APR 0 3 200

PRINTED: 03/22/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '		CONSTRUCTION	(X3) DATE S COMPL	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILO	NG		C	
		345070	B. WING			_	7/2013
NAME OF PR	OVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
	MINOR OF BEHARM IT	ATION CENTER		l	I1 S LASALLE STREET		
DURHAM	NURSING & REHABILITA	ATION CENTER		D	URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCEO TO THE APPROPRI DEFICIENCY)	e Ate	(X6) COMPLETION DATE
F 241 SS=D	manner and in an envenhances each reside full recognition of his This REQUIREMENT by: Based on observation interviews with reside to provide mouth care.	note care for residents in a vironment that maintains or ent's dignity and respect in	F	241	This Plan of Correction is submitted required under State and Federal Lar facility's submission of the Plan of Correction does not constitute an acon the part of the facility that the fir cited are accurate, that the findings constitute a deficiency, or that the sand severity determination is correct Because the facility makes no such admissions, the statement made in of Correction cannot be used against facility in any subsequent administration.	w. The imission adings cope et. the Plan at the	3)31/13
	Findings include: Resident #26 was read/15/11. Resident #2	admitted to the facility on 6 had diagnoses including ulmonary disease, chronic			F241 The facility does and will continue promote care for residents in a mai	nner that	
	The care plan, most 11/21/11, indicated the assistance with and/odaily living (ADLs) will Goals included that the experience cleanline receive assistance, a day. Interventions income	recently updated on ne resident required or provision for activities of hich include mouth care. he resident would ss and comfort each day and as needed, for ADLs each cluded that staff would set up			maintains or enhances each resider dignity and respect in full recognition or her individuality. 1. Resident #26 was provided mour on 03/07/13 and will continue per Guide. 2.A list of residents having the potential be affected was compiled on 03/07/15.	on of his th care ADL Care ential to 3/13 by	
	dated 11/19/12, indic cognitively intact, pa and did not exhibit b	al Minimum Data Set (MDS), cated the resident was rticipated in the assessment, ehaviors of rejecting care.	PE-		the Minimum Data Set Coordinato the assessment criteria: (setup and supervision through total care – po hygiene) from the Minimum Data	d/or ersonal	(X9) DATE

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

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

Event ID: QTOR11

Facility ID: 923264

If continuation sheet Page 1 of 13

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION	COMPL	ETED
		345070	B. WNG			l	7/2013
	ROVIDER OR SUPPLIER NURSING & REHABIL	ITATION CENTER		41	EET ADDRESS, CITY, STATE, ZIP CODE I1 S LASALLE STREET URHAM, NC 27705		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	41E E	(X5) COMPLETION DATE
F 241	personal hygiene, sextensive assistant. The Nursing Summ stated the resident able to make decisidally activities indenot reject care, and stated the resident, extensive to total at to his [diagnoses] costeoarthritis, multipain." At 11:43am on 3/4/don't help me brush to help me, but the do it 'when they ge teeth were observe white/yellow coatin in between all visib At 1:50pm on 3/5/1 one has brushed masked them. It was shift." Resident #2 thick, white/yellow and in between all The nursing assist dated 3/5/13 for the indicated that NA# Resident #26.	tional status indicated that for self-performance, he needed see. Tary assessment dated 2/28/13 was "cognitively intact. He is ions regarding his clothing and pendently." It indicated he did was easily understood. It "continues to require sist with his ADLs secondary of [right] hip disarticulation, joint contractures and chronic 13, Resident #26 stated, "They may teeth. I have asked them yodon't. They said they would that around to it'." Resident #26's aid to be covered with a thick, go covering the surface of and le teeth. 3, Resident #26 stated, "No may teeth today or yesterday. It is either on the third shift or first 6's teeth were covered with a coating covering the surface of visible teeth. ant (NA) assignment sheet third shift (11pm-7am) 1 worked and was assigned to the course of the shift of the third shift	F	241	Mouth care was provided by Certific Nursing Assistants to the residents identified on 03/08/13 and will cont per ADL Care Guide. Also beginning 3/08/13 highlighted in Orientation p. 3. An in-service was conducted and Supervisors 3/08/13-3/31/13 for Licensed Nurses and Certified Nursin Assistants regarding mouth care/ora hygiene and the requirements that facility staff is responsible for performed documenting. 4. Observation audits of 10 residual will be performed by the Unit coor or Supervisor during rounds five the one week, then three times a week three weeks, then once a week time months or until compliance is ach The results of this audit will be not reviewed in the monthly Quality A Performance Improvement meeting results will be brought to the mon Quality Assurance Performance Improvement Incompliance I	by DON or ng all the orming sidents redinator mes for k for nes two leved. The thly ctor of utified will ance littee as	
	(11pm-7am) indica	ted that NA #1 had not DL care for Resident #26.					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1		CONSTRUCTION	(X3) DATE 5		
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		c		
		345070	B. WING			1	7/2013	
	NOVIDER OR SUPPLIER	ATION CENTER		41	EET ADDRESS, CITY, STATE, ZIP CODE I1 S LASALLE STREET URHAM, NC 27705			
DUKRAM				<u> </u>	PROVIDER'S PLAN OF CORRECTION	-	(X5)	
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F 241	At 1:45pm on 3/6/13, covered with a thick, covering the surface teeth. At 2:47pm on 3/6/13 asked [NA #1] this meteth. She just ignorn neglected when I asl me." His teeth were white/yellow coating in between all visible. The NA assignment third shift (11pm-7an worked and was assed to brush my tem My arms can't take it telephone interview 3/7/13. At 10:55am on 3/7/1 regarding ADL care, washing a person's shaving. It is what I that is usually done should be done on a At 11:31am on 3/7/1	Resident #26's teeth were white/yellow coating of and in between all visible. Resident #26 stated, "I corning if she would brush my red me. It makes me feel k them and they won't help covered with a thick, covering the surface of and a teeth. sheet dated 3/6/13 for the m) indicated that NA#2 signed to Resident #26. 3, Resident #26 stated, "I eth myself, but not anymore. t." NA#2 was unavailable for at 12:00pm and 3:18pm on 13, the DON was interviewed. She stated, "That is from face, brushing teeth, and call AM care. That is care on the first shift. AM care a daily basis."	F	241	ensure continued compliance. The Assurance Performance Improveme Committee consists of the Administ the Director of Nursing, MDS Coord Admission Coordinator, Rehabilitati Manager, Medical Director, Directo Social Services, Environmental Serv	nt rator, inator, on r of		
	At 10:55am on 3/7/1 regarding ADL care. washing a person's shaving. It is what I that is usually done should be done on a At 11:31am on 3/7/1 She stated, "I work ADL care that included baths, showers needed and brushinget them up or whee	She stated, "That is from face, brushing teeth, and call AM care. That is care on the first shift. AM care a daily basis."						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMPLETED	
		345070	B. WING			03/07/20	13
	ROVIDER OR SUPPLIER NURSING & REHABILI	TATION CENTER		41	EET ADDRESS, CITY, STATE, ZIP CODE 1 S LASALLE STREET URHAM, NC 27705	·	<u>.</u>
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F 241 F 280 SS=D	required she stated, when I took care of I get him up in his chat He uses the toothbrokim. He uses his ha #1 also said, "Brush every day." 483.20(d)(3), 483.10 PARTICIPATE PLANTICIPATE P	at #26 and the mouth care he "I think it was [3/3/2013] (Resident #26]. Sometimes I air and he brushes his teeth. ush and I stand there with ands good, kinda, sort of." NA ing teeth should be done O(k)(2) RIGHT TO NNING CARE-REVISE CP e right, unless adjudged rwise found to be the laws of the State, to ang care and treatment or it treatment. are plan must be developed		241	 Resident #18 care plan and ADL Carguide has been updated on 3/08/13 to reflect the current splint/device goals, interventions and instructions. An audit was completed by the ME Coordinator and Supervisors on 03/11/for residents with splints/devices havin potential to be affected to ensure care goals, interventions/instructions were updated on resident care plan and ADL Guide. Clinical/Rehabilitation Manager(s) Minimum Data Set Coordinator were in serviced on 03/11/13 by Director of Nation F280 requirements to include 	os 13 g the plan . Care	1/13
	for the resident, and disciplines as determent, to the extent put the resident, the resident, the resident representative and revised by a teach assessment. This REQUIREMENT by: Based on staff interfacility failed to upd	I other appropriate staff in mined by the resident's needs, racticable, the participation of sident's family or the resident's; and periodically reviewed am of qualified persons after IT is not met as evidenced rviews and record review the ate a care plan for contracture care plan lacked instructions			developing, revising and updating the resident's plan of care periodically and needs change. 4. The DON, Unit Organizer and Supervisors will audit five care plans w splints/devices 5 days week for four w then five care plans once a month for months and/or until compliance is ach to ensure care plan goals, intervention updated. The results of this audit will k noted and reviewed in the monthly Qu	rith eeks, 2 ileved as are	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE S COMPL	LETED	
		345070	B. WING_			1	7/2013	
	ROVIDER OR SUPPLIER NURSING & REHABILITA	ATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 411 S LASALLE STREET DURHAM, NC 27705					
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F 280	for nursing to apply a when the splint was r of three sampled resi Resident #18. The findings included Resident #18 was as 10/7/10 with diagnose dementia, and diabet Minimum Data Set (Minimum Data Set (Minimum Data Set) was an Resident #18 require assistance by staff for The quarterly MDS as limitations in movement extremities. Review of a care plar problems of falls and living. These problem physical mobility due contracture. There we related to actual continuse of the carrots by as an approach under care plan. The physician 's ordioccupational therapy a splint for four hours Resident #18 was to device shaped like a the fingers from closi splints were not worn	device in the right hand not used by therapy for one dents with contractures. Imitted to the facility on es including hemiplegia, es. Review of a quarterly MDS) dated 11/28/12 18 had long and short term d could not be interviewed.	F	280	Assurance Performance Improvement meeting. The results will be brought monthly Quality Assurance Performation Improvement Meeting by the Direct Nursing. Any issues or trends identified addressed by the Quality Assurant Performance Improvement Committed arise and the plan will be revised ensure continued compliance. The Committee consists of the Administ the Director of Nursing, MDS Coording Admission Coordinator, Rehabilitati Manager, Medical Director, Director Social Services, Environmental Services, Env	to the ince or of fied will ice tee as ed to Quality interator, inator, on r of		

	S FOR MEDICARE & DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE (CONSTRUCTION	(X3) DATE SI	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDI	NG		С	
		345070	B. WING			03/07/2013	
	OVIDER OR SUPPLIER		. 	41	ET ADDRESS, CITY, STATE, ZIP CODE 1 S LASALLE STREET JRHAM, NC 27705		
(X4) ID PREFIX TAG	CACH DESIGNA	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE ATE	(X6) COMPLETION DATE
F 280	revealed she was no supposed to have the splint was removed to	#1 on 3/6/13 at 4:00 PM it aware Resident #18 was e carrot in place after the from the right hand.	F	280	F 312 1.Resident #26 was provided mouth 03/07/13 and thereafter per ADL Ca	n care on	3)31/13
F 312 SS=E	Interview with nurse revealed she was not have a carrot in place interview revealed the Resident #18 and the splint and use of the Interview on 3/6/13 nurse #2 revealed use to be done for changed decreased and interfor areas on the carshe would make sum nature would be upour may not make it of communicating use administrative morned 483.25(a)(3) ADL CONTRES A resident who is used to have a controlled the property of the communication of the communication and all yliving receives maintain good nutricand oral hygiene.	#2 on 3/6/13 at 4:13 PM of aware Resident # 18 should the in her right hand. Further herapy was working with ley were responsible for the le carrot. at 2:10 PM with administrative pdates to the care plans used ges. Staffing hours had been im changes were not made le plan. She further explained for problems of a long term dated, but other problems may to the care plan. The process pdates occurred during the ling meetings. ARE PROVIDED FOR IDENTS mable to carry out activities of the necessary services to tion, grooming, and personal		F 312	2. A list of residents having the p to be affected was compiled on 3/0 the Minimum Data Set Coordinator the assessment criteria: (setup and supervision through total care – pe hygiene) from the Minimum Data S Mouth care was provided by Certif Nursing Assistants to the residents identified on 03/08/13 and thereaf ADL Care guide. 3. An in-service was conducted and Nursing Supervisors 3/08/13-3 for Licensed Nurses and Certified I Assistants regarding mouth care/of hygiene and the requirements that facility staff is responsible for performed by the Unit coor Supervisor during rounds five to one week, then three times a week weeks, then once a week times to	os/13 by utilizing /or rsonal set 3.0. ied fter per ed by DON 3/31/13 Nursing oral t the forming sidents rdinator imes for ek for 3	
	This REQUIREME	NT is not met as evidenced			weeks, then once a week times to	vo montn	3

AND PLAN OF CORRECTION DENTIFICATION NUMBER: A. BUILDING C 345070 B. WNG STREET ADDRESS, CITY, STATE, ZIP CODE 411 S LASALLE STREET DURHAM, NC 27705 CALID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION COMPI	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
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DURHAM NURSING & REHABILITATION CENTER DURHAM NURSING & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (PACH DEFICIENCIES (PACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DIEMFIFMIO MYORMATION) FOR Based on observation, record review, and interviews with resident and staff, the facility failed to provide assistance for brushing a resident's teeth for 1 of 2 sampled residents (Resident #26) reviewed in Stage 2 for activities of daily living (ADLs). Findings include: Resident #26 was readmitted to the facility on 4/15/11, Resident #26 had diagnoses including chronic obstructive pulmonary disease, chronic pain, and osteoarthritls. The care pian, most recently updated on 11/2/111, inclicated the resident required assistance with and/or provision for ADLs which include mouth care. Goals included that the resident would seprence cleanliness and comfort each day and receive assistance, as needed, for ADLs each day. Interventions included that staff would set up supplies and cue the resident to perform oral hygiene twice a day. Resident #26's annual Minimum Data Set (MDS), dated 11/19/12, indicated the resident was cognitively intact, participated in the assessment, and did not exhibit behaviors of rejecting care. The resident's functional status indicated that for personal hygiens, self-performance, he needed			345070	B. WNG			1	
SUMMARY STATEMENT OF DEFICIENCIES PRECEDED BY FULL PROVIDERS PLANCE CORRECTION COORDING ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDERS PLANCE CORRECTION ACTION SHOULD BE (EACH DEFICIENCY) MUST BE PRECEDED BY FULL PROVIDER SEAL CORRECTION ACTION SHOULD BE (EACH DEFICIENCY) PREFIX PROVIDERS PLANCE CORRECTION ACTION SHOULD BE (EACH CORRECTION EACH CORRECTION EACH CORRECTION EACH CORRECTION EACH CORRECTION EACH CORRECTION SHOULD BE (EACH CORRECTION EACH CORRECTED ACTION EACH CORRECTE					41	11 S LASALLE STREET		
SUMMARY SIALEMENT OF DEPLECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 312 Continued From page 6 by: Based on observation, record review, and interviews with resident and staff, the facility failed to provide assistance for brushing a resident's teeth for 1 of 2 sampled residents (Resident #26) reviewed in Stage 2 for activities of daily living (ADLs). Findings include: Resident #26 was readmitted to the facility on 4/15/11, Resident #26 had diagnoses including chronic obstructive pulmonary disease, chronic pain, and osteoarthritis. The care plan, most recently updated on 11/2/1/11, indicated the resident required assistance with and/or provision for ADLs which include mouth care. Goals included that the resident would experience cleanliness and comfort each day and receive assistance, as needed, for ADLs each day. Interventions included that staff would set up supplies and oue the resident to perform oral hygiene twice a day. Resident #26's annual Minimum Data Set (MDS), dated 11/19/12, indicated the resident was cognitively intact, participated in the assessment, and did not exhibit behaviors of rejecting care. The resident's functional status indicated that for personal hygiene, self-performance, he needed							TION	(X6)
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The Nursing Summary assessment dated 2/28/13 stated the resident was "cognitively intact. He is able to make decisions regarding his clothing and		by: Based on observinterviews with resident for 1 of 2 streviewed in Stag (ADLs). Findings include: Resident #26 was 4/15/11. Resident chronic obstruction pain, and osteodom the care plan, resident would ecomfort each daneeded, for ADL included that state the resident to pain and of the composition of the care plan, resident would ecomfort each daneeded, for ADL included that state the resident to pain and did not exhip the resident's find personal hygien extensive assists.	vation, record review, and esident and staff, the facility failed ance for brushing a resident's ampled residents (Resident #26) e 2 for activities of daily living e 2 for activities of daily living e 2 for activities of daily living e 3 for activities of daily living e 4 for activities of daily living e 5 for activities of daily living e 6 for activities of daily living e 7 for activities of daily living e 8 for activities e 8 for activities e 9 for activities e 1	F	312	and/or until compliance achieved results of this audit will be noted reviewed in the monthly Quality Performance Improvement meet results will be brought to the mo Quality Assurance Performance Improvement Meeting by the Di Nursing. Any issues or trends id be addressed by the Quality Assurance Improvement Com they arise and the plan will be reensure continued compliance. Assurance Performance Improve Committee consists of the Admithe Director of Nursing, MDS Co Admission Coordinator, Rehabili Manager, Medical Director, D	d and Assurance ting. The onthly irector of entified will urance mittee as evised to The Quality ement inistrator, oordinator, litation ector of	

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l .	OVIDER OR SUPPLIER		<u> </u>	411	ET ADDRESS, CITY, STATE, ZIP CODE S LASALLE STREET IRHAM, NC 27705			
DURHAM					PROMDER'S PLAN OF CORRECTIO	N	(X5) COMPLETION	
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	Continued From pag stated the resident, 'extensive to total ass to his [diagnoses] of osteoarthritis, multi j pain." At 11:43am on 3/4/1 "They don't help me asked them to help they would do it 'wh Resident #26's teeth covered with a thick covering the surface teeth. At 1:50pm on 3/5/1 one has brushed m asked them. It was shift." Resident #26 thick, white/yellow and in between all the NA assignment third shift (11pm-7a worked and was as A review of ADL ca (11pm-7am) indica documented any A at 1:45pm on 3/6/2 and 15 thick with a third shift (11pm-7am) indica documented any A at 1:45pm on 3/6/2 and 15 thick as third shift (11pm-7am) indicated and was as a second with a third shift (11pm-7am) indicated any A thir	continues to require sist with his ADLs secondary [right] hip disarticulation, oint contractures and chronic 3, Resident #26 stated, brush my teeth. I have me, but they don't. They said then they get around to it'." In were observed to be see white/yellow coating the of and in between all visible 3, Resident #26 stated, "No ty teeth today or yesterday. I the either on the third shift or first the seth were covered with a coating covering the surface of	F	312				
	acked INA #11 this	13, Resident #26 stated, " I s morning if she would brush my nored me. It makes me feel			·		shoot Page 8 of 1	

STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE S		
AND PLAN OF	CORRECTION	INCUTATION TO MOREO.	A. BUILD	ING _		С		
		345070	B. WING			03/0	7/2013	
	ROVIDER OR SUPPLIER NURSING & REHABILIT	ATION CENTER		41	EET ADDRESS, CITY, STATE, ZIP CODE 11 S LASALLE STREET URHAM, NC 27705			
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F 312	neglected when I ask me." His teeth were white/yellow coating in between all visible. The NA assignment third shift (11pm-7am worked and was ass. At 10:25am on 3/7/1 used to brush my tee My arms can't take it telephone interview a 3/7/13. At 10:55am on 3/7/1 regarding ADL care, washing a person's shaving. It is what I that is usually done should be done on a At 11:31am on 3/7/1 She stated, "I work ADL care that included baths, showers, needed and brushing them up or wher When asked about the assigned to Resider required she stated, when I took care of get him up in his challenges in the uses the toothbrushim. He uses his he	them and they won't help covered with a thick, covering the surface of and teeth. sheet dated 3/6/13 for the nindicated that NA#2 igned to Resident #26. 3, Resident #26 stated, "I she myself, but not anymore." NA#2 was unavailable for at 12:00pm and 3:18pm on 3, the DON was interviewed She stated, "That is from face, brushing teeth, and call AM care. That is care on the first shift. AM care	F	312				
F 318	483.25(e)(2) INCRE	ASE/PREVENT DECREASE		F 31	8			

CENTER	S FOR MEDICARE &	MEDICAID SERVICES	CAST PRINT	TIPI F	CONSTRUCTION	(X3) DATE S	URVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A BUILDING			COMPLETED		
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	OVIDER OR SUPPLIER		<u>.l</u>	4	EET ADDRESS, CITY, STATE, ZIP CODE 11 S LASALLE STREET DURHAM, NC 27705		
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F 318 SS=D	IN RANGE OF MOTO Based on the comprove resident, the facility of with a limited range of appropriate treatmer range of motion and decrease in range of medical record review apply splinting device Occupational Theraterist with control of the findings included Resident #18 was 10/7/10 with diagnor dementia, and diab Minimum Data Set recorded Resident memory problems Resident #18 requires assistance by staff The guarterly MDS	consequences of a services to increase from the formation receives and services to increase from the formation. The increase from the from the from the formation of the format	F	: 318	1. Resident # 18 splint/device is as instructed by occupational there beginning on 3/7/13. 2. Residents with splints/devices have the potential to be affected by reviewed by Director of Nursing, Supervisors and Unit Organizers as 3/11/13 for application of splint/dorders and/or Occupational Thera instruction. ADL Care Guides update reflect current resident needs. Be 3/11/13 will be highlighted in Oriel Process. 3. An in-service beginning 3/11 3/31/13 conducted by Director of Nursing Supervisors and Unit Org Licensed Nurses and Certified Nurses and Certified Nurses and Certified Nurses and Splints/devices according to orders/Occupational Therapist in The in-service included the care of the resident is communicated staff on the ADL Care Guide (Kiost	apy on athat have been s of levice per py ated to ginning entation /13 to f Nursing, anizer for rsing of estructions. plan needs to the care	
	problems of falls a living related to im	lan dated 6/14/12 revealed nd decreased activity of daily paired physical mobility due to ulti-joint contracture. There es related to actual contracture			4. The DON, Nursing Supervisor Organizer will audit five care play splints/devices five times a week	ans with	

STATEMENT C AND PLAN OF	OF DEFICIENCIÉS CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		CONSTRUCTION	COMPL	ETED	
		345070	B. WING			03/0	7/2013	
	OVIDER OR SUPPLIER		ID	411	ET ADDRESS, CITY, STATE, ZIP CODE 1 S LASALLE STREET JRHAM, NC 27705 PROVIDER'S PLAN OF CORRECTION			
(X4) ID PREFIX TAG	/EACH DEFIGIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETION DATE	
F 318	management. Review of the occupion 2/26/13 revealed an Resident #18 was redecline in range of modeline in rangement. Occupte right hand, apply upgrade to six hours carrots (positioning of which would prevent the palm) when splir nursing staff was to placement in her hand. Review of the therapy revealed education is staff on placing the object of the palm. Nursing staff were in resident to ensure the hand. Observations on 3/4 Resident #18 did not hand, and the carrous observations on 3/5 Resident #18 did not hand, and the carrous observations on 3/6 Resident #18 did not hand, and the carrous observations on 3/6 Resident #18 did not hand, and the carrous observations on 3/6 Resident #18 did not hand, and the carrous observations on 3/6 Resident #18 did not hand, and the carrous observations on 3/6 Resident #18 did not hand, and the carrous observations on 3/6 Resident #18 did not hand, and the carrous observations on 3/6 Resident #18 did not hand.	ational therapy notes dated evaluation was completed. ferred to therapy due to a notion in the right hand. Ition, an order was written by 1/26/13 for the splinting pational therapy would treat a splint for four hours, then. Resident #18 was to wear device shaped like a carrot the fingers from closing into the were not worn. The monitor the carrots to ensure and. In the resident 's right was removed by therapy. The structed to monitor the carrot was kept in her 1/13 at 2:47 PM revealed thave the carrot in her hand.	F	318	weeks then five care plans once a magnetic care plan goals, intervention updated. The results of this audit would and reviewed in the monthly Assurance Performance Improvement meeting. The results will be brough monthly Quality Assurance Perform Improvement Meeting by the Direct Nursing. Any issues or trends identified be addressed by the Quality Assurance Performance Improvement Committely arise and the plan will be revisensure continued compliance. The Assurance Performance Improvement Committely arise of the Administing the Director of Nursing, MDS Coord Admission Coordinator, Rehabilitat Manager, Medical Director, Director Social Services, Environmental Services, Environmental Services.	eved to sare and a sare all be Quality and a sare and a		

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING _ AND PLAN OF CORRECTION 03/07/2013 B. WNG 345070 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 411 S LASALLE STREET **DURHAM NURSING & REHABILITATION CENTER DURHAM, NC 27705** (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PŘEFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG F 318 Continued From page 11 F 318 revealed she was not aware Resident #18 was supposed to have the carrot in place after the splint was removed from the right hand. During the interview, Nurse #1 entered Resident #18's room, looked in the bedside drawers and on the floor, but did not find the carrot. Interview with Aide #1 on 3/6/13 at 4:10 PM revealed she was the aide for Resident #18 and was not aware a carrot was to be used in her right hand. Interview with Nurse #2 on 3/6/13 at 4:13 PM revealed she was the nurse for Resident #18, but was not aware the resident should have a carrot in place in her right hand. Further interview revealed therapy was working with Resident #18 and they were responsible for the splint and use of the carrot. Interview with occupational therapy staff member on 3/7/13 at 10:14 AM revealed she placed a splint on the right hand for four hours. After the splint was removed, the carrot was placed in the right hand. Continued interview revealed the nursing staff were to place the carrot in the right hand. If the carrot was soiled, the staff could put a towel in her hand. A therapy note for education was provided to an aide, a nurse and charge nurse. When asked if the carrot was missing on 3/6/13, she reported it was behind the dresser in the room. When asked how important was it for nursing staff to ensure the carrot was in Resident #18 right hand, she responded "very important." It was further explained the resident did have slight movement in her fingers and the carrot could come out of her hand.

PRINTED: 03/22/2013 FORM APPROVED

STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION /		DATE SURVEY COMPLETED
VIAN LEMM OL	ANTHORNE		B, WING			j	C 03/07/20 <u>13</u>
	OVIDER OR SUPPLIER	345070 TATION CENTER	B, vinto	411	ET ADDRESS, CITY, STATE, ZIP CODE S LASALLE STREET RHAM, NC 27705	<u> </u>	
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FOLL		ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	-lould be	(X6) COMPLETION DATE
F 318	nursing staff membe the updates on resid Kiosk (computer for Nursing staff would r	e 12 at 3:00 PM with administrative r revealed the aides know ent care by reviewing the documentation by the aides). monitor the resident by ervations of the resident.	F	318			
				A. de constitution of the second seco			
,				and the state of t			
		•					

PRINTED: 04/15/2013 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB-NO, 0938-6391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A. BUILDING 01 - MAIN BUILDING 01 IDENTIFICATION NUMBER: (01/3) n4/10/2013 APR 2 B. WING 345070 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 411 S LASALLE STREET 🔆 DURHAM, NC 27705 **DURHAM NURSING & REHABILITATION CENTER** PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PREFIX TAG This Plan of Correction is submitted as required under State and Federal Law. The K 000 INITIAL COMMENTS facility's submission of the Plan of K 000 Correction does not constitute an admission This Life Safety Code(LSC) survey was on the part of the facility that the findings conducted as per The Code of Federal Register cited are accurate, that the findings at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced constitute a deficiency, or that the scope publications. This building is Type III construction, and severity determination is correct. one story, with a complete automatic sprinkler Because the facility makes no such system. The facility has a license for 126 beds, admissions, the statement made in the Plan current census was 81. of Correction cannot be used against the The deficiencies determined during the survey facility in any subsequent administrative or are as follows: K 032 NFPA 101 LIFE SAFETY CODE STANDARD civil proceeding. K 032 Not less than two exits, remote from each other, SS≈D K Tag 032 are provided for each floor or fire section of the building. Only one of these two exits may be a 1. The Center's Maintenance Director checked all exit doors for releasing 19.2.4.1, 19.2.4.2 horizontal exit. with fire alarm activation. Simplex Grinnell installed 2 relays in the fire alarm system to deactivate the maglocks on all This STANDARD is not met as evidenced by: doors when fire alarm is activated. 42 CFR 483.70(a) The Maintenance Director will run Based on observation on 4/10/2013 at approximately noon the following exit egress was a weekly check for doors to release non-compliant, specific findings include; exit during fire alarm activation for 4 doors #2 and #10 did not release with fire alarm weeks then check door release activation. The doors did release with delayed following our fire drill schedule and egress. K 045 NFPA 101 LIFE SAFETY CODE STANDARD place results on the fire drill K 045 Illumination of means of egress, including exit record. SS=D Results of these weekly and discharge, is arranged so that fallure of any single monthly checks will be submitted lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency to the Monthly Safety Committee

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

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

lighting in accordance with section 7.8.)

EVENTID: QTOR21

19.2.8

-Facility-ID=923264---

TITLE

-If-continuation-sheet-Page_1-of-4

(X6) DATE

PRINTED: 04/15/2013 FORM APPROVED OMB-NO-0938-0391

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CON A. BUILDING 01 - M			CONSTRUCTION CO	ATE SURVEY MAPLETED
		345070	B. WING	CTOF	ET ADDRESS, CITY, STATE, ZIP GODE	*
IAME OF PF	OVIDER OR SUPPLIER	NU STATION CENTER		411	I S LASALLE STREET	
		ATEMENT OF DEFICIENCIES	ID PREF	<u> </u>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE PROPERTY OF THE APPROPRIATE	COMPLETION DATE
(X4) ID PREFIX TAG	(EACH DEFICIENC' REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	· TAC	•	for review. The Safety Committee	
K 045	Continued From pa	age 1	К	045	minutes will be reviewed in the Monthly Quality Assurance	•
K 052 SS=D	42 CFR 483.70(a) By observation on the following egree non-compliant, spi prayer room would NFPA 101 LIFE S A fire alarm systel installed, tested, a with NFPA 70 Nat 72. The system has	This STANDARD is not met as evidenced by: 42 CFR 483.70(a) By observation on 4/10/13 at approximately noon the following egress illumination was observed at the compliant, specific findings include; the the prayer room would leave the patient in darkness. NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is Installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFP 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4		(052	Performance Improvement meeting. The QAPI committee consists of the Administrator, the Director of Nursing, MDS Coordinator, Admissions Coordinator, Rehabilitation Manager, Medical Director, Director of Social Services, Environmental Services, Director of Maintenance, Dietary Manager and Activity Manger. K Tag 045 1. The Center's Maintenance Dire inspected all current egress illumination for compliance. 2. Lighting was installed on 4/18, in the Prayer room. The light is wired into emergency circuit E A1-8.	ria M- 4/1/13
K 06 \$S=	42 CFR 483,70(Based on record facility fire alarm accordance with findings include; testing had not b two years. NFPA 101 LIFE	o is not met as evidenced by: (a) review and staff interview, the system was not being tested in NFPA 70 and 72, specific the smoke detector sensitivity been conducted within the past SAFETY CODE STANDARD atic sprinkler systems are		K 06	3. System was checked on emery power. This check will be done weekly time four weeks, then monthly with fire drill schedu Results will be recorded on the drill form. 4. Results of these weekly and monthly checks will be submit to the Monthly Safety Committee.	e. e fire

PRINTED: 04/15/2013 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB-NO:-0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES. (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION 04/10/2013 B, WING 345070 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 411 S LASALLE STREET **DURHAM NURSING & REHABILITATION CENTER** DURHAM, NC 27705 (X6) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG for review. The Safety Committee minutes will be reviewed in the K 062 Continued From page 2 K 062 Monthly Quality Assurance continuously maintained in reliable operating condition and are inspected and tested Performance Improvement 19.7.6, 4.6.12, NFPA 13, NFPA meeting. The QAPI committee periodically. consists of the Administrator, the 25, 9.7.5 Director of Nursing, MDS Coordinator, Admissions This STANDARD is not met as evidenced by: 4/19/13 Coordinator, Rehabilitation 42 CFR 483.70(a) Manager, Medical Director, Based on record review and staff interview, the facility sprinkler system was not being tested in Director of Social Services, accordance with NFPA 25 - Standard for the Environmental Services, Director of Inspection, Testing and Maintenance of Maintenance, Dietary Manager Water-Based Fire Protection Systems (1999 edition), documentation indicated failure to and Activity Manger. demonstrate inspection, testing and maintenance K Tag 052 in accordance with NFPA 25 1-4.2, specific We are in compliance with this tag. findings include: Sensitivity testing was done on 3/4/12. . A Documentation indicated the quarterly inspections had not been completed over the past Copy scanned with the POC. year. Records indicate a quarterly inspection 5/8/12 and an annual inspection 10/4/12. K Tag 062 B. Documentation indicated the five year Testing of the center's sprinkler calibration for all gauges had been last conducted system was completed on 4/11/13 on 2/1/08. by Simplex Grinnell. K 067 NFPA 101 LIFE SAFETY CODE STANDARD K 067 2. For compliance all quarterly fire Heating, ventilating, and air conditioning comply SS=F sprinkler inspections will be with the provisions of section 9.2 and are installed schedule one year in advance. (in accordance with the manufacturer's See schedule with Simplex Grinnell 19.5.2.1, 9.2, NFPA 90A, specifications. sent with POC)

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

19.5.2.2

Event ID: QTOR21

Facility ID: 923264

If continuation sheet Page 3 of 4

DEPAR	MENT OF HEALTH	AND HUMAN SERVICES	No.			FORM A MB-NO-C	04/15/2013 PPROVED 0938-0391 ×
CENTER	ERS FOR MEDICARE & MEDICAID SERVICES INT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A BUILDING 01 - MAIN BUILDING 01					(X3) DATE SURVEY COMPLETED	
•		345070	B. WING	·		04/10/2013	
NAME OF PROVIDER OR SUPPLIER DURHAM NURSING & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES					EET ADDRESS, CITY, STATE, ZIP CODE 11 S LASALLE STREET URHAM, NC 27705 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	, os i	(X5) COMPLETION DATE
(X4) ID PREFIX TAG	······································	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	<i>D</i> A16
K 067	This STANDARD I At the time of survi corridor as a return is requested, the pr following conditions units must be equip (2) There must be detection system.	ge 3 s not met as evidenced by: ey, the facility was using the air plenum. Note: If a waiver evider must certify that the are met: (1) Air handling eped with smoke detectors. a complete corridor smoke (3) Smoke detectors must be erm system. (4) Fire alarm flown all air handling units	K	067	 Waiver requested as center the corridor as a return air Air handling units are equiwith smoke detectors Smoke detectors are wired fire alarm system Fire alarm system shuts do air handling units when according to the content of the content	plenum. pped I to the own all	419/13
FORM CMS-	2567(02-99) Pravious Version	is Obsolete Event ID: QTO	R21	F	aclity ID: 923264 If conf	inuation sh	eet Page 4 of 4