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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

<table>
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<tr>
<th>(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:</th>
<th>(X2) MULTIPLE CONSTRUCTION</th>
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<tr>
<td>345436</td>
<td>A. BUILDING</td>
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<td>B. WING</td>
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<td>10/31/2012</td>
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NAME OF PROVIDER OR SUPPLIER
WELLINGTON REHABILITATION AND HEALTHCARE

STREET ADDRESS, CITY, STATE, ZIP CODE
1009 TANDALL PLACE
KNOTTDALE, NC 27545

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SS=B
483.10(b)(5) - (10), 483.10(b)(1)
NOTICE OF RIGHTS, RULES, SERVICES, CHARGES

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.

F 156
1. Residents #40 and #112 responsible parties were contacted on 11/14/2012 to confirm that they had received the Advanced Beneficiary Notice mailed by the facility Director of Social Services. They both confirmed that they had received the notification and confirmation of such was documented in their record under the Social Services tab.

2. Residents receiving Medicare benefits who have been discontinued from receiving those benefits from 10/1/12 to 11/15/12 have been reviewed by the Director of Social Services to confirm acknowledgement of receipt of the Medicare non-coverage notice within 5 days of discontinuing Medicare coverage. Documentation of confirmed receipt was obtained from the notices that had not been received back in the facility. The Social Worker was educated by the Executive Director on the facility policy and procedure regarding Advanced Beneficiary Notices.

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

ALGALDIA, M. HENDLAND

TITLE
EXECUTIVE DIRECTOR

DATE
11/16/2012

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 discoverable 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 discoverable 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.
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<tr>
<td>A description of the manner of protecting personal funds, under paragraph (c) of this section;</td>
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<td>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</td>
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<td>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</td>
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<td>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's</td>
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F 156: Continued From page 2

policies to implement advance directives and applicable State law.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:

Based on documentation and staff interview the facility to acquire a acknowledged receipt of the Medicare provider non coverage notice for 2 of 3 sampled residents' (Resident #40 and #112).
The Non coverage notice identifies the resident's right to appeal the decision for discontinuation of physical, speech or occupational services under Medicare. The denial of payment under Medicare must be provided to the resident/responsible party in advance.

The non-coverage notices identifies the right to appeal decision for services such as physical, occupational therapy, or speech services after the effective date indicated and services one may have to pay for any therapeutic services one received after the date Medicare A ends. The right to appeal decision identifies with a signature that the responsible person and/or individual had been notified that the coverage of services would
F 156 Continued From page 3

end on the effective date indicated on the notice and that they may appeal the decision by contacting the QIO (Quality Improvement Organization). The QIO is the independent reviewer authorized by Medicare to review the decision to end the services.

1. Resident #40 was admitted to the facility on 7/16/12. Her diagnoses included difficulty walking, joint contracture and abnormal posture. The Minimum Data Set (MDS) dated 9/12/12, indicated that Resident #40 had some short and long term memory and decision making problems. Resident #40 received occupational and therapy services.

Review of the non-coverage notice identified the end of coverage date as 7/23/12 and the letter was mailed on 7/17/12. There was no signature that indicated that the responsible person or Resident #40 had been notified that the coverage of services would end on the effective date indicated on the notice and that they may appeal the decision by contacting the QIO (quality improvement organization).

During an interview on 10/31/12 at 11:47AM, the business office manager indicated that the SW (social worker) was responsible for sending out the non-coverage letters. She indicated that once the date had been determined for discharge the treatment team would discuss the discharge plan and the SW would send the letters and follow-up with resident/family and inform BOM so that billing could be monitored during the appeal process. She indicated that she was unaware of when the notices were sent and the dates on BO file for Resident #40 indicated that end of services would be 10/18/12 and Resident #112...
F 156 Continued From page 4
6/18/12. The non-coverage notices were reviewed and revealed the dates did not match what was on the financial file. The BOM indicated she did not know what system the SW used to follow-up on whether the RP/resident received the notices.

During an interview on 10/31/12 at 12:35PM, the SW indicated that non-coverage letters was sent for Resident #112 on 6/11/12 (end of coverage 6/16/12), he did not have a signed copy of the letter nor was he sure the family/resident received the letter. He indicated that he did not have a system in place to follow-up to ensure the letter was received or a signature obtained. Resident #40 end date 7/23/12 sent 7/17/12 there was no signature on document and SW indicated that he had not follow-up on whether the residents received the document. There was no response on the process to correlate the discharge dates with the BOM for billing purposes.

2. Resident #112 was admitted on 5/29/12 and discharged on 6/18/12. Her diagnoses included difficulty walking, general muscle weakness and rehabilitation services. The Minimum Data Set (MDS) dated 5/29/12, indicated that Resident #112 had no short or long term memory or decision problems. Resident #112 received occupational and physical therapy.

Review of the non-coverage notice identified the end coverage date as 9/10/12 and the letter was mailed on 6/11/12. There was no signature that indicated that the responsible person or Resident
### Continued From page 5

#112 had been notified that the coverage of services would end on the effective date indicated on the notice and that they may appeal the decision by contacting the QIO (quality improvement organization).

During an interview on 10/31/12 at 11:47 AM, the business office manager indicated that the SW (social worker) was responsible for sending out the non-coverage letters. She indicated that once the date had been determined for discharge the treatment team would discuss the discharge plan and the SW would send the letters and follow-up with resident/family and inform BOM so that billing could be monitored during the appeal process. She indicated that she was unaware of when the notices were sent and the dates on BO file for Resident #40 indicated that end of services would be 10/18/12 and Resident #112 6/18/12. The non-coverage notices were reviewed and revealed the dates did not match what was on the financial file. The BOM indicated she did not know what system the SW used to follow-up on whether the RP/resident received the notices.

During an interview on 10/31/12 at 12:35 PM, the SW indicated that non-coverage letters was sent for Resident #112 on 6/11/12 (end of coverage 6/16/12), he did not have a signed copy of the letter nor was he sure the family/resident received the letter. He indicated that he did not have a system in place to follow-up to ensure the letter was received or a signature obtained.

Resident #40 and date 7/23/12 sent 7/17/12 there was no signature on document and SW indicated that he had not follow-up on whether the
Continued From page 6

Residents received the document. There was no response on the process to correlate the discharge dates with the BOM for billing purposes.

During an interview on 10/31/12 at 3:13PM, the administrator indicated the expectation was the SW would send the non-coverage letters out certified and SW expected to follow-up to ensure the resident/family receives and make follow-up phone call.

Review the Social worker notes for each of the residents neither resident had a note indicating the non-coverage notice was sent and whether the resident/RP received the information.

The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident’s dignity and respect in full recognition of his or her individuality.

Based on observation and staff interview the facility failed to maintain an environment in which there are no signs posted in residents’ rooms that are visible where other residents and/or visitors can see confidential clinical or personal information for 24 of 26 sampled residents.

(Resident #15, #74, #89, #43, #51, #37, #104, #85, #53, #57, #29, #18, #38, #19, #22, #80, #41, #62, #58, #71, #21, #72, #20, #88.)

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<tr>
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<td>F 241</td>
<td>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</td>
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<td>This REQUIREMENT is not met as evidenced by:</td>
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1. The signage was removed from resident #15’s room on 10/31/12.

Consents were obtained for residents 15, 74, 89, 43, 51, 37, 104, 85, 53, 57, 29, 18, 38, 19, 22, 80, 41, 62, 58, 71, 21, 72, 20, and 88 to have a falling star used as a part of the facility’s fall risk program. Consents were also obtained for residents 74, 89, 43, 51, and 15 to have a hummingbird icon used as an identifier in the facility to alert staff of their dietary restrictions.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

| (X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION
| A. BUILDING | B. WING |
| 345436 | |

**NAME OF PROVIDER OR SUPPLIER**
Wellington Rehabilitation and Healthcare

**STREET ADDRESS, CITY, STATE, ZIP CODE**
1008 Tandall Place
Knightdale, NC 27545

**ID PREFIX TAG**

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<th>F 241</th>
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<td>Findings include:</td>
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On 10/29/2012 at 09:58:49 AM a sign was observed on the wall over the bed of resident #15. The sign identified the resident by name that read: "float heels when in bed. No shoes or Ted Hose To Right Foot. The sign was observed as stated above on 10/29/12 at 3:00PM and on 10/30/12 at 10:00am.

An interview with nurse #4 on 10/30/12 at 11:30am revealed that the sign on the wall over resident #15's bed was placed there by the nurses.

On initial tour of the facility 10/28/12 at 9:30am a picture of a falling star was observed next to 21 residents name located next to the entrance to resident rooms. Resident #41, #62, #58, #71, #21, #72, #20, #86, #37, #104, #51, #85, #53, #57, #29, #18, #38, #19, #22, #30, and #89 had a picture of a falling star next to their names. The falling star sign was observed on 10/29/12, 10/30/12 and on 10/31/12 next to resident names outside the entrance to their rooms.

An interview with the Assistant Director of Nursing on 10/28/12 at 11:00am that signage was used for keeping resident safe and so new staff knew how to care for resident. A falling star indicates that resident is on the fall risk program.

On the initial tour of the facility on 10/28/12 at 9:30am and on 10/29/12, 10/30/12 and on 10/31/12 a picture of a hummingbird was next to the name of 5 resident beside the entrance to their rooms. Resident #74, #89, #43, #51 and #15

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| F 241 | |

**PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)**

2. An audit of current residents was completed by the MDS Coordinator and Dietary Manager to ensure consents were obtained for residents needing a care identifier 10/30/2012. The Interdisciplinary Team was educated by the Executive Director on the facility policy and procedure regarding Resident Care Identifiers and need for consent to be obtained at the time of implementation of care identifiers. The education will be provided to newly hired staff during the orientation process.

3. The DCS or Unit Manager will conduct Quality Improvement (QI) monitoring of new care identifiers to ensure consents have been obtained at the time of implementing the identifier 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months.

4. The DCS or Unit Manager will report results of QI monitoring to the Performance Improvement Committee monthly x 12 months for continued compliance and/or revision.

5. Date of completion 11/28/2012

FORM CMS-2567(OH-49) Previous Versions Obsolete

Event ID: 948711

Facility ID: 9235537

If continuation sheet Page of 8 of 18
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were observed to have a picture of a hummingbird next to their names beside the entrance to their rooms.

An interview with the ADON on 10/28/12 at 11:00am that signage was used for keeping resident safe and so new staff knew how to care for resident. A picture of a hummingbird indicated the resident was on nectar thick liquids.

**F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING**

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:

- Based on observation, record review and staff interview, the facility failed to provide positioning for a resident in a wheel chair for one of 3 sampled residents. Resident #28

Findings included:

- Resident #28 was admitted to the facility on 10/3/11. Active diagnoses include Dementia, Parkinson, hypertension and depression.

- A review of the annual minimum Data Set dated 8/28/12 revealed resident has long and short term memory problems. Cognitive status was severely impaired. No range of motion limits were
Continued From page 9

identified. Bed mobility was with extensive assist with one person. Activities of daily living require extensive assist with 1 person.

A review of the current care plan dated 9/10/12 identified a problem of fragile skin prone to skin tears. The interventions included reposition every round and as necessary and use pillows or other supportive/protective devices to assist with positioning.

A review of the kardex used by the nursing aides providing care for Resident #28 identified she was to be repositioned every 1 to 2 hours.

On 10/29/12 at 10:23am Resident #28 was observed sitting in a wheelchair leaning to the left side of chair, a family member placed a pillow in the wheel chair to straighten resident up. He stated that she is always leaning and the staff do not always put the pillow in place.

On 10-30-12 at 9:45Am resident was observed sitting next to her bed in a broda wheelchair. She was leaning toward the left side of the chair with her head resting against the side of the chair; there was no positioning device in place.

On 10/31/12 at 11:20am Resident #28 was observed sitting in a broda wheelchair next to the bed leaning to left with her head resting on side of chair; no positioning device was in place.

A review of the physician orders revealed a order listed on the October 2012 monthly pre-printed order sheet with an original date of 12/19/11 that read may use neck collar for head positioning.

An interview with the nurses aide (NA) #1 on 10/31/12 at 10:31am revealed that she provided care daily for Resident #28. NA#1 indicated that
**Statement of Deficiencies and Plan of Correction**

**NAME OF PROVIDER OR SUPPLIER:**

WELLINGTON REHABILITATION AND HEALTHCARE

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

1900 TANDALL PLACE

KNIGHTDALE, NC 27545

**DATE SURVEY COMPLETED:**

10/31/2012

<table>
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<tr>
<th>(X1) ID</th>
<th>SUMMARIZING STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LEGAL IDENTIFYING INFORMATION)</th>
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she positioned resident every 2 hours. Further discussion revealed that a pillow was used to put on her side and she had a neck brace to help position her in the wheelchair. "I do not put them on when she is active, she will use them to try and stand up. I only put them in when she is sleeping." |
| F 315  | **F-315**
483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on medical record review, resident and staff interview, the facility failed to provide a diagnosis and order for the use of a urinary catheter for one of two residents with urinary catheters (Resident #39). Findings include:

- Resident was admitted to the facility 1/13/12 and readmitted on 3/9/12. Cumulative diagnoses included: Diabetes Mellitus, Hypertension, Chronic pain syndrome and history of prostate cancer. Diagnoses also included the use of an indwelling urinary catheter (suprapubic catheter).

A Significant Change Minimum Data Set (MDS)

- 1. A diagnosis of Urinary Retention was received for resident #39 on 10/31/2012.
- 2. Current residents with urinary catheters have been reviewed to ensure there is a diagnosis supporting continued catheter use and an order for use in place. Current licensed nurses were educated on the acceptable clinical condition to utilize a urinary catheter and need for physician order to care for the urinary catheter.
- 3. The DCS or Unit Manager will conduct Quality Improvement (QI) monitoring supporting documentation and orders for caring for the urinary catheter 5 x weekly for 4 weeks, then 3 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. New admission charts and telephone orders will be reviewed daily to identify any new orders related to urinary catheters.
Education will be provided to newly hired licensed nurses during the orientation process.
4. The DCS/Designee will report results of QI monitoring to the Risk Management/Quality Improvement (RM/QI) Committee monthly x 12 months for continued compliance and/or revision.
5. Date of completion 11/28/2012
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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On 10/31/12 at 9:59 AM, Resident #39’s primary physician stated Resident #39 had chronic hematuria (blood in urine) and problems with obstruction due to prostate cancer history. He further indicated he would recommend the indwelling catheter be changed on an “as needed” basis. Resident #39’s physician said he was unaware there was not a physician’s order for the indwelling catheter or for the catheter to be changed as needed by the nursing staff.

On 10/31/12 at 5:15 PM, the Director of Nursing stated there should be a physician’s order for the use of the indwelling catheter (suprapubic catheter).

| F 320 | SS=D | 483.25J) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS |

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically

F-329

1. Resident #15 and #74 antipsychotic medication has been discontinued by the physician.

2. Current residents receiving antipsychotic medications have been reviewed by the Director of Clinical Services and Unit Manager. An audit was completed to ensure there was a diagnosis supported for continued use of the medication and need for risk versus benefit statement for continued use of an antipsychotic medication without a dose reduction. Three gradual dose reductions and eight eliminations were initiated by the physician on 11/16/2012.

Current licensed nurses were educated on the requirement of
**Pediatrician**:

*Continued From page 13*

contraindicated, in an effort to discontinue those drugs.

This **REQUIREMENT** is not met as evidenced by:

Based on observation, record review and staff interview, the facility failed to have a diagnoses for the use of antipsychotic medication (Risperidal) and Seroquel) for 2 of 10 residents. (Resident #15 & #74) The facility also failed to have documentation which included the benefits versus the risk for continued use of an antipsychotic medication with out a dose reduction for 1 of 10 sampled residents. (Resident #15 & #74)

Findings include:

- Resident #15 was admitted to the facility on 8/10/12. Diagnoses included but not limited to hypertension, cardiovascular accident, contracture right hand, dysphagia, hiatal hernia, anemia, abnormal posture, depression and anxiety.

- A review of the physician orders for the month of October 2012 revealed an order for Risperidal 0.25mg take 1 tab daily. The original date of order was 1/30/12.

- A review of Resident #15's medical record had no documentation of a diagnoses for the use of Risperidal.
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<td>An interview with the director of nursing on 10/31/12 at 1:00pm revealed that she did not see a diagnoses or medical justification in the residents chart for the use of Respidual.</td>
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<td>Resident #74 was admitted to the facility on 3/8/12. The active diagnoses were listed as hypertension, dementia and depression.</td>
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<td>A review of the current physician orders for the month of October 2011 revealed an order for Seroquel 25mg every hours of sleep (hs).</td>
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<td>A review of the medical record revealed the resident was admitted to the facility on Seroquel. Further review of the medical record revealed there was no documentation of a diagnoses for the use of Seroquel.</td>
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<td>An interview with the assistant director of nursing on 10/31/12 at 3:15pm confirmed there was no diagnoses for the use of Seroquel. The assistant director of nursing indicated that she had reviewed the residents medical record and there was diagnoses available.</td>
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<td>2. Resident #15 was admitted to the facility on 8/10/12. Diagnoses included but not limited to hypertension, cardiovascular accident, contracture right hand, dysphagia, hialtal hernia, anemia, abnormal posture, depression and anxiety.</td>
<td>A review of the medical record for Resident #15 revealed a pharmacy consultation report dated 8/11/12 that recommended a dose reduction for the Respidual. The physicians' response was that the daughter indicated the resident was</td>
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hospitalized after changers in medication and she refused any further reduction in dosing of medication. The response also stated this discussion was done via a phone call.

Further review of the medical record revealed there was no documentation of the benefits over weighted the risks in the use of Respidal was available.

An interview with the director of nursing on 10/31/12 at 1:00pm revealed that she could not find any documentation in Resident #15's chart indicating the benefits of the use of Respidal over weighted the risks associated with the medication.

The facility must post the following information on a daily basis:
- Facility name.
- The current date.
- The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift.
  - Registered nurses.
  - Licensed practical nurses or licensed vocational nurses (as defined under State law).
  - Certified nurse aides.
- Resident census.

The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:
- Clear and readable format.
- In a prominent place readily accessible to
**F 356** Continued From page 16 residents and visitors.

The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This **REQUIREMENT** is not met as evidenced by:
Based on observation and staff interview the facility failed to have the daily staffing hours posted in the facility for 1 of 1 required posting.

Findings include:

- On 10/28/12 during the initial tour of the facility no daily staffing hours were observed posted within the facility. On 10/29/12. 10/30/12 and the morning of 10/31/12 no staffing hours were observed posted within the facility.
- On 10/28/12 at 11:50am the Assistant Director of Nursing brought in a daily staffing sheet to the conference room.
- An interview with the Director of Nursing on 10/30/12 at 2:00pm revealed that the daily staffing hours were usually posted daily. She also stated that the staffing hours was reviewed daily in the facility stand up meeting, however they have not had a stand up meeting like they normally do this week and she did not realize it was not posted.

**F 356**

4 weeks and then one time monthly for 9 months to ensure daily staffing posting is accurate and complete.

5. The Nursing Home
Administrator or designee will report the results of the Quality Improvement tool to the Performance improvement committee monthly x 3 months to identify trends and need for further education and/or monitoring. Date of completion 11/28/2012
<table>
<thead>
<tr>
<th>ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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WELLINGTON REHABILITATION AND HEALTHCARE

1000 TANDALL PLACE
KNIGHTDALE, NC 27545

NAME OF PROVIDER OR SUPPLIER:

WELLINGTON REHABILITATION AND HEALTHCARE

STREET ADDRESS, CITY, STATE, ZIP CODE:

1000 TANDALL PLACE
KNIGHTDALE, NC 27545

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/QUA IDENTIFICATION NUMBER:

345438

(X2) MULTIPLE CONSTRUCTION:
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED:
10/31/2012
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
WELLINGTON REHABILITATION AND HEALTHCARE

**STREET ADDRESS, CITY, STATE, ZIP CODE**
1900 TANDALL PLACE
KNIGHTDALE, NC 27545

**DATE SURVEY COMPLETED**
11/27/2012

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<tr>
<td>K 012 SS=D</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1</td>
<td>K 012</td>
<td>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.</td>
<td></td>
</tr>
<tr>
<td>K 018 SS=D</td>
<td>NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</td>
<td>K 018</td>
<td>1. The Maintenance Director added fire caulking and dry wall around the pipes in the sprinkler riser room and the kitchen water heater room on 12/18/2012. 2. An audit was completed by the Maintenance Director to ensure that all areas around the hot water heaters were sealed to meet code K012. 3. The Maintenance Director will conduct Quality Improvement (QI) monitoring of this standard 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months. 4. The Maintenance Director will report results of QI monitoring to the Risk Management/Quality Improvement (RM/QI) Committee monthly x 12 months for continued compliance and/or revision. 5. Date of completion 12/31/2012.</td>
<td>12/18/12</td>
</tr>
</tbody>
</table>

**LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

[Signature]

**TITLE**
EXECUTIVE DIRECTOR

**DATE**
12/18/12

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 60 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.
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<tr>
<td>K018</td>
<td>Continued From page 1</td>
<td></td>
<td>This STANDARD is not met as evidenced by: A. Based on observation on 11/27/2012 the door to the MDS office failed to latch. 42 CFR 483.70 (a)</td>
<td>K018</td>
<td></td>
<td></td>
<td>2. An audit was completed by the Maintenance Director to ensure that all doors latched in accordance with K018.</td>
<td>12/31/12</td>
</tr>
<tr>
<td>K062</td>
<td>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</td>
<td></td>
<td>This STANDARD is not met as evidenced by: A. Based on observation on 11/27/2012 the facility had no records of a five (5) year obstruction test for the dry sprinkler system. 42 CFR 483.70 (a)</td>
<td>K062</td>
<td></td>
<td></td>
<td>3. The Maintenance Director will conduct Quality Improvement (QI) monitoring of this standard 2 x weekly for 4 weeks, then 1 x weekly for 4 weeks, and then 1 x monthly for 9 months.</td>
<td>12/31/12</td>
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<td>4. The Maintenance Director will report results of QI monitoring to the Risk Management/Quality Improvement (RM/QI) Committee monthly x 12 months for continued compliance and/or revision.</td>
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<td>5. Date of completion 12/31/2012.</td>
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**NOTE:** FORM CMS-2587(02-99) Previous Versions Obsolete

**Event ID:** 048721

**Facility ID:** 923537

If continuation sheet Page 2 of 2