/12, 6/21/	F	279		•	
		from her shoulder to I AV fistula procedure I her pain as "excrucial could only take Tylen heart. She Indicated I temporarily, Resident had negatively impac	ted her left arm had hurt ner fingertips daily since the n early June. She described ling" at times and said she of for the pain due to her hat Tylenol helped #114 said her left arm pain ted her life. She said she felt lil the lime because she did					

CENTER	MEDICAID SERVICES				OWB NO. 0938-0391		
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		LE CONSTRUCTION	(X3) DATE SUF COMPLET	
THE PERMIT OF TH			B. WNG		-		- (2.2.4.2)
	·	345414				07/26/2012	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
HAYMOUN	IT REHABILITATION &	NURSING CENTER, INC		1	346 BARRINGTON CIRCLE AYETTEVILLE, NC 28303		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	ΊX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 279 F 309 SS=G	not sleep well at night arm. She said some hair or button her shi arm. She explained thas had to learn to underself because her Resident #114 held to in front of her and may the fist on the right to on the left hand was reported it was too pher left hand. She said alt with the pain on no one had helped hon 7/26/12 at 3:15 Finterviewed. She said ong the significant that resident #114 hapain and had receive nurse said resident #plan for pain. 483.25 PROVIDE CANIGHEST WELL BEET WELL	It due to the pain in her left days she could not brush her rit due to the pain in her left hat she was left handed but se her right arm to feed left arm was painful. The poot of her arms straight out ade a fist with both hands. The poot of the painful but the fist not fully closed. She ainful to make a tight fist with id a lot of times she just in her own because she felt er. What the MDS nurse was id she was responsible for change MDS. She recalled ad complained of moderate and pain medication. The MDS in the she was responsible for change MDS are called and complained of moderate and pain medication. The MDS in the she was responsible for change MDS are called and complained of moderate and pain medication. The MDS in the should have had a care was a care and services to attain the practicable physical,		= 309			
	This REQUIREMEN by: Based on observati	T is not met as evidenced on, interviews with resident dreviews the facility failed to					

		MEDICAID SERVICES	02011	un 3001	LE CONSTRUCTION	(X3) DATE SU	₹VEY
STATEMENT (AND PLAN OF	of Deficiencies Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	LONG		COMPLET	ED
		345414	8. WI			07/26/2012	
	OVIDER OR SUPPLIER			STRI	eet address, city, state, zip code M6 Barrington circle		
HAYMOU	IT REHABILITATION &	NURSING CENTER, INC		F	AYETTEVILLE, NO 28303		~~
(X4) 1D PREFIX TAG	ACACHISTERCIENC	ATEMENT OF DEFICIENCIES AY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IO PREI TAG	7X	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	CONVETION DATE
F 309	Gontinued From pag	e 14	F	309	F309 Resident #114 was reassessed	for	
	and failed to assess	ess sile after a procedure continued complaints of left ampled dialysis resident			pain by the DON and MD was notified of findings. (7/26/12)	S ·	7/26/12
	Findings Include:	to the dealth william of the best of the state of the sta			The shunt site for resident #11 was reassessed by the Unit Coordinator and findings repo		
•	Resident #114 was a and readmilled 5/25/ end stage renal dise	idmilled to the facility 4/25/12 12, Her diagnoses included ase,			to the MD. (7/26/12). All residents with physician's		7/26/12
	6/2/12 revealed resident intact. She was not on the decision making. She	et (MDS) assessment dated tent #114 was cognitively coded for impairment for daily a required limited one person tobility, transfers, walking,			orders for dialysis were identi as having a shunt site by the I Two other residents were identified.	fied	7/27/12
	dressing, tollet use, in hygiene. She require to comotion on the uncoded for pain or distance to the coded for the coded for the coded for pain or distance to the coded for t	bathing and personal and set up help only for hit and eating. She was not lysis.			The shunt site of the 2 identif residents was re-assessed by t Unit Coordinator. No negative findings were noted.	he	7/30/12
	revealed resident #1 (AV) fistula (a surgic and vein for dialysis) 3/5/12 due to stage When she was admit her chronic kidney d	14 had an arterlovenous al connection of an artery placed in her left arm on four chronic kidney disease. Itled to the hospital on 5/6/12 Isease had progressed into			All 3 resident will shunt sites be assessed daily for bruit and thrill by the charge nurse. Findings will be documented the MAR daily by the charge	İ	7/2712
	recommended. The had not malured for the standard in her chest	ase and hemodialysis was listola in her left upper arm use so a calheter was for dialysis. Resident #114 ue facility on 5/25/12 with			nurse. (7/27/12) Resident #114 was reassessed the PA for pain and effectives	ness	
	orders for dialysis th	ree lintes a week.			of pain medication. (7/27/12)		7/27/12
	A physician's order of 650 milligrams (mg) needed.	Jaled 6/25/12 read; Tylenol by mouth every six hours as			Resident was ordered an additional PRN dose of pain medication.		7/26/12 at Page 15 of 26

	FOR MEDICARE & DEFICIENCIES	(XI) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTPL	ECONSTRUCTION	(X3) DATE SUR!	ÆY D
AND PLAN OF	CORRECTION	IOENTIFICATION NUMBER:	A BUIL	DING			
	• · · · · · · · · · · · · · · · · · · ·	345414	B. WN	G		07/26	2012
	OVIDER OR SUPPLIER			23	ET ADDRESS, CITY, STATE, ZIP CODE 46 BARRINGTON CIRCLE		
HAYMOUN	IT REHABILITATION &	NURSING CENTER, INC		FA	YETTEVILLE, NC 28303 PROVIDER'S PLAN OF CORRECT	TON .	(X5) COMPLETION
(X4) ID PREFIX TAG	ICANU DECINERO	Atement of Deficencies y Must be preceded by full LSC Identifying information)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	O THE APPROPRIATE	
F 309	Conlinued From pag A significant change	e 15 MDS assessment was and resident #114 remained		309	Licensed nursing staff was in-son the PRN policy by the DON supervisor of medications and notification. (7/28/12, 8/15/12) Care plan conference was held	and RN √ID with	8/15/12
	coded as cognilively extensive one person dressing, bathing an required one person transfers walking, to	Intact. She required n assistance for bed mobility, d personal hygiene. She Ilmited assistance for comotion on the unit, eating			resident #114 and family to dist of care with emphasis on Pain management and ADL care. Me conducted by Interdisciplinary' 8/14/12.	eeting Team on	8/14/12
	and toileting. She wa medications as need occasional pain. She	es coded to use pain led and to have moderate, was also coded for dialysis.			Licensed nursing staff was in-so on the notification to MD of sig changes by the RN supervisors DON.	nificant	8/15/12
	Identified the following	sident #114 dated 6/4/12 ng; "I require renal dialysis." suffer no complications due			Licensed nurses were in-service Dialysis Policy and the procede assessing bruit and thrill by the	are for	8/15/12
THE PARTY OF THE P	"Monitor my shunt id	/2/12. Interventions included; or palency, thrill (a vibration riery and caused by turbulent e sound blood makes as it les)."			Licensed nurses will be in-serv upon hire and annually thereaft Dialysis Policy and the procedu checking bruit and thrill by the and/RN designee.	er on the are for	8/16/12
	resident #114 was s	y taken of a fistula after a s been injected) of her left			Licensed nurses not in-serviced completion date for in-service Dialysis Policy and checking of and thrill by the DON/RN desi prior to next scheduled working	on f bruit gnee g day.	8/16/12
	6/6/12 revealed the	e note for resident #114 dated left arteriovenous fistulogram derate degree of stenosis g) in the proximal portion of			100 % audit will be conducted residents with a shunt site will conducted by the DON weekly monthly thereafter.	be x4, then	8/17/12
	the left upper extrer lack of thrill. Balloor and there was good residual narrowing, throughout the entil or blockers. Beside	g) in the proximar point of an interpretation of an interpretation of an interpretation of the angle of the a	- Hardinary Commission of the		Findings will be taken to the Q committee by the DON month then quarterly x2, then as need negative findings will be revie the QA.committee and change made to the plan as indicated to Committee. Staff will be re-in by DON or designee as needed.	ly x3, ling. Any wed by s will be by the QA serviced	8/20/12

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB IAC	. 0936-0391	
		IVIEDICALD SERVICES	(X2) M	ULTI	IPLE CONSTRUCTION	(X3) DATE SURVEY	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUII			COMPLET	: υ
		345414	B. WIN	IG_	·	07/2	3/2012
	OVIDER OR SUPPLIER	NURSING CENTER, INC	<u>'</u>		TREET ADDRESS, CITY, STATE, ZIP CODE 2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303		
(X4) ID PREFIX TAG	SUMMARY ST	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1D PREF TAG	iX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 309	Continued From page instructions read; "Le clothing, blood press arm. Report or call for severe pain in left are A nurse's note dated #114 returned from bandage on her left no complaints of pain A nurse's note on 6/left arm tender to too. There were no assess resident #114's left 6/7/12, 6/8/12 or 6/8. A nurse's note on 6/thrill to touch." A nurse's note on 6/complained of "left medicated with Tyle A nurse's note on 6/complained of pain not severe" and she	er 16 eft arm restriction; No tight sure or needle sticks in left or bleeding, swelling or m." 16/6/12 indicated resident her procedure with the upper arm dry and intact, with n, and no swelling noted. 17/12 read; "resident states uch." 18 ssments documented of arm or left AV fistula site on 19/12. 18 19/10/12 read; "shunt bruted 18 19/11/12 indicated resident #114 arm site pain" and she was enol. 18 19/11/12 revealed resident #114 in her "left arm fistula site but the was medicated with Tylenol.	F	30			
	was medicated with arm soreness. A nurse's note on 6	6/18/12 revealed resident #114 in Tylenol for complaints of left 6/20/12 indicated resident #114 in Tylenol for complaints of left					
	A dialysis note from	n the nephrologists dated he left arm AV fistula was not					

CENTERS FOR MEDICARE & MEDICAID SERVICES		Ţ			OMB NO. 0938-0391			
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[, ,		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
and Plan OF	CORRECTION	IDENTIFICATION NOTICE.	A. BUI	LDIN	NG			
		345414	B. WIN	4G _		07/2	6/2012	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
HAYMOUN	NT REHABILITATION	& NURSING CENTER, INC	2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303					
(X4) ID PREFIX TAG	(FACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 309	referred back to th	d resident #114 may be e surgeon. essments documented of	<u> </u>	30	9			
	6/11/12 through 6/	t arm or left AV fistula site from /20/12. 6/21/12 read; "Permacath site eft arm are both good no	, (************************************		·			
		ed 6/22/12 indicated resident of left arm pain and was denol.						
	There were no as: resident #114's le: 6/22/12, 6/23/12 c	sessments documented of ft arm or left AV fistula site on or 6/24/12.					THE SHAPE OF THE S	
	A nurse's note on fistula site was; "c	6/25/12 indicated the left AV lear with no bleeding noted."						
	practitioner at the patient scheduled	6/27/12 from the nurse dialysis center read; "Will have to see (surgeon) due to pain in giogram and no thrill or bruit ds."					And the state of t	
	dialysis today can see (physician) d/	6/29/12 read; "resident went to ne at 530pm with order to go it (due to) c/o (complaints of) n access Monday July 2, 2012."						
		sessments documented of ft arm or left AV fistula site from //30/12.						
	Review of the Jur	ne 2012 medication						

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391	
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345414	B. WIN	√G		07/26	/2012
	OVIDER OR SUPPLIER	NURSING CENTER, INC	•				
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	XI	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 309	administration record #114 received Tylene 6/11/12, 6/18/12, 6/2 6/25/12, 6/26/12, 6/2 received Tylenol 650 6/13/12, 6/15/12 and There were no asses pain level in the June the June 2012 MAR. Review of the "Dialys communication shee concerns of left AV fi discussed between t center. A physician's progre assistant dated 7/2/1 left AV fistula was "n bruit or thrill. She pla with the surgeon for declot (remove the c A nurse's note dated resident #114 had re appointment and que note that the fistula to was no bruit or thrill. A nurse's note dated was medicated for c pain. Nurse's notes on 7/4	(MAR) revealed resident of 650 mg once a day on 0/12, 6/21/12, 6/22/12, 8/12 and 6/30/12. She mg twice a day on 6/12/12, 6/19/12. sements of resident #114's e 2012 nurse's notes or on sis Visit Findings and Orders" ts for June 2012 revealed no stula pain or left arm pain he facility and the dialysis es note from the surgeon's 2 revealed resident #114's ot working," there was no nned to discuss the findings a possible procedure to	F	309			

STATEMENT ((X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		BEITH 10/110/110/110	A. BUIL					
		345414	B. WIN	G		07	/26/2012	
NAME OF PROVIDER OR SUPPLIER HAYMOUNT REHABILITATION & NURSING CENTER, INC				2346	FADDRESS, CITY, STATE, ZIP COL BARRINGTON CIRCLE ETTEVILLE, NC 28303	DE.		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE AC' TAG CROSS-REFERENCED TO DEFICIENT		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 309	There were no asses resident #114's left at July 2012. Review of the July 20 administration record #114 received Tyleno 7/2/12, 7/3/12, 7/5/12, 7/15/12, 7/16/12, 7/15 She received Tyleno 7/9/12, 7/11/12, 7/12/12, 7/19/12, 7/11/12, 7/12/12, 7/19/12, 7/20/12, 7/2 The national Institute scale classified pain 7-10 as severe. Revirevealed resident #1 pain on 7/16/12 and on 7/9/12, 7/10/12, 7/7/19/12, 7/20/12, 7/2 Pain was not assess was not documented administered. Review of the "Dialys communication shee concerns of left AV fid discussed between the center. On 7/24/12 at 2:20 Pobserved in bed in her	10/12 indicated resident #114 If hand and left arm pain. If hand and left arm pain are room. If hand and left arm pain hand pain or left arm pain hand pain	F	309				
	left arm had hurt sind	ind shoulder. She said her ce early June when she had N fistula. She indicated she						

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

OLIVILIN	OT ON MEDIOMICE W		T."				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345414	B. WING		07/2	6/2012	
	OVIDER OR SUPPLIER	NURSING CENTER, INC	23	ET ADDRESS, CITY, STATE, ZIP COD 46 BARRINGTON CIRCLE LYETTEVILLE, NC 28303	E		
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 309	did not help much. On 7/25/12 at 4:30 Pi was interviewed. She received dialysis thro and the AV fistula in I dialysis. The nurse rehad complained of let occasions and she (the left arm pain to the not dialysis center but co reported the pain. The the left AV fistula was was at dialysis but she AV fistula was found. The nurse reported the appointment schedule surgeon for the left A' indicated that residenther left arm discomforthe dialysis center the She said the facility a communicated by the Findings & Orders' sl could not recall specicalled to the facility for the dialysis center reported that she man assessed the AV fistula She said resident #1" her left arm since she procedure in early Ju notes and indicated of fistulogram there was	M the dialysis center nurse indicated resident #114 ugh a catheter in her chest her left arm was not used for ported that resident #114 fram pain on several he nurse) had reported the urse practitioner at the uld not recall when she is assessed each time she is could not recall when the to be without a bruit or thrill, hat the resident had an ed July 30, 2012 with the V fistula. The dialysis nurse if #114 received Tylenol for rit and reported to the staff at at the Tylenol was effective, and the dialysis center written "Dialysis Visit heet and by phone. She fically any concerns she had	F 309				

Event ID:WSNU11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		IDENTIFICATION NUMBER: A. BUILDING COMPLETED					
		345414	B. WIN	G		07/2	6/2012
HAYMOUNT REHABILITATION & NURSING CENTER, INC 2346 BARR		EET ADDRESS, CITY, STATE, ZIP CODE 346 BARRINGTON CIRCLE AYETTEVILLE, NC 28303					
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO BE	(X5) COMPLETION DATE
F 309	resident see the surge said resident #114 was surgeon on July 30, 2 On 7/26/12 at 8:50 Al interviewed. She stat from her shoulder to have from her shoulder to her pain as "excruciat could only take Tylendheart. She indicated the temporarily. Residenthad negatively impact depressed and tired a not sleep well at night arm. She said some of hair or button her shir arm. She explained the has had to learn to us herself because her le Resident #114 held be in front of her and marthe fist on the right had on the left hand was reported it was too pather left hand. Resident facility had palpated her in the said she nurse had asked her to the trylenol. She said she nurse had asked her to the trylenol or after to see lot of times she just down because she felt.	thrill. She would have the eon for follow up. The NP as scheduled to see the 012. If the resident was ed her left arm had hurt her fingertips daily since the nearly June. She described ing" at times and said she of for the pain due to her hat Tylenol helped #114 said her left arm pain ted her life. She said she felt all the time because she did due to the pain in her left lays she could not brush her to due to the pain in her left lays she could not brush her to due to the pain in her left lays she could not brush her to due to the pain in her left lays she could not brush her to due to the pain in her left lays she could not brush her to due to the pain in her left lays she could not brush her to the pain in her left lays she could not brush her to the pain full. The left lays she could not had helped. She inful to make a tight fist with the tit #114 said no one at the er left arm to assess for a fistula to assess for a bruit lained of pain and asked for could not recall that any or rate her pain prior to if it had helped. She said a lealt with the pain on her no one had helped her.	F	309			

OLIVIERO FOR MEDIOVIRE G		1				CHIE 110: 0000 0001		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345414	B. WIN	G		07/2	26/2012	
	ROVIDER OR SUPPLIER NT REHABILITATION & I	NURSING CENTER, INC	FAYETTEVILLE, NC 28303					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	When asked about the she stated "something was not sure what had when the resident had pain she had only "loo not look at it every time palpated or listened to indicated the facility or dialysis center via paywas not aware of any fistula. She said reside Tylenol for pain almost called the physician. The resident's left arm but could not recall with a said she had never fistula for bruit or thrill her it didn't work. Nurthed told her the AV fistula for bruit or thrill tasks with her left har On 7/26/12 at 11:56 A interviewed. She said and was often the nurth 114 back from dialyst received dialysis through a level 8 and steel 8 and stee	d and cognitively intact. e resident's left arm pain g was done to her left arm, d been done." Nurse #1 said d complained of left arm oked" at the left arm but did ne and she had never to the left arm AV fistula. She communicated with the oer sheet and via phone but concerns with the AV ent #114 had received at daily but she had never She said she had reported pain to the unit supervisor then she reported it. Nurse r assessed the left AV because someone had told se #1 could not recall who stula did not work or when rese #1 said she was not 4 being unable to perform ad.	F	309				
	why she had not docu findings. When nurse	2 said she was not sure amented her abnormal #2 was read the NP note e was no thrill or bruit she					WATCHING AND THE PROPERTY OF T	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345414	B. WIN	IG		07/2	6/2012
	OVIDER OR SUPPLIER	JURSING CENTER, INC		2	REET ADDRESS, CITY, STATE, ZIP CODE 2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	fistula and could not edocumented the abnormal did not notify the physical did not notify the physical did not notify the physical did not notify the physician. Nurse of the notify the physician of any of her assessment arm. On 7/26/12 at 12:25 Finterviewed. She said with resident #114. Shoccasionally complains she assessed the left she worked with the nassessed the AV fistual 21 and 22) and the fish Nurse #3 was read the here was no thrill or be have gotten busy last the AV fistula." Nurse she did not document. On 7/26/12 at 1:05 Phinterviewed. She said an active dialysis according to the physical did not	It a bruit or thrill in the AV explain why she had not ormal findings. She said she sician because he was resident's left arm pain and of working. Nurse #2 also ident #114 complained of nd said she did not notify #2 could not explain why the left hand numbness or why she did not document has of resident #114's left. PM nurse #3 was a she worked weekend days he said the resident hed of left arm pain and that arm AV fistula each time esident. She said she last ha "this past weekend" (July tula was "normal." When he NP note from 6/28/12 that bruit she said that she "may weekend and not assessed #3 could not explain why any of her assessments. If the unit supervisor was her expectation was that her expectation was	L.	309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ULTIPL	LE CONSTRUCTION	(X3) DATE SU COMPLE		
		345414	B. WI	ie		07/:	26/2012	
NAME OF PROVIDER OR SUPPLIER HAYMOUNT REHABILITATION & NURSING CENTER, INC				. 23	EET ADDRESS, CITY, STATE, ZIP CODE 146 BARRINGTON CIRCLE AYETTEVILLE, NC 28303			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) .		ID PREFIX TAG		(EACH CORRECTIVE ACTION :	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
	On 7/26/12 at 2:40 PM (DON) was interviewed staff to assess an AV a recent procedure shabe assessed every shabe expected the staff assessment. The DOI have a policy or procedure assessment of the assessment of	In the Director of Nursing and She said she expected fistula daily. If the site had be expected the AV fistula to iff. The DON also indicated to document the N stated the facility did not adure for dialysis residents dialysis access sites. In resident #114 was She used her right arm and ctivity. If the certified occupational TA) was interviewed. She was interviewed. She will the complained of left arm impair her ability to dress hair with her left arm at cated she told the nurse ocument it and could not the date resident #114 had	F	309				
	order written to assess	#114 should have had an the left arm AV fistula and included the frequency of		-				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/26/2012	
	345414						
NAME OF PROVIDER OR SUPPLIER HAYMOUNT REHABILITATION & NURSING CENTER, INC				°23	EET ADDRESS, CITY, STATE, ZIP CODE 846 BARRINGTON CIRCLE AYETTEVILLE, NC 28303		·
(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)		(X5) COMPLETION DATE
F 309	the assessment. The expected the facility to for assessment of dial he expected that resid have been assessed for the expected that the facility is the expected that the expected t	facility physician said he have a procedure in place ysis access sites. He said lents #114's left arm would or each complaint of pain.	F	309	DEPICIENCY		

DEPART	MENT OF HEALTH	AND HUMAN SERVIC	EO				OMB NO	0.0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LIA (X2)	A BUILDING 03-MAIN BUILDING 1 2 20 2 COMPLETED						
		345414	В, У	AING		TAICTCHT	08/	21/2012	
NAME OF P	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, 0	CITY, STATE, ZIP COD	E-Savier Conte		
HAYMOL	INT REHABILITATION	i & nursing center, i	NC -			E, NC 28303			•
(X4) ID PREFIX TAG	THAPH DESIDENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FUL O IDENTIFYING INFORMATIO	L PRI	D EFIX AG	ICANU O	IDER'S PLAN OF COR ORRECTIVE ACTION FERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE	٠
K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was			⟨ 000	Nursing (nt Rehabilitation Center acknowle The Statement of The yand proposes	edges of		٠
K 012	conducted as per T at 420FR 483.70(a section of the LSC publications. This b one story, with a co system. The deficiencies de are as follows:	he Code of Federal Ke): using the New Health	ruction, kler	₹ 012	of correct summary correct ar complian and the p to resider correction	tion to the extent of findings is faid in order to move the with application of qualits. The plan of n is submitted and of compliance	t that the actually aintain ble rules ity care		
SS=0	Building construction of the following: 18 This STANDARD Based on observa approximately 1:30 1) There are two is in the top layer of slocated above the integration of the state of the st	on type and height meels, 1,6,2, 18,1,8,3, 18,2,5,5,4,6,2, 18,1,8,3, 18,2,5,5,5,5,5,5,5,5,5,5,5,5,5,5,5,5,5,5,	by: 2 at noted: 5 hole		Statemen plan of co agreemen Haymoun Nursing reserves documen deficienc appeals p	w response to the tof Deficiency correction does not with the citation to Rehabilitation. The facithe right to substation to refute by through informative or legal ngs.	and the ot denote on by 1 and lity nit the stated mal		
K 029 88=F	Hazardous areas a with 8.4. The area fire-rated barder, w	FETY CODE STANDA re protected in accorda s are enclosed with a fith a 3/4 hour fire-rated a accordance with 8.4). automatic closing in 2.1.8. 18.3.2.1	nce ne hour door,	K 029	·	The two large has smaller hole is layer of sheetro attic above the were patched by Maintenance D	n the top ck in the kitchen y the	9/14/12	
1 1 1	ANIX () I	DEMBURNIER NEPHESENTA			Adm	inistrat	DP C	(16) DATE	لو
other sateau	ards provide sufficient pro date of survey whether o ig the date these docume	on asterisk (*) denotes a deficient of the patients. (See I r not a plan of correction is prints are made available to the	ovided. For nurs facility. If deficts	sing hom encles er	an the choice H	indings and plans of corrections	enrection ata dis	continued	

021010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG 03 - MAIN BUILDING	(X3) DATE SURVEY COMPLETED	
		345414	B. WING_	•	08/21/2012	
•	ROVIDER OR SUPPLIER INT REHABILITATIO	n & Nursing Center, Inc		REET ADDRESS, CITY, STATE, ZIP CODE 2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303		
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCEO TO THE AF DEFICIENCY)	HOULD BE COMPLETION	
K 029 K 052 ss=E	This STANDARD Based on observa approximately 1:30 1) The corridor do- norishment and cla Long Term nursing and seal. 42 CFR 483.70 NFPA 101 LIFE SA A fire alarm system installed, tested, ar with NFPA 70 Natio 72, The system has and testing program	is not met as evidenced by: tion on Tuesday 8/21/12 at PM the following was noted: ors to the solled linen, an linen rooms located at the station did not close, latch AFETY CODE STANDARD A required for life safety is and maintained in accordance onal Electrical Code and NFPA an approved maintenance in complying with applicable PA 70 and 72. 9.6.1.4	K 029	2. The total attic are inspected to ensure no other non-consistes were present as the Maintenance Director will inspected and will fix as not and will fix as not and will fix as not contractors performed work in the attic be advised to correct/report and that are created fix their work. 4. The Maintenance Director or design complete a montinspection of the area for three montinspection of the area for three montinspection that the next the next the second atticked and the second atticked area for three montinspection of the area for three montinspection that the second atticked area for three montinspection of the area for three montinspection area.	re that inpliance ont. sect the r holes cessary. orming area will y holes rom 9/17/12 onee will hly attic onths and	
K 069	Based on observa approximately 1:30 1) Upon review of dated 7/10/12 from there are deficience were not corrected a. Smoke detecto operate. b. Smoke detecto	is not met as evidenced by: tion on Tuesday 8/21/12 at PM the following was noted: Fire Alarm inspection report VSC Fire and Sprinkler Inc., es noted in the report that : r outside therapy did not or needed to be cleaned.	K 069	onome proper crosses	hly. s and/or be ngly. to the ment, ed at the ere tenance have r to e and	
8\$≃D	Cooking facilities a	re protected in accordance		sealing.	8/28/12	

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING 03 - MAIN BUILDING B. WING 345414 08/21/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2346 BARRINGTON CIRCLE HAYMOUNT REHABILITATION & NURSING CENTER, INC FAYETTEVILLE, NC 28303 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL) PROVIDER'S PLAN OF CORRECTION ID PREFIX (X6) Completion Date PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K029 cont. K 069 Continued From page 2 K 069 with 9.2.3. 18,3,2,6, NFPA 96 3. Staff will be in-serviced to notify the Maintenance Director of doors that do not close and seal properly so This STANDARD is not met as evidenced by: that the doors can be Based on observation on Tuesday 8/21/12 at corrected. 9/17/12 approximately 1:30 PM the following was noted: 4. The Maintenance Director 1) The kitchen makeup air for the kitchen hood or designee will complete a was not sufficient at the time of survey. The monthly inspection of all kitchen was experiencing a negative air balance corridor doors. Findings will at the time of the survey. be discussed by the Safety Committee monthly. Facility 42 CFR 483.70 protocols and/or in-servicing will be adjusted accordingly. K 104 NFPA 101 LIFE SAFETY CODE STANDARD K 104 9/25/12 SS=D K052 Penetrations of smoke barriers by ducts are 1. Maintenance Director was protected in accordance with 8.3.6. already aware of the nonfunctioning smoke detector. The smoke detector is scheduled to be replaced by This STANDARD is not met as evidenced by: 9/14/12. 9/14/12 Based on observation on Tuesday 8/21/12 at 2. All smoke detectors will be approximately 1:30 PM the following was noted: inspected by a contractor 1) The two smoke dampers located above the service to ensure they work kitchen did not operate when tested. properly and are clean. Any deficiencies found will be 42 CFR 483.70 corrected by the contractor service or Maintenance Director. 9/14/12 3. Maintenance Director will randomly check smoke detectors during the two monthly fire drills. Contractor service will continue to inspect smoke detectors on an annual basis to ensure they work properly 9/17/12 and are clean.

PRINTED: 08/25/2012

FORM APPROVED

PRINTED: 08/25/2012 FORM APPROVED OMB NO. 0938-0381 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER: 345414	A. BUI B. WII	ILDIN	G 03 - MAIN BUILDING	COMPLETED 08/21/2012	
NAME OF PROVIDER OR SUPPLIER HAYMOUNT REHABILITATION & NURSING CENTER, INC STREET ADDRESS, CITY, STATE, ZIP CODE 2346 BARRINGTON CIRCLE FAYETTEVILLE, NC 28303						
PRESENT TEACH DESIG	RY STATEMENT OF DEFICIENCIES DIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREP TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION ST OROSS-REFERENCED TO THE AP DEFICIENCY)	KODED BE	COMPLETION DATE
				K052 cont.		
				4. Monthly checks and inspections will be disc the Safety Committee Facility protocols and/servicing will be adjustaccordingly.	cussed by monthly. or in-	. 9/25/12
				K069 1. The kitchen makeup the kitchen hood system inspected by a contract service. 2. Maintenance Director inspect the hood system ensure proper function	m was for or will n to	9/17/12
				weekly for 4 weeks and monthly thereafter. 3. Inspections will be by the Safety Committ monthly. Facility proteind/or in-servicing will adjusted accordingly.	discussed ee ocols	9/17/12
	•			K104 1. The two smoke dam located above the kitch scheduled to be repaire 9/14/12.	nen are	9/14/12
	Control Front In Walk			atte ID: 923149 If c	onlinuation she	al Page and

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY ITATEMENT OF DEFICIENCIES WD PLAN OF CORRECTION COMPLETED A. BUILDING 03 - MAIN BUILDING B. WING 08/21/2012 345414 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2346 BARRINGTON CIRCLE HAYMOUNT REHABILITATION & NURSING CENTER, INC FAYETTEVILLE, NC 28303 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X9) COMPLETION DATE Ю (X4) ID PREFIX TAG PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) K104 cont 2. All smoke dampers will be inspected by a contractor service to ensure they work properly and are clean. Any deficiencies found will be corrected by the contractor 9/14/12 service or Maintenance Director. 3. Maintenance Director will randomly check smoke dampers during the two monthly fire drills. Contractor service will continue to inspect smoke dampers on an annual basis to ensure they work 9/17/12 properly. 4. Monthly checks and annual inspections will be discussed by the Safety Committee monthly. Facility protocols and/or inservicing will be adjusted 9/25/12 accordingly.

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